openings surrounded by melanophages, while yellow dots are associated with hyperkeratosis.[1]

Erosions were present in a minority of our LPBP cases. In vulvovaginal LP, glazed erythema and painful erosions are characteristic clinical manifestations, while WS have been observed in only a fraction of cases.[4]

The main limitation of our study is its small sample size. We could not determine the relation between disease activity and the dermoscopic features. Further studies need to define the clinical significance of the different WS and vascular patterns, and the intensity of erythema in LPBP. We speculate that these features might be useful to predict or monitor the response to treatment.

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Attendance at an Emergency Dermatology consultation during 1 year of the COVID-19 pandemic: towards new sensitivities?

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Dear Editor,

The consequences of the COVID-19 pandemic forced dramatic changes in health systems around the world, including the cancellation of in-person consultations, with emergency services (ES) being the only option for face-to-face (F2F) consultations, including for dermatological conditions.[1] Our tertiary hospital in Seville, Spain, has an Emergency Dermatology (ED) service, which provides treatment for patients referred from the ES with dermatological issues. We performed a study to analyse changes in attendance to the ED service during the first year of the COVID-19 pandemic.

We retrospectively analysed the number of patients (both those who attended and those who did not attend scheduled appointments) to our ED service from 14 March 2020 [the date the first state of emergency (SoE) was declared] to 13 March 2021 and compared them with data from the previous time period (14 March 2019 to 13 March 2020). In addition, data on weekly confirmed COVID-19 cases in the province of Seville were collected.[2]

Statistical analysis was performed using the χ^2 or Student *t*-test with 95% CIs on Excel® spreadsheets (2010; Microsoft Corp., Redmond, VA, USA). The data that support the findings of this study are available from the corresponding author upon reasonable request.

In total, 1381 patients were scheduled for ED consultation during the 2020–21 period, compared with 2013 patients during the 2019–20 period (Table 1), which was significantly different ($P < 0.01$). Of these, 1319 (95.51%) and 1809 (89.87%), respectively, attended their appointment, while 62 (4.49%) and 204 (10.13%), respectively, did not attend ($P < 0.01$).

We found that in contrast to the 2019–20 period (Fig. 1a), attendance was at its lowest in the first 4 weeks after the declaration of the first SoE (Fig. 1b) with a later

Table 1 Attendance data at an Emergency Dermatology service during two study periods between 2019 and 2021.

Parameter	Study period: 14 March 2019 to 13 March 2020	Study period: 14 March 2020 to 13 March 2021	*P*
Total appointments available, *n*	2122	2123	
Appointments scheduled, *n* (%[a])	2013 (94.86)	1381 (64.05)	< 0.01[b]
Attendances, *n* (%)	1809 (89.87)	1319 (95.51)	< 0.01[b]
Absences, *n* (%)	204 (10.13)	62 (4.49)	< 0.01[b]
Patients seen per week, mean ± SD	34.78 (5.85)	25.37 (10.25)	< 0.01[c]
Absences per week, mean ± SD	3.92 (2.64)	1.19 (1.24)	< 0.01[c]
Vacant appointments per week, mean ± SD	2.10 (2.24)	14.27 (9.73)	< 0.01[b,c]

[a] Percentage of available appointments available; [b]χ^2 test; [c]Student *t*-test.

