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Table II. Loan distribution, n (%)

Loan range	\$5-\$10 million	\$2-\$5 million	\$1-\$2 million	\$0.35-\$1 million	\$0.15-\$0.35 million	P value (chi-square test)
Total	1 (0.09)	11 (1.03)	43 (4.03)	345 (32.36)	666 (62.48)	
Business type						.1339
Limited liability company	1 (100)	3 (27.3)	9 (20.9)	75 (21.7)	193 (28.9)	
Corporation	—	6 (54.5)	19 (44.2)	145 (42)	234 (35.1)	
Professional association	—	—	3 (7)	17 (4.9)	22 (3.3)	
Partnership	—	—	2 (4.7)	11 (3.2)	18 (2.7)	
Sole proprietor	—	—	—	—	16 (2.4)	
Subchapter corporation	—	2 (18.2)	9 (20.9)	91 (26.4)	174 (26.1)	
Limited liability partnership	—	—	—	6 (1.7)	5 (0.8)	
Cooperative	—	—	—	—	3 (0.5)	
Nonprofit organization	—	—	1 (2.3)	—	1 (0.2)	
US geographic region						.4552
Southeast	—	5 (45.5)	19 (44.2)	112 (32.5)	211 (31.7)	
West	1 (100)	1 (9)	4 (9.3)	64 (18.5)	150 (22.5)	
Northeast	—	—	11 (25.6)	81 (23.5)	144 (21.6)	
Midwest	—	2 (18.2)	6 (13.9)	54 (15.6)	90 (13.5)	
Southwest	—	3 (27.3)	3 (7)	34 (9.9)	71 (10.7)	
Number of medical providers in practice						<2.2e-16
1	—	1 (9.1)	—	48 (13.9)	278 (41.7)	
2-5	—	—	5 (11.6)	194 (56.2)	367 (55.1)	
6-10	—	2 (18.2)	19 (44.2)	93 (26.9)	21 (3.2)	
>10	1 (100)	8 (72.7)	19 (44.2)	10 (3)	—	
Jobs retained						<2.2e-16
<10 (micro)	—	2 (18.2)	4 (9.3)	30 (8.7)	80 (12)	
10-49 (small)	—	—	1 (2.3)	176 (33)	531 (79.7)	
50-249 (medium)	—	6 (54.5)	36 (83.7)	114 (51)	4 (0.6)	
>250 (large)	1 (100)	3 (27.3)	—	2 (0.6)	1 (0.2)	
Unanswered	—	—	2 (4.7)	23 (6.7)	50 (7.5)	

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Retrospective study of trends in dermatology telemedicine and in-person visits at an academic center during COVID-19



To the Editor: Many dermatologists have encountered difficulties providing timely in-person appointments during the COVID-19 pandemic because of social distancing requirements. While telemedicine may be effectively used for dermatologic care, triaging patients for in-person visits (IPVs) versus video visits (VVs) has not been adequately studied.¹ Our objectives were to analyze the characteristics of in-person and telemedicine dermatology visits to determine effective appointment allocation.

In accordance with New York State—mandated closures beginning March 22, 2020, Weill Cornell Dermatology limited in-person visits from March 23 through June 1 for patients requiring immediate in-person care. Patient visits March 16 through May 5

Table I. Demographics, visit type, and follow-up

Demographics and visit information	Video visits, n = 200	In-person visits, n = 50	P value
Age, y	39.56	54.08	.00*
Female, %	62	59	.75
Single, %	53	52	.89
Home-to-clinic distance (miles from 10065)	32.32	34.16	.96
Private insurance, %	79	54	.00*
History of nonmelanoma skin cancer, %	12	26	.01*
History of melanoma, %	3	10	.02*
Visits that were new patient visits, %	20	22	.69
Visits that were established patients with new complaints, %	28	22	.43
Time until next follow-up visit for this issue			
In-person follow-up for this issue, %	25	36	.12
Average time until follow-up in-person visit for this issue, days	81.1	82.2	.93
Video follow-up for this issue, %	27	22	.47
Average time until follow-up video visit for this issue, days	42.8	29.1	.20

