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Epidemiology of alopecia areata in black patients

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Black patients have greater odds of alopecia areata when compared to whites (odds ratio, 1.77; 95% confidence interval, 1.37-2.28).¹ Few studies in the literature have examined the epidemiology of alopecia areata exclusively in Black patients, demonstrating an increased need for understanding in this area. To investigate the epidemiology of alopecia areata in Black patients, a retrospective analysis was conducted in 265 pediatric and adult patients diagnosed and treated for alopecia areata at Wake Forest Baptist Health between January 2015 and December 2020. Patients were assessed according to distribution by age, sex, medical and autoimmune comorbidities. 190 (71.7%) of patients were female (female-to-male ratio, 2.5:1). The largest age group presenting for care was the 18-34 year age group (35.8%) followed by the 10-17 year age group (15.1%). These results suggest a female predominance and increased prevalence of disease in younger patients. Further evaluation of epidemiology can provide greater understanding of alopecia areata in Black patients. 1. Lee H, Jung SJ, Patel AB, et al. Racial characteristics of alopecia areata in the United States. *J Am Acad Dermatol.* 2020 Oct;83(4):1064-1070.



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Racial and language disparities in teledermatology visits for acne during the COVID-19 pandemic

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Background: Teledermatology has emerged as an essential model of care during the COVID-19 pandemic. However, the impact of the rapid transition to teledermatology on patients of certain racial/ethnic and language groups due to differential access to technology, lower digital health literacy, language barriers, or cultural perceptions is unknown. We sought to identify race and language disparities in teledermatology utilization for patients with acne, one of the most frequent diagnoses seen via teledermatology, before and during the pandemic. Methods: A retrospective chart review of all in-person and virtual visits for acne at a large academic dermatology department from March-May 2019 and March-May 2020 was conducted. Virtual visit types included video- or audio-only visits. Chi-squared analyses were performed to compare populations across visit types. Results: 3544 visits were analyzed. Virtual visits accounted for 1229/1630 (75.6%) during- pandemic visits. Racial and language distributions of patients for overall visits were not statistically significantly different pre- and during-pandemic. However, video visits (versus audio-only) comprised a greater proportion of virtual visits during-pandemic for White (86.9%) compared to non-White patients (82.0%), and for English-speaking (86.2%) compared to non-English-speaking patients (60.5%) (both $p < 0.001$). During-pandemic, interpreters use was documented for 23.1% of all non-English-speaking patients for in-person visits versus 9.3% of virtual visits ($p < 0.001$). Conclusions: Non-White and non-English-speaking patients were less likely to use video visits for acne during the pandemic than White and English-speaking patients. Non-English-speaking patients were less likely to receive interpreters in virtual visits than in-person visits. These findings suggest underlying disparities in teledermatology access and barriers to interpreter use during virtual visits.



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Lifestyle and demographic risk factors in mycosis fungoides and Sezary syndrome: A single institution cohort study

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Background: Mycosis fungoides (MF) and Sezary syndrome (SS) are common subtypes of cutaneous T-cell lymphoma (CTCL). Risk factors and impact on quality of life (QoL) are poorly understood. Previous studies of CTCL risk factors have not analyzed disease stage, severity, and QoL together. We explored associations between demographic and lifestyle factors and these parameters. Methods: A cohort study was conducted at a large CTCL multidisciplinary clinic from April 2019 to December 2020. REDCap surveys were administered to 115 MF/SS patients, investigating 11 demographic and lifestyle factors. QoL was evaluated using Skin-dex-29; pain and itch with Likert scales. Disease severity was assessed using the modified Severity Weighted Assessment Tool (mSWAT). Factors were compared using t-test, chi-squared, and linear or logistic regression models. Results: History of chemical exposures was associated with greater disease severity ($p=0.034$) and worse QoL ($p=0.005$), but not with pain/itch severity ($p=0.118$). Disease severity and stage were associated with worse QoL (both $p < 0.001$). There were significant racial differences in early (IA-IIB) versus late (IIIA-IV) stage disease ($p=0.034$) and QoL ($p=0.039$). There was a significant relationship between smoking and disease stage ($p=0.028$) but not severity ($p=0.360$). Obesity was correlated with disease severity ($p=0.021$), but not with stage or QoL ($p=0.582$; 0.232). Conclusion: We provide an analysis of patient lifestyle and demographic factors in the context of MF/SS severity, stage, and QoL. We identified race and smoking as potential risk factors for advanced disease, and chemical exposures and obesity for increased disease severity. Worse QoL was significantly associated with a history of chemical exposure, severe pain/itch, race, and stage. Identification of demographic and lifestyle associations in MF/SS will enable physicians to provide more individualized patient care and education.