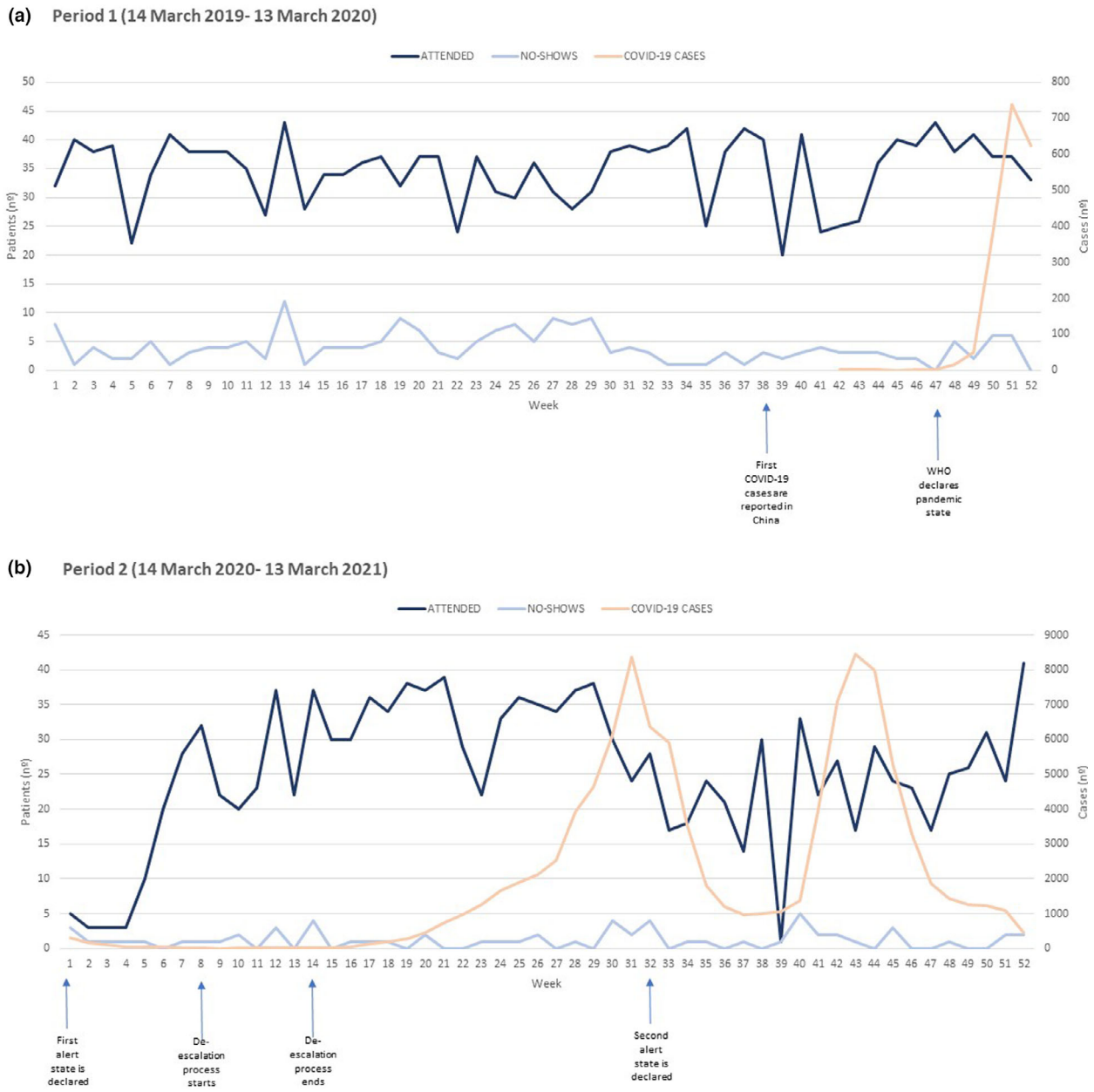

Figure 1 (a,b) Changes in the number of patients given appointments to the Emergency Dermatology services, together with the diagnosed cases of COVID-19 in the province of Seville during the periods (a) 14 March 2019 to 13 March 2020 and (b) 14 March 2020 to 13 March 2021

increase, which consolidated once the de-escalation process started in Week 8. Similar decreases in attendance were observed when the number of COVID-19 cases peaked again in autumn and winter of 2020, even taking into account the imposed restrictions. Despite the greater impact of the pandemic, the number of patients seen in the spring of 2021 was higher than that in spring 2020, reflecting a possible lower perception of risk, as coexistence with COVID-19 has progressed.[3] Similar studies in other countries also reported a decrease in urgent consultations, so this seems to be a generalized pattern.[1,4]

During the second study period, there was a striking decrease in the percentage of non attendees, perhaps indicating a higher awareness of the value of F2F healthcare

among patients. These data are in contrast to those of other series, which reported an increase in the percentage of non attendees.[5]

We consider that keeping our ED service open not only allowed diagnosis of acute conditions, but also allowed the incidental diagnosis of melanomas or other tumours. This would not have been possible with teleconsultation, as pointed out by other authors.[4]

There are some limitations to this study: it was a single-centre study, with data collected retrospectively and was with a previous time series. However, the data reveal changes in healthcare provision and in the usage patterns of healthcare resources as a result of the pandemic. It would be interesting to know why those patients required urgent attention, and if these trends will continue over time or return to pre-pandemic levels.

In conclusion, we found that ED consultations remain important during the pandemic period. The observed data are consistent with those reported for the first wave of the virus in other parts of the world.

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COVID-19 vaccines do not trigger psoriasis flares in patients with psoriasis treated with apremilast

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Dear Editor,

Although COVID-19 vaccination is strongly recommended for patients with psoriasis (PsO) by several dermatological societies worldwide, only one recently published Italian case series has reported the safe and effective role of the vaccine in this patient subset. Notably, the vaccine information highlights that there are limited data about the vaccine in immunosuppressed patients and that vaccination should be performed in agreement with the vaccinator.[1] Furthermore, PsO itself is not considered an immunosuppressive status, but some antipsoriatic, effective and safe drugs are codified as immunosuppressants. Thus, patients with moderate to severe PsO undergoing targeted therapies [e.g. interleukin (IL)-17 inhibitor (i), IL-12/23i, IL-23i and tumour necrosis factor-α], small molecule therapy (apremilast, dimethyl fumarate) and conventional therapies (methotrexate, ciclosporin) are considered immunosuppressed by the World Health Organization.[2] Among the systemic antipsoriatic treatments, only acitretin is not considered an immunosuppressant (Table 1).

Apremilast, a phosphodiesterase (PDE)-4 inhibitor, displays immunomodulatory effects on both keratinocytes and immune cells, decreasing cutaneous hyperplasia and mitigating the proinflammatory microenvironment. Notably, apremilast is orally delivered and well-tolerated in young patients, needlephobics and patients with other circumstances that represent a relative contraindication for biologics (e.g. neoplasia or HIV).[2] For some patients with PsO, the COVID-19 pandemic has affected adherence,[3] anti-vaccination opinions[4] and lifestyle,[4] complicating the monitoring of chronic immunosuppressive therapy. There are no data on interactions between apremilast and COVID-19 vaccines to guide physician daily practice during the ongoing pandemic. We report three patients with PsO under apremilast who also received COVID-19 vaccination.

Patient 1 was a 48-year-old man with PsO and psoriatic arthritis (PsA). Following nonresponse to ixekizumab or etanercept, the patient was commenced on apremilast, achieving stable remission, which was maintained for 8 months. He experienced flares of both his PsO and PsA during asymptomatic COVID-19, which resolved spontaneously 10 days after COVID-19 remission. Six months after this infection, he received both doses of the Pfizer mRNABNT162b2 vaccine without experiencing any PsO flare.

Patient 2, a 76-year-old man with PsO, had been taking apremilast since 2017 with a stable residual Psoriasis Area Severity Index (PASI) of 3. After the first dose of the AstraZeneca-Oxford vaccine AZD1222 he experienced fever

