However, beyond unavoidable regional omissions, some toponyms need to be discussed, as there were numerous errors. For instance, the ‘Indian single file’ pattern originates from white settlers’ description of the Native American way of walking along a trail in North America and has nothing to do with India.

‘Mongolian spots’ and ‘Norwegian scabies’ are bygone expressions that are considered offensive today. The first term is rooted in an 18th-century pseudoscientific belief in the inferiority of all nonwhite racial groups, and was viewed as evidence for arrested evolution. The second was initially coined because the first cases of crusted scabies appeared among Norwegian patients with leprosy; it has little to do otherwise with Norwegians. The authors cite also the surprising ‘Bangladeshi syndrome’ from an obscure textbook of venereal disease from the 1980s, which is likely to be offensive for the Bengali community. The American (!) radiologist Wilma Jeanne Canada described the eponymous syndrome in 1955; her name has nothing to do with the country.

The authors did not really go very far to find the origins of some toponyms. Why is Ambras used in the syndrome of Ambras? Why is balsam of Peru so named when the plant is not native Peru? Why Congo Red or Sudan Black stains? Why are German measles so called?

Lastly, the authors have included entities whose existence is debatable such as acne Mallorca, a misnomer for an actinic folliculitis or a variant of polymorphic light eruption.

If this review had been handled with more seriousness, a critical eye and collaboration with colleagues from other continents, it had the potential to provide interesting historical perspectives and cultural understandings of some toponyms in dermatology. As it is, this review is unfortunately a missed opportunity.

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A qualitative assessment of patient satisfaction with remote dermatology consultations utilized during the UK’s first wave of the COVID-19 pandemic in a single secondary care dermatology department

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Dear Editor,

During the first wave of the SARS-CoV-2 coronavirus (COVID-19) pandemic, conventional face-to-face (F2F) appointments in many UK dermatology departments were largely replaced by remote consultations to minimize viral transmission. In our department, most new and follow-up patients were triaged to receive either telephone or video consultation, as published previously. Patients were asked to submit photographs of their skin problem via email.

To evaluate these patients’ perspectives of remote consultations, we retrospectively surveyed a random sample of patients who had appointments during the period May–June 2020 via an email invitation asking for feedback via an online questionnaire (SmartSurvey, 2020). Multiple choice answers were sought, with detailed free-text responses encouraged (Fig. 1). The primary outcomes evaluated were patient-reported satisfaction with remote consultation, and future preference of appointment type. Secondary outcomes included which areas of the process were thought to be inadequate, with suggestions for improvement invited. The questionnaire was approved locally, and data were collected in an anonymized format.

In total, 486 patients were contacted and completed responses were received from 177 (36.4%). Of these, 37 participants (21%) had attended an F2F appointment and were excluded from the analysis. Participant characteristics are summarized in Table 1.

Of the 177 participants, 76 (51%) had previously attended an F2F appointment in the department. Of these, over half (54%) thought a remote discussion was a ‘little’ or ‘much’ worse than their previous in-person consultation, with only 46% considering a remote consultation being ‘the same’ or ‘better’ in comparison.
The majority of respondents (102; 73%) reported that their remote appointment ‘fully addressed their concerns and skin problem’ and overall, 60 (43%) were ‘very satisfied’ with their remote consultation. However, if given the choice, 98 (70%) would prefer future appointments in person, with only 10 (7%) happy to receive a telephone consultation and 3 (2%) a video consultation. A sizable minority (28; 20%) had no preference for type of future consultation.

In total, 134 (96%) respondents were asked to email images prior to their appointment; 4 (3%) denied having been asked to do this and 1 (< 1%) had a video consultation so emailed images were not required. Many (n = 112; 85%) found the process of emailing photographs easy to do, but nearly half (n = 66; 47%) of patients required help from family or friends. Interestingly, none of the respondents commented on whether they perceived this to be a problem, although one patient did remark that uploading photos with the help of a family member took several hours.

The utility of photographs being relied upon was questioned by some respondents, and simple issues such as difficulties in talking on the phone if a patient was hard of hearing, plus difficulties of explaining problems without visual aids to communication, were raised. A lack of personal contact was highlighted as a negative area.

Savings were mentioned as beneficial, with regards to both National Health Service (NHS) and patient costs (e.g. time, travel expenses). The extraordinary circumstances of the global pandemic were recognized as extenuating, with satisfaction expressed by patients that they were assessed with minimal delay during the lockdown period.

Adapting to a global crisis forced the UK NHS to implement changes more rapidly than ever before. Increased use of remote consultations will undoubtedly be a legacy
of the global pandemic, and the opinions of patients who will be affected by these changes are invaluable in order to ensure effective methods of working are adopted. This assessment of patients’ perceptions about remote dermatology appointments reveals some potential for their future use, but highlights some developments and improvements needed for implementation.

We urge our dermatology colleagues, both in the UK and abroad, to consider carefully every aspect of remote consultations, when implemented alongside more traditional methods of patient interactions, to ensure good quality of healthcare provision and a high level of patient satisfaction.

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Janus kinase inhibitor treatment improved both subcutaneous and pulmonary sarcoidosis in a patient with glaucoma

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Dear Editor,

Sarcoidosis is a rare inflammatory illness characterized by the formation of noncaseating granulomas, which affects a variety of organ systems, predominantly the lungs,1 lymph nodes and skin.2,3 Sarcoidosis is usually treated with corticosteroids.4 We describe the first case of a patient with subcutaneous sarcoidosis who had contraindications to corticosteroids and was treated with tofacitinib, resulting in remission of his skin and lung disease.

A 61-year-old man presented with a 2-month history of several subcutaneous nodules involving his nates, upper arms and thighs. Physical examination revealed multiple subcutaneous nodules in clusters on his arms and legs. The nodules were firm, painless and nonpruritic, and about 30–50 mm in diameter (Fig. 1). The patient had been diagnosed with glaucoma 14 years previously, which was medically controlled. He had no other ocular complaints or shortness of breath.

Laboratory investigations showed that the patient’s serum angiotensin-converting enzyme level was within normal limits and tuberculosis (T-SPOT) result was negative. Autoimmune investigations, liver function tests and serum creatine kinase were all normal.

Histopathology of a biopsy taken from a cutaneous lesion demonstrated the presence of noncaseating granulomas, containing epithelioid cells surrounded by chronic lymphocytic infiltrate (Fig. 2a). The result of periodic acid-Schiff and acid-fast bacilli stains were negative.

Computed tomography (CT) of the chest revealed ground-glass attenuation in the bilateral lower lobes, and lymphadenopathy with involvement of the pulmonary hilum and mediastinum (Fig. 2b), but pulmonary function test was normal.

A diagnosis of sarcoidosis was thus made.

Although corticosteroids are currently considered first-line treatment, the patient’s glaucoma was a contraindication, and so he was started on treatment with tofacitinib 5 mg twice daily. The subcutaneous nodules resolved completely after 1 month (Fig. 1), and the enlarged hilar and mediastinal lymph nodes were significantly reduced, while the interstitial lung disease was also improved (Fig. 2b). During the tofacitinib administration, there was no deterioration of the patient’s glaucoma.

To our knowledge, this is the first case to report on the use of tofacitinib to treat subcutaneous sarcoidosis, with the subcutaneous nodules disappearing after 1 month of

Figure 1 Response to tofacitinib treatment in sarcoidosis. Subcutaneous nodules (white arrows) with normal overlying skin on the left upper thigh before treatment and resolution after treatment.