*Statistically significant ($P < .05$).**Table II.** Diagnoses and medications

	Percent or n		P value
Diagnoses, %			
Dermatitis and eczema (L20-L30)	26	22	.61
Acne (L70)	20	16	.52
Other skin disorders (L81 and L83-L99)	20	28	.22
Other long term (current) drug therapy (Z79)	10	12	.68
Cysts and follicular disorders (L72-73)	9	12	.52
Nail disorder (L60-62)	9	2	.10
Hair disorders (L63-68)	7	8	.81
Papulosquamous disorders (L40-45)	6	2	.26
Actinic keratosis (L57)	6	14	.04*
Personal history of malignancy (Z85)	4	6	.54
Benign nevi/neoplasms (D22-23, I78.1, and Q82.5)	4	14	.00*
Diseases of lips, oral mucosa, tongue (K13-14)	4	2	.59
Rash (R21)	4	4	.87
Rosacea (L71)	4	4	.87
Seborrheic keratosis (L82)	4	22	.00*
Viral skin infections (warts, zoster) (B0-B09)	4	2	.59
Neoplasm of uncertain behavior (D48)	3	6	.31
Mycoses (B35-36)	3	2	.84
Skin infections (L00-L08)	3	2	.84
Disorder of skin sensation (R20)	2	8	.03*
BCC/SCC (C44 and D04)	2	12	.00*
Chilblains (T69)	2	0	1.00
Urticaria (L50)	2	0	1.00
Bullous disorder (L10-L14)	1	2	.56
Medications, n			
Average new medications started	0.58	0.44	.25
Average medications continued/reordered	0.65	0.72	.65
Average medications changed	0.07	0.02	.18
Average medications stopped	0.1	0.08	.76

*Two-tailed t test for independent means was used for all continuous variables (ie, age, distance, etc). The χ^2 test was used for categorical variables (gender, insurance, diagnoses, etc); when cell frequency was <5 , the Fisher exact test was used. All tests were done at a significance level of $\alpha = 0.05$.

were queried from EPIC after institutional review board approval. All IPVs and VVs were sorted and ordered randomly. IPVs after VV triage were excluded. A total of 250 charts (50 IPVs and 200 VVs) were analyzed.

Patients presenting for IPVs versus VVs were on average older (54.1 vs 39.6 years of age), Medicare-insured (44% vs 16%), and had melanoma (10% vs 2.5%) and nonmelanoma skin cancer histories (26% vs 12%; all $P < .05$). There were no significant differences in gender, home-to-clinic distance, and new versus established patients (Table I).

There were significantly greater proportions of benign nevi (14% vs 3.5%), actinic keratoses (14% vs 5.5%), seborrheic keratoses (22% vs 3.5%), disorders of skin sensation (8% vs 2%), and nonmelanoma skin cancer (12% vs 1.5%) diagnoses in IPVs compared with VVs (Table II). IPVs were significantly more likely to present with chief complaints related to skin lesions (34% vs 18% in the VVs). Notably, a procedure was performed in 64% of IPVs.

There was no significant difference in average medication number or type initiated or discontinued between the 2 visit types (Table II). There were no differences in proportion of patients with follow-up visits or time to follow-up (Table I). Only 8% of VV patients had in-person consultation within 60 days of their VV. For the majority of VVs (71%), an IPV was not recommended.

Older adults may be overrepresented in IPVs versus VVs because skin cancers are more prevalent in older individuals and they may have more difficulties using telemedicine. Simplified connections, increased education, and house calls may be considered to improve their usage.² Median distance to clinic was lower for IPVs versus VVs in previous studies³; therefore, our discrepant findings may be because of COVID-related safety concerns. Approximately twice as many chief complaints in IPVs versus VVs were for skin lesions. Telemedicine has lower diagnostic accuracy in identifying pigmented lesions and is inadequate in diagnosing precancerous versus cancerous lesions.^{4,5} Therefore, patients with concerning lesions should be scheduled for IPVs for clinical examination, dermoscopy, and possibly obtaining a biopsy specimen.

Limitations of this study include its single-center, retrospective design and the limited number of patients. We could not account for patients who temporarily relocated from their billing addresses. Outcomes were not analyzed, and this is an important topic for future study.

Our findings indicate that diagnosis, treatment, and follow-up for most dermatologic conditions does not vary between IPVs and VVs. In-person dermatology appointments should be preferentially scheduled for examination of concerning skin lesions, full-body skin examination in patients with skin cancer history, and necessary procedures.

Rbiannon C. Miller, BA, Claire R. Stewart, BA, and Shari R. Lipner, MD, PhD

From the Department of Dermatology, Weill Cornell Medicine, New York, NY.

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Correspondence to: Shari R. Lipner, MD, PhD, Department of Dermatology, Weill Cornell Medicine, 1305 York Ave, New York, NY 10021

E-mail: shl9032@med.cornell.edu

Conflicts of interest

None disclosed.

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5-Aminolevulinic photodynamic therapy versus carbon dioxide laser therapy for small genital warts: A multicenter, randomized, open-label trial



To the Editor: 5-Aminolevulinic acid photodynamic therapy (ALA-PDT) has been reported as a better treatment of genital warts than carbon dioxide laser