References

1 Galván Casas C, Catalá A, Curretero Hernández G et al. Classification of the cutaneous manifestations of COVID-19: a rapid prospective nationwide consensus study in Spain with 375 cases. Br J Dermatol 2020; 183: 71–7.

2 Seirafianpour F, Sodagar S, Pour Mohammad A et al. Cutaneous manifestations and considerations in COVID-19 pandemic: a systematic review. Dermatol Ther 2020; 33: e13986.

3 Zhao Q, Fang X, Pang Z et al. COVID-19 and cutaneous manifestations: a systematic review. J Eur Acad Dermatol Venereol 2020; 34: 2505–10.

4 Li H, Zhao Y, Zhou L, Hu J. Cutaneous, skin histopathological manifestations and relationship to COVID-19 infection patients. Dermatol Ther 2020; 33: e14157.

5 Catalá Gonzalo A, Galván Casus C. COVID-19 and the skin. Actas Dermosifiliogr 2020; 111: 447–9.

Dealing with suspended new routine general dermatology referrals during the COVID-19 pandemic: a virtual model from our local departmental experience
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The burden of skin disease is reflected in ever-increasing waiting times for specialist care.1–3 The COVID-19 pandemic brought further unexpected disarray, with all routine outpatient clinical activity coming to an abrupt halt, obligating dermatology departments across the UK to rethink models of care.

We looked at 381 routine general primary care referrals to our dermatology department made between August and October 2019. All routine face-to-face (FTF) clinics in this department had been suspended since March 2020 due to COVID-19, creating an unpredictable delay for this patient cohort. We devised a triage model with the aim of bypassing the need for FTF consultation in most cases. All referrals were assessed by a consultant dermatologist and streamlined into one of three groups: (i) those who would need to be seen FTF; (ii) those suitable for clinical photographs and a telephone consultation; and (iii) those suitable for a telephone consultation without images. Clinical photographs were preferred to video consultations because of the superior image resolution and availability of technology.

Only 23% (88/381) of referrals were triaged to an FTF consultation. This essentially comprised cases considered inappropriate for clinical photography (such as genital dermatoses) or those with absent or subtle cutaneous signs. Illustrative examples of the latter include generalized pruritus, for which physical examination is required in order to identify subtle xerosis or even scabies infestation, and psychocutaneous disorders such as delusional infestations, which are unlikely to yield photographic clues and for which the diagnosis is usually one of exclusion, requiring an initial physical examination at the very least. Hair disorders can also be challenging, and virtual assessment limits the opportunity for trichoscopy and for assessing hair density across the scalp.

The majority of referrals were triaged for virtual consultation (Table 1). Of these, 64% (244/381) were triaged into the second group, which required administrative staff to contact patients and request photographs via a secure National Health Service email address. Images were subsequently uploaded onto the electronic patient record and
are fortunate to have a dedicated ‘booking pod’ requesting photographs was longer than usual, and we administration time for coordinating virtual consultations and FTF clinic slots for the most appropriate patients. Admin-
istration team who have risen to this challenge and worked flexibly to deliver an adapted service. Our model has enabled us to provide continued routine care under these unusual circumstances of COVID-19, but looking ahead into a post-pandemic future, we hope to use lessons learnt to continue this service and reduce FTF clinic throughput in the longer term. Initial verbal feedback from patients has been positive, but we aim to formally assess both patient and clinician satisfaction with the virtual service in the future.

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References
1 Schofield J, Grindlay D, Williams HC. Skin conditions in the UK: a health care needs assessment. Centre of Evidence Based Dermatology, University of Nottingham. 2009 Available at: https://www.nottingham.ac.uk/research/h/groups/cedb/documents/hcnskinconditionsuk2009.pdf (accessed 24 June 2020).
2 Expert Working Group (EWG). Making real our shared vision for the NHS: optimising the treatment and care of people with long-term skin conditions in England. 2018. Association of the British Pharmaceutical Industry Dermatology Initiative (ABPI DI). Available at: https://www.abpi.org.uk/media/4684/der-0080-0517-dermatology_initiative_report_rev16.pdf (accessed 15 June 2020).
3 Transforming elective care services dermatology. NHS England 2019. Available at: https://www.england.nhs.uk/wp-content/uploads/2019/01/dermatology-elective-care-handbook-v1.pdf (accessed 4 July 2020).

Chilblains and COVID-19: can recent epidemiological data shed light on the aetiological debate?

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In March and April 2020, at the peak of the COVID-19 pandemic, several countries imposed lockdown measures. Concurrently, a significant number of chilblains were observed in otherwise healthy adolescents and young adults. The physiopathology of these chilblains has not been completely elucidated and their direct link to COVID-19 remains unconfirmed and debated.1 Reverse transcription (RT)-PCR on nasopharyngeal swabs and anti-SARS-

Table 1 Case mix of patients triaged for virtual consultation.

| Group 2 | Group 3 |
|---------|---------|
| Reason for referral | Reason for referral |
| % | % |
| Acne | 47 | Eczema | 17 |
| Eczema | 18 | Psoriasis | 20 |
| Psoriasis | 11 | Cutaneous infection | 10 |
| Cutaneous infection | 5 | Alopecia | 7 |
| Pigmentation problem | 3 | Urticaria | 10 |
| Urticaria | 2 | Intertrigo | 7 |
| Vasculitis | 1 | Lichen planus | 3 |
| Drug-related | 1 | Hidradenitis suppurativa | 3 |
| Tattoo reaction | 0.5 | Other inflammatory | 23 |
| Other inflammatory | 2 | | |
| Other | 9.5 | | |

Group 2 were for clinical photographs with telephone consultation and Group 3 were telephone consultation only.

the patient was booked for a virtual clinic. Most (75%) of these patients had successful telephone consultations following receipt of clinical photographs. Patients with acne comprised a significant proportion of this group, and were reviewed and followed up in a dedicated virtual acne clinic. Of the patients receiving virtual consults, 50% were diagnosed and discharged after the initial consultation, while the remaining 50% required follow-up or were referred for further treatment or investigation. Photographs were of variable quality, but nonetheless all except one were considered clear enough to establish a diagnosis and formulate a management plan. Only seven patients were converted to FTF appointments, with reasons including patient choice, inability of the patient to send photographs or complexity of the case.

Group 3 (13%) represented patients with a previous confirmed diagnosis from the dermatology department, or those with a likely diagnosis of urticaria, who were considered suitable for a direct telephone consultation. The majority of these patients (71%) subsequently volunteered to send photographs, which were helpful in most cases.

Interestingly, of all those triaged for virtual consultation (Groups 2 and 3), 38% were removed from the waiting list either because of resolution of the dermatosis, the patient declining appointment for some other reason or lack of patient response to the booking request. This may be an inevitable by-product of prolonged waiting times (mean 10 months) in our cohort at the time of data collection.

In conclusion, using a simple triage model, we were able to appropriately manage the majority of patients entirely virtually, of whom half were discharged successfully. This mitigated the unnecessary risk of attending hospital in the current climate, conserving the limited FTF clinic slots for the most appropriate patients. Administration time for coordinating virtual consultations and requesting photographs was longer than usual, and we are fortunate to have a dedicated ‘booking pod’