Current situation

Dermatology as a specialty is largely outpatient based. The HES data for 2018-19 shows that we saw more outpatients and 2-week wait referrals than any other specialty. We are also responsible for the diagnosis and treatment of skin disease in children.

Skin cancer is rare in children, but inflammatory skin conditions such as eczema are common. In general, most GPs do not have surety about diagnosis of skin conditions in general, reflected in the usually high levels of referral to secondary care. Presently, new referrals are broadly down across the board due to the impact of COVID-19 on patients and their primary care teams.

Due to the temporary loss of medical and nursing staff to the medical wards, most non-urgent referrals (18-week pathway) are being put on pause, with priority being given to the time-dependent new referrals (skin cancers and emergency inflammatory skin disease) as detailed in the previously submitted time-dependent procedures grid (attached). We are also still monitoring the thousands of patients with severe inflammatory disease who are currently controlled on immunosuppressive therapies.

Much activity is being delivered remotely and sometimes sub-optimally. As a specialty, we intend to collect this data to ensure that, going forward we embrace change whilst maintaining standards of care. Below we describe the impact of COVID-19 on usual care for skin cancer and inflammatory skin disease on both adults and children.

General considerations for those in the over-70 age group and those with skin cancer

1. Skin cancer increases significantly in the older population. Without access to HCPs we will be faced with diagnostic delay, later disease presentations requiring more complex surgery, and metastatic disease.
2. Shielding patients: a significant proportion will be on immunosuppressants and again at risk of skin cancer.
3. General population will not be seen for routine appointments either with GP or follow up, therefore will miss opportunities to pick up skin cancer incidentally; 2-week wait referrals have already been significantly reduced.[1]
4. The forced changes in practice in secondary care, follow-up/new patients via telephone/video, with/without a photograph and the lack of dermoscopic image may lead to difficulties with diagnosis and possible misdiagnosis for all conditions and particularly skin cancers.
5. Time-dependent referrals and treatment for action within 4 weeks are in the main being offered by most dermatology centres, providing 2-week wait service and urgent surgery (attached) via remote imaging. Therefore, we as a specialty are hoping to capture some but not all primary skin cancers such as melanomas, Merkel cell tumours and squamous cell cancers. Some of these important time-dependent diagnoses will be missed though, for reasons outlined.
6. Basal cell cancer is the commonest cancer. There will be an increasing backlog[2] of patients needing surgery to treat these tumours as all are generally being deferred for 3 months. Some

[1] E.g. Southern Derbyshire received 87 2-week wait referrals w/c 11/11/19 compared with 11 referrals w/c 6/4/20.

[2] E.g. Southern Derbyshire (population 550-600k; expected to operate on around 100-120 cancers per week; not a Mohs centre) has approximately 400 cases that have been cancelled over the last month due to COVID-19 restrictions and will need to be reassigned dates.

will be on high-risk sites such as in the periocular region, which require Mohs micrographic surgery. Delay in treatment could result in increased morbidity.

Other skin conditions in adults and children

1. Within the urgent 72-hour pathway, we still aim to capture dermatology emergencies such as toxic epidermal necrolysis, vasculitis and severe drug eruptions. However, inflammatory skin conditions are common with 2% of the population suffering from psoriasis and 20% of children suffering from eczema and there are predictable problems from delayed treatment.
2. As a result of the new guidance around holding off or pausing prescribing any new immunosuppressive treatments for a wide range of inflammatory skin conditions such as psoriasis and eczema, patients' skin conditions are likely to flare, present later and develop secondary infections; some will need admission to hospital which might otherwise have been prevented.
3. In children, poorly controlled eczema may lead to faltering growth from sleep disturbance and increase the risk of safeguarding issues, particularly exacerbated by sleep disturbance which effects the whole family.
4. In adults, poorly controlled inflammatory skin disease is associated with depression and suicide.
5. Delay in referral and treatment for acne vulgaris will result in unnecessary scarring and psychological morbidity with an increased risk of depression and suicide. Currently, there is a risk of relying on patients to conduct their own pregnancy testing with isotretinoin therapy.
6. Self-isolating patients (those in the over 70s age group in particular) will not be seen by their GPs for routine and chronic skin conditions, and their appointments in secondary care may have been cancelled or deferred. There may be problems accessing blood tests for these patients and this may result in avoidable liver and renal impairment from the medication.
7. Genital dermatoses will also be affected and potential pre-cancerous and cancerous lesions in this group missed; virtual consultation (teledermatology/video) for this group is more difficult.
8. Delay in the diagnosis and treatment of haemangiomas in the neonatal period may result in permanent visual or other impairment and avoidable deformity.

Psychological morbidity

Physical health and emotional well-being are closely linked. Times of heightened anxiety, such as might be expected during a pandemic and the ensuing economic consequences, may create a vicious cycle of stress that is exacerbating an existing skin condition and thus increasing stress.

Studies have identified a high co-morbidity between dermatological diseases and psychological disorders, with at least one in four skin patients affected,[3] and with one study identifying 70% of skin disease patients as having a psychiatric disorder.[4] Undiagnosed skin disease, and untreated skin disease, will only exacerbate this psychosocial comorbidity.

Impact on secondary care Dermatology training

On re-booting, we will need to not only assess the impact of time out of dermatology, but on their return we need to ensure that our trainees have exposure to the relevant case mix for training. Experience on the medical wards is unlikely to contribute to dermatology training. On repatriation to dermatology the patient mix will skewed towards skin cancer and urgent disease. The logistics of training may also be altered if there is a significant ongoing reduction in face to face consultations.

[3] Picardi *et al.* https://www.ncbi.nlm.nih.gov/pubmed/11069507
[4] Attah Johnson *et al.* https://www.ncbi.nlm.nih.gov/pubmed/7790138