COVID-19 pandemic. In total, 269 staff members had skin problems on their hands and 65 had sought treatment. The majority \((n = 29/65; 45\%)\) had sought treatment from their general practitioner (GP). Others self-treated (37\%) or sought advice from occupational health (5\%) or dermatology (8\%). Moisturizers and topical corticosteroids were the most commonly used treatments \((n = 49/65; 75\%)\). Of those treated, 10-8\% believed their problem had resolved, with partial improvement in 66-2\% or worsening in 23-1\%. Excess hand-washing was felt to be the cause of hand problems in 90-9\% \((n = 229/252)\) and 34-1\% suspected this was also due to wearing gloves. Seventy-on per cent \((n = 180/252)\) estimated washing their hands > 15 times daily and 21-8\% estimated wearing gloves for > 9 h daily. One hundred and ninety-two had skin problems on their face: 30 (15-6\%) had sought treatment. The majority \([n = 13/29 (44-8\%); \text{one nonresponder}]\) had sought treatment from their GP. Others self-treated (37-9\%) or sought advice from occupational health (3-5\%) or dermatology (10-3\%). Seventeen per cent believed their skin problem had resolved, with partial improvement in 52\% or worsening in 31\%. In total, 188 of those who responded reported their facial skin problems as acne (55-9\%), dermatitis (25-5\%) or nasal bridge damage (18-6\%). Thirty-eight per cent wore FFP3 masks and 53-5\% estimated wearing masks for > 9 h daily. This survey confirms that the COVID-19 pandemic has led to a significant impact on the skin of hospital staff, as seen in other studies (O’Neill H, Narang I, Buckley DA et al. Occupational dermatoses during the COVID-19 pandemic: a multicentre audit in the UK and Ireland. Br J Dermatol 2021; 184: 575–7). The hands or face were affected predominantly and most staff had no previous skin issues. Staff mainly either self-treated their skin condition or consulted their GP, and most did not fully improve after initial treatment. This survey supports being proactive with continued resource allocation for close teamworking with occupational health, primary care and dermatology services to provide quick access for staff.

CD08

Occupational dermatoses during the second COVID-19 pandemic wave: an audit of 401 healthcare workers

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Healthcare workers (HCWs) assessed by dermatologists during the first wave of the COVID-19 pandemic had high rates of irritant hand dermatitis, facial dermatitis and acne triggered by wearing personal protective equipment (PPE) (Ferguson FJ, Street G, Cunningham I et al. Occupational dermatology in the time of the COVID-19 pandemic: a report of experience from London and Manchester, UK. Br J Dermatol 2021; 184: 180–2). We report data from a tertiary National Health Service trust during the second COVID-19 wave in winter 2020–21. At its peak, the Trust had 835 COVID-positive inpatients and 263 intensive care unit (ICU) beds – one of the largest ICUs in Europe. Building on the published experience of dermatology units, we ran 30 dermatology pop-up clinics over 3 weeks in allocated rest areas across the Trust: 08.00–09.00 h and 13.00–14.00 h on weekdays, from 18 January 2021. HCWs requiring formal dermatology referral were provided with letters to their line managers. In 3 weeks, 401 HCWs were assessed: 327 females and 74 males (mean age 35-2 years). The most frequently seen occupation was nurses \((n = 130; 32-4\%\)) followed by doctors \((n = 74; 18-4\%\)). On average, staff spent 9.5 h in PPE per shift. Consistent with the existing literature, the most common diagnosis was irritant hand dermatitis \((n = 186; 46-4\%)\). There was an increased incidence of acne \((n = 171; 42-6\%)\) vs. the first wave, where the reported incidence was 17\% in a multicentre study (O’Neill H, Narang I, Buckley DA et al. Occupational dermatoses during the COVID-19 pandemic: a multicentre audit in the UK and Ireland. Br J Dermatol 2021; 184: 575–7). Less common in the second wave was facial eczema \((n = 50, 12-5\%)\) and pressure injury \((n = 30; 7-5\%)\). Thirty-one (16-7\%) of the HCWs with hand dermatitis required the prescription of potent topical corticosteroids, suggesting at least moderate symptoms. The majority received emollient samples. It was rare for HCWs to require formal referral \((n = 11; 2-2\%)\). In our cohort, at least four (1-0\%) HCWs required time off work owing to their skin problems. Our data support previous reports of increased occupational dermatoses in HCWs during the COVID-19 pandemic. We highlight the sheer scale of the issue, with 401 HCWs presenting for dermatological assessment in only 3 weeks in one trust. Compared with our experience during the first wave, acne exacerbated or precipitated by masks is increasingly common, which may be due to emollient use to prevent facial eczema or injury when wearing masks.

