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## Fast-tracking teledermatology into dermatology trainee timetables, an overdue necessity in the COVID era and beyond

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Teledermatology is defined as using technology-enabled healthcare delivery models to provide dermatology patient care, from a distance.<sup>1,2</sup> The increasing use of teledermatology has primarily been driven by a significant rise in demand on Dermatology departments and a shortage of consultant dermatologists in the UK.<sup>3</sup> The British Association of Dermatologists supports the use of teledermatology as a means of improving access to dermatology professionals.<sup>4</sup> Currently, teledermatology in the NHS plays a particularly important role in triaging referrals on the skin cancer 2-week-wait (2WW)

pathway, given the necessity for rapid lesion assessment, the ever-increasing volume of 2WW referrals received by Dermatology departments, and the significant proportion of benign lesions referred that do not require a face-to-face consultation. Skin cancer 2WW referrals to our centre have sharply increased by 44.1% over the past 2 years, and in the 12 months preceding the UK COVID-19 lockdown (March 2019 to February 2020) represented 41.8% of all referrals to the Dermatology department. Teledermatology for 2WW referrals was implemented at our centre in 2019 to manage this demand.

As skin cancer services must be consultant-led, and teledermatology is particularly amenable to solitary working, there is a risk that the need to educate trainees in the practice of teledermatology is being neglected. This may be compounded by the effects of the COVID-19 pandemic, during which the over-riding priority has been to maintain clinical services. UK dermatology trainees do not currently receive any formal teledermatology training as part of the Joint Royal College of Physicians Training Board national curriculum, and so the overdue addition of teledermatology to the curriculum from August 2021 is welcomed.<sup>5</sup> We propose that supervised teledermatology clinics must be fast-tracked into trainee timetables nationwide, enabling the next generation of dermatologists to become adept and experienced in this relatively novel practice.

One way for trainees to become involved in teledermatology would be to shadow a consultant teledermatology clinic list until they become familiar with the technique. Subsequently, the trainee would take on their own reduced teledermatology list in parallel with the consultant, with a review of all trainee cases at the end of each session; the number of cases per session could be built up gradually over time. Consultant clinic templates and job plans would clearly need to be adjusted accordingly. Such an approach would mirror training techniques practised by other visual specialties such as ophthalmology and radiology. At our centre, we have also established a weekly teledermatology multidisciplinary team meeting attended by consultants and trainees, at which challenging cases are discussed for consensus; this not only enhances patient outcome and safety, but also promotes teledermatology training. We propose that such a model could be adopted widely across NHS trusts.

Fast-tracking teledermatology clinics into trainee timetables is an essential step to prepare the trainee for life as a consultant, which will inevitably involve some aspect of regular teledermatology work in the years ahead. The COVID-19 pandemic has necessitated and hastened the adoption of teledermatology across the UK, and in doing so has sharply highlighted the effectiveness, flexibility and overall importance of this practice.

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## Palmar digital vein thrombosis in a patient with COVID-19

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A 53-year-old woman presented with a 3-week history of intermittent blue nodules on the palmar digits of her hands, coincident with COVID-19 infection. The patient carried the factor V Leiden mutation. She had a strong family history but no personal history of venous thromboembolism. She had not undertaken any strenuous or heavy manual labour prior to the onset of the nodules.

On physical examination, a soft, nontender subcutaneous blue nodule, 5 mm in size, was seen near the proximal interphalangeal joint (PIPJ) on the palmar aspect of the left third digit (Fig. 1). Full physical inspection of the skin revealed no other similar cutaneous manifestations. The patient was diagnosed with palmar digital vein thrombosis.

Thrombosis of the palmar digital veins causing cutaneous nodules is rare. Digital vein thrombosis was first described in 1936 by Jadassohn.<sup>1</sup> In the few cases reported, patients were generally women, with an age range of 35–65 years. The nodules are commonly described on the palmar aspect of the digits and found at or near the level of the PIPJ, but they can also be located over the middle or distal interphalangeal joint.



**Figure 1** A small, soft, nontender, subcutaneous blue nodule, 5 mm in size, on the left third palmar digit in a patient with COVID-19.

The condition appears to have a predominance for the fourth digit but it does not discriminate between dominant and nondominant hands. Pain, tenderness, erythema and warmth are features that are suggestive of this diagnosis.<sup>2</sup>

There are four functional systems draining blood from the digits: the arborizing veins, venous arch, and the deep and superficial axial veins. Thrombosis is more commonly reported in the superficial axial veins, particularly the palmar veins, which are small in diameter and contain more valves. The role of hypercoagulable states in digital vein thrombosis is poorly understood and has not been formally investigated. Lechner *et al.* described a patient who developed deep vein thrombosis of the legs with recurrent lung emboli, which were preceded by digital vein thrombosis.<sup>3</sup> In 2002, Hofer described an isolated case of antiphospholipid syndrome causing digital vein thrombosis.<sup>4</sup>

The diagnosis of palmar digital vein thrombosis is based mainly on clinical symptoms although noninvasive assessment by ultrasonography can be undertaken. The mainstay of treatment is conservative therapy, including massage and compression. Surgical removal can be considered if the condition is painful or progressive.

The marked inflammation triggered by COVID-19 infection results in coagulopathy and endothelial dysfunction.