



Figure 2 Widespread epidermal lymphocyte exocytosis associated with prominent spongiosis and red blood cell extravasation consistent with a viral exanthem. There was evidence of prominent interface dermatitis and marked oedema in the papillary dermis and prominent perivascular infiltrate of lymphocytes in the upper dermis. Haematoxylin and eosin, original magnification $\times 200$.

presenting as widespread macular toxic erythema in the absence of systemic symptoms. We consider it important to recognize COVID-19 infection as a differential for a toxic exanthemous skin eruption during this pandemic, especially in the context of novel treatments that may improve mortality.

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Dealing with suspended new routine general dermatology referrals during the COVID-19 pandemic: a virtual model from our local departmental experience

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The burden of skin disease is reflected in ever-increasing waiting times for specialist care.^{1–3} The COVID-19 pandemic brought further unexpected disarray, with all routine outpatient clinical activity coming to an abrupt halt, obligating dermatology departments across the UK to rethink models of care.

We looked at 381 routine general primary care referrals to our dermatology department made between August and October 2019. All routine face-to-face (FTF) clinics in this department had been suspended since March 2020 due to COVID-19, creating an unpredictable delay for this patient cohort. We devised a triage model with the aim of bypassing the need for FTF consultation in most cases. All referrals were assessed by a consultant dermatologist and streamlined into one of three groups: (i) those who would need to be seen FTF; (ii) those suitable for clinical photographs and a telephone consultation; and (iii) those suitable for a telephone consultation without images. Clinical photographs were preferred to video consultations because of the superior image resolution and availability of technology.

Only 23% (88/381) of referrals were triaged to an FTF consultation. This essentially comprised cases considered inappropriate for clinical photography (such as genital dermatoses) or those with absent or subtle cutaneous signs. Illustrative examples of the latter include generalized pruritus, for which physical examination is required in order to identify subtle xerosis or even scabies infestation, and psychocutaneous disorders such as delusional infestations, which are unlikely to yield photographic clues and for which the diagnosis is usually one of exclusion, requiring an initial physical examination at the very least. Hair disorders can also be challenging, and virtual assessment limits the opportunity for trichoscopy and for assessing hair density across the scalp.

The majority of referrals were triaged for virtual consultation (Table 1). Of these, 64% (244/381) were triaged into the second group, which required administrative staff to contact patients and request photographs via a secure National Health Service email address. Images were subsequently uploaded onto the electronic patient record and

Table 1 Case mix of patients triaged for virtual consultation.

Group 2		Group 3	
Reason for referral	%	Reason for referral	%
Acne	47	Eczema	17
Eczema	18	Psoriasis	20
Psoriasis	11	Cutaneous infection	10
Cutaneous infection	5	Alopecia	7
Pigmentation problem	3	Urticaria	10
Urticaria	2	Intertrigo	7
Vasculitis	1	Lichen planus	3
Drug-related	1	Hidradenitis suppurativa	3
Tattoo reaction	0.5	Other inflammatory	23
Other inflammatory	2		
Other	9.5		

Group 2 were for clinical photographs with telephone consultation and Group 3 were telephone consultation only.

the patient was booked for a virtual clinic. Most (75%) of these patients had successful telephone consultations following receipt of clinical photographs. Patients with acne comprised a significant proportion of this group, and were reviewed and followed up in a dedicated virtual acne clinic. Of the patients receiving virtual consults, 50% were diagnosed and discharged after the initial consultation, while the remaining 50% required follow-up or were referred for further treatment or investigation. Photographs were of variable quality, but nonetheless all except one were considered clear enough to establish a diagnosis and formulate a management plan. Only seven patients were converted to FTF appointments, with reasons including patient choice, inability of the patient to send photographs or complexity of the case.

Group 3 (13%) represented patients with a previous confirmed diagnosis from the dermatology department, or those with a likely diagnosis of urticaria, who were considered suitable for a direct telephone consultation. The majority of these patients (71%) subsequently volunteered to send photographs, which were helpful in most cases.

Interestingly, of all those triaged for virtual consultation (Groups 2 and 3), 38% were removed from the waiting list either because of resolution of the dermatosis, the patient declining appointment for some other reason or lack of patient response to the booking request. This may be an inevitable by-product of prolonged waiting times (mean 10 months) in our cohort at the time of data collection.

In conclusion, using a simple triage model, we were able to appropriately manage the majority of patients entirely virtually, of whom half were discharged successfully. This mitigated the unnecessary risk of attending hospital in the current climate, conserving the limited FTF clinic slots for the most appropriate patients. Administration time for coordinating virtual consultations and requesting photographs was longer than usual, and we are fortunate to have a dedicated 'booking pod'

administration team who have risen to this challenge and worked flexibly to deliver an adapted service. Our model has enabled us to provide continued routine care under these unusual circumstances of COVID-19, but looking ahead into a post-pandemic future, we hope to use lessons learnt to continue this service and reduce FTF clinic throughput in the longer term. Initial verbal feedback from patients has been positive, but we aim to formally assess both patient and clinician satisfaction with the virtual service in the future.

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Chilblains and COVID-19: can recent epidemiological data shed light on the aetiological debate?

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In March and April 2020, at the peak of the COVID-19 pandemic, several countries imposed lockdown measures. Concurrently, a significant number of chilblains were observed in otherwise healthy adolescents and young adults. The physiopathology of these chilblains has not been completely elucidated and their direct link to COVID-19 remains unconfirmed and debated.¹ Reverse transcription (RT)-PCR on nasopharyngeal swabs and anti-SARS-