CD09

A review of semi-virtual patch testing during the SARS-CoV-2 pandemic: practicalities and patient experience

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At the beginning of the COVID-19 pandemic, patch testing was stopped to reduce face-to-face (F2F) contact with patients. This was resumed in our centre in July 2020, when we introduced ‘semi-virtual patch testing’. This consisted of suitable patients removing patches at home on day 2 (D2) following written, verbal instructions and a brief video, before taking images of the results, which were reviewed during the day 4 (D4) F2F appointment. Our aim was to review the efficiency and practicality of the first 5 months of semi-virtual patch testing. We aimed to assess for problems or improvements vs. the standard practice of F2F review on D2. We also aimed to evaluate the service from a patients’ perspective. Our cohort was all patients booked for patch testing from July to November 2020. We retrospectively reviewed the patient notes to assess the rate and outcomes of semi-virtual patch testing. We
then contacted all patients via telephone (up to three attempts) to complete a pre-prepared Trust-approved questionnaire with their consent. Ninety-five patients were booked for patch testing, of whom 82 attended. Eighty-one completed patch testing (60 females and 21 males; average age 46 years). Seventy-five of the 81 (93%) removed patches at home on day 2. Thirteen of the 81 (16%) required additional patches to be applied on D4. Twelve of the 13 had virtual follow-up of additional results. Fifty-two of 81 patients were able to be contacted and consented to complete the questionnaire. Fifty-one of the 52 (98%) agreed or strongly agreed that ‘I was happy to have a patch test appointment arranged during the pandemic’. Forty-three of the 52 (83%) were ‘confident’ or ‘fairly confident’ in removing patches at home. Forty-six of the 47 patients (98%) who removed patches at home saved time doing so, with the average time saved being 2–3 h. Thirty-one of the 47 (66%) would have had to take time away from work or caring commitments had they had a F2F D2 appointment. Only three of 47 (6%) would have preferred to come in person for patch removal. Forty-nine of 52 (94%) reported their overall patch-test experience to be ‘very good’ or ‘good’. Our review demonstrated that semi-virtual patch testing is a practical and effective management option for the majority of patients, and produces high levels of patient satisfaction. As patients are increasingly able to take competent quality images, we would recommend this form of patch testing should continue to be used beyond the current pandemic, when appropriate.

**CD10**

**Two cases of follicular allergic contact dermatitis following the use of cyanoacrylate surgical glue**

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Follicular contact dermatitis (FCD) describes a clinical presentation of contact dermatitis that may be irritant or allergic. There are reports of this type of allergic contact dermitis (ACD) to various allergens, including potassium dichromate, cobalt, copper, formaldehyde, neomycin, nickel, paraphenylenediamine and sodium tungstate. We report two cases of ACD in a follicular pattern following the use of surgical glue after laparoscopic surgery during the summer months. Both patients were initially diagnosed with infection and treated with antibiotics with no benefit. Patient 1 was a 24-year-old woman who developed discharge from the portal sites and an itchy eczematous rash 2 weeks after laparoscopic left salpingectomy for an ectopic pregnancy, with Liquiband (butyl and octylcyanoacrylate) used to close the portal sites. She was initially treated with co-amoxiclav. Examination revealed multiple follicular papules extending beyond the portal sites over the abdomen. She had no previous history of exposure to surgical glue or artificial nails. Patch testing to several series, including the British Society for Cutaneous Allergy (BSCA) acrylate series and Liquiband diluted in white soft paraffin (WSP) (1 : 4), showed positives to ethyl cyanoacrylate (D2+, D4++) and Liquiband (D2-, D4+). Patient 2 was a 42-year-old woman who developed a pruritic follicular rash with associated discharge at the portal sites 3 days after her laparoscopic gastric hand removal. The rash was present around the portal sites, extending more widely around the sites where Dermabond surgical glue (2-octylcyanoacrylate) had been used. She was treated with flucloxacillin, with little benefit. She had a history of previous laparoscopic surgeries for cholecystectomy and appendectomy, with primary closures of the portal sites with sutures only. She had a history of working in beauty salons and working with and applying artificial nails. Examination revealed erythematous follicular papules adjacent to the scar. Patch testing to the BSCA standard and acrylate series showed positive reactions to Dermabond (2-octylcyanoacrylate) diluted in WSP (1 : 4; D2+++ , D4++) and 2-hydroxyethylmethacrylate (D2+/-, D4+). To the best of our knowledge, there are no reported cases of FCD related to cyanoacrylate. In these two cases the patch tests to cyanoacrylates did not show a follicular pattern. We report these cases to raise awareness of this unusual presentation of ACD. This led to a delay in reaching a diagnosis as infection was initially suspected. This also highlights the importance of testing to the patient’s own products as there is currently only one cyanoacrylate, ethyl cyanoacrylate.

**CD11**

**Flare-up phenomenon to LiquiBond (N-octyl cyanoacrylate): will this be a more frequent occurrence?**

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An 82-year-old woman underwent a hip revision in June 2020 with the use of a surgical glue for the primary wound closure. Over the course of the next week, she developed an angry, tender vesicular eruption with yellow crusts at the site of the wound. We treated for bullous impetigo with oral antibiotics. However, our patient had multiple negative skin swabs and an extremely itchy and uncomfortable widespread secondary interface dermitis reaction formed. The patient was otherwise fit and well, with no other comorbidities. A skin biopsy was taken and immunofluorescence (IMF) was done to rule out bullous pemphigoid; the biopsy findings showed a spongiotic dermitis with eosinophils, with negative IMF. Oral prednisolone was required alongside methotrexate, which was titrated up to 15 mg weekly. Patch testing was done to the extended European standard battery, orthopaedic, medicaments, and Dermabond and LiquiBond. On day 4 she developed a 4+ blistering reaction to LiquiBond. She simultaneously developed a florid reaction with vesiculation at the hip revision site. This is known as the flare-up phenomenon. Topical skin adhesives containing N-octyl cyanoacrylate (LiquiBond) were approved in 1998, but it is only more recently that a spate of contact allergies have been reported. The typical sequela is a cutaneous eruption a few days after surgery with