Table 1 Epidemiological and clinical distribution of patients diagnosed with nonuraemic cutaneous calciphylaxis.

Patient	Year of diagnosis	Sex	Age, years	Type of lesion	Associated aetiological factors								Treatment
Excess weight	DMII		CID	Warfarin	Outcome	SCS		Iron therapy	BPP	ST			
1	2015	M	64	Leg ulcer	Yes	Yes	NA	NA	NA	NA	NA	NA	Death
2	2016	F	88	Leg ulcer	Yes	NA	NA	NA	NA	Yes	NA	NA	Amputation
3	2016	F	71	Leg ulcer	Yes	Yes	NA	NA	NA	NA	NA	NA	CR
4	2016	F	78	Leg ulcer	Yes	Yes	Yes	Yes	Yes	NA	NA	NA	Death
5	2018	F	81	Leg ulcer	NA	NA	Yes	Yes	NA	NA	Yes	NA	CR
6	2018	F	41	Abdominal mass	Yes	NA	Yes	NA	Yes	NA	NA	NA	CR
7	2019	F	66	Leg ulcer	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	CR
8	2019	F	73	Leg ulcer	Yes	Yes	Yes	NA	Yes		Yes	Yes	CR

BPP, bisphosphonates; CID, chronic inflammatory diseases (rheumatoid arthritis, psoriasis, central nervous system vasculitis); CR, complete resolution; DM, diabetes mellitus; NUC, nonuraemic calciphylaxis; SCS, systemic corticosteroids; ST, sodium thiosulfate.

(72 years). NUC is a multifactorial disease with a broad list of aetiological factors.[1,5] Our population follows the general aetiological and epidemiological tendency (≥ 2 aetiological factors, besides race and sex: in our population, there was a mean of 3.25 factors), with weight excess and diabetes mellitus constituting the two main concomitant conditions.

Data on treatment of NUC are very limited, without any established therapeutic guidelines.[1,2] Control of aetiological factors has to be addressed. Calcium-chelating agents such as bisphosphonates and sodium thiosulfate have been used previously, with favourable outcomes.[1,2] Their beneficial role was also apparent in our population, in spite of being used in only three patients. The mortality observed (25%) was lower than that reported in the literature.[4,5] The present literature is scarce and significant conclusions cannot be deduced, leaving the management of NUC dependent on clinical experience and the available observational published data.

J. M. Neves,[1] J. Cabete[1] and C. Fernandes[1]
[1]*Department of Dermatology and Venereology, Hospital de Santo António dos Capuchos, Centro Hospitalar Universitário de Lisboa Central, Lisbon, Portugal*
E-mail: josemoneves@gmail.com
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Two cases of COVID-19 presenting with a clinical picture resembling chilblains: first report from the Middle East

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The clinical characteristics of COVID-19 disease were identified in a cohort study involving 1099 patients from China,[1] and it was found that COVID-19 most commonly presented with fever, cough, fatigue and congestion. Of the 1099 patients, 2 were reported to have skin rash, but the time of onset and clinical description of rash were missing.[1] Another study focused primarily on cutaneous manifestations associated with COVID-19, and evaluated 88 patients from Italy; of these, 18 patients developed cutaneous manifestations, but only 8 developed skin lesions at disease onset.[2] The majority of these eight cases had an erythematous rash, while three patients had widespread urticaria and one patient developed chicken-pox like vesicles.[2] Since then, more cases of COVID-19 presenting with cutaneous