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Cumulative ultraviolet radiation exposure is associated with both increased melanoma and non-cutaneous cancer risk

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Ultraviolet radiation (UVR) exposure is associated with increased risk of skin cancer. However, mixed evidence suggests a protective, inverse relationship between UVR and risk of certain non-cutaneous cancers, depending on temporality of exposure. To address this discrepancy, we examined three ongoing U.S. prospective cohort studies, the Health Professionals Follow-Up Study (HPFS) and Nurses' Health Study (NHS) I and II, to identify associations between cumulative UV exposure and cancer risk. We used an established spatiotemporal exposure model to calculate cumulative time-varying average UV exposure, defined as average July noon-time erythemal UVR. Our sample included 47,714 males from HPFS, and 112,507 and 99,940 females from NHS I and II, respectively. In each study, participants were stratified into quintiles by cumulative UVR exposure, using the first quintile as reference for Cox proportional-hazards modeling. In the meta-analysis of all three cohorts, we found increased total cancer risk across all UVR exposure quintiles after controlling for potential confounders [highest quintile Hazard Ratio (HR), 1.04; 95% Confidence Interval (CI), 1.01-1.07; $p=0.002$; P for heterogeneity=0.49]. All UVR exposure quintiles were also associated with increased risk of total cancer excluding melanoma (highest quintile HR, 1.03; 95% CI, 1.01-1.60; $p=0.02$; $P_{het}=0.56$). Lastly, UVR was associated with the highest risk for melanoma (highest quintile HR, 1.20; 95% CI, 1.07-1.34; $p=0.002$; $P_{het}=0.70$). These findings suggest that UVR is associated with increased risk of both melanoma and non-cutaneous cancers. Despite emerging data for the protective benefits of UVR against cancer, further research is necessary to understand the health effects of sun exposure and underlying mechanisms.



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Rates, characteristics, and comparison of hidradenitis suppurativa readmissions in the united states: A national population-based study

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This study aims to describe the rates and characteristics of non-elective 30-, 90- and 180-day readmissions for adult patients hospitalized for Hidradenitis suppurativa (HS) in the United States (US). We also aim to compare HS 180-day readmission rates to that of heart failure (HF), the most common cause of readmissions for Medicare patients. We analyzed the 2017 National Readmission Database (NRD). We included hospitalizations for all adult HS and HF patients (≥ 18 years) and excluded elective or planned readmissions. Chi-square tests were used to compare baseline characteristics between readmissions and index hospitalizations. Multivariate cox regression was used to identify independent predictors of readmissions. A total of 2204, 1719, and 1053 index hospitalizations with a primary diagnosis of HS, that were discharged alive, were included in the 30-, 60- and 90-day HS readmission analysis. Among these, 392 (17.8%), 582 (33.9%), and 512 (48.6%) were readmitted within 30, 60, and 180 days, respectively. For all three readmission timeframes, HS, followed by sepsis, were the two most common reasons for readmission. The 180-day readmission rate of HS patients was comparable to that of heart failure (48.6% vs 48.0%). HS Readmissions within 90-days were associated with a total of 3,823 hospital days and 33 million US dollars in hospital charges. Compared to index hospitalizations, the readmissions cohort had a higher Charleston comorbidity index score, severe or extreme loss of function, electrolyte disturbance, anemia, and sepsis. The leading reason for readmissions in patients with HS is the skin disease itself. We found that HS readmissions at 6 months are similar to HF. Interventions aimed at improving access to early dermatological care are essential in preventing unnecessary readmissions of HS patients.



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Age of melanoma diagnosis in patients with limited English proficiency

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Patients with Limited English Proficiency (LEP) often receive substandard care. The United States LEP population was 8% as of 2013 and continues to grow. We aim to estimate the association between stage of melanoma diagnosis and LEP by comparing age of melanoma diagnosis between patients with differing self-reported household English-use from a nationally representative sample. We performed a retrospective cross-sectional study with pooled data from the 1999/2000 through 2017/2018 National Health and Nutrition Examination Surveys (NHANES). Demographics and self-reported age of melanoma diagnosis were compared between non-LEP and LEP patients, defined as speaking some English versus no English in the household, respectively. Frequencies and means were compared between groups using Rao-Scott χ^2 and design-based t-tests, respectively, using a weighted-subject, stratified design. A total of 314 unweighted adult melanoma patients were identified from 1999/2000 to 2017/2018, of whom 4 were LEP (1.2%). This amounted to 1,708,858 weighted adult melanoma patients (95% CI: 1,438,719-1,978,998), of whom 4,297 were LEP (95% CI: 0-9,388). Compared to non-LEP adult melanoma patients, LEP melanoma patients were more likely to be of Hispanic ethnicity ($p < 0.001$) or other/mixed/Asian American race ($p < 0.001$). Mean age of diagnosis of non-LEP adult melanoma patients (51.9 years, 95% CI: 49.9-53.9 years) was less than LEP adult melanoma patients (63.4 years, 95% CI: 54.1-72.6), with an 11.5 year estimated difference in means (95% CI: 2.0-21.0 years, $p=0.02$). Our results indicate the need for melanoma screening and awareness in LEP populations for earlier detection of melanoma. Limitations to the study include not having the patient's stage of melanoma, self-reported data, and a small sample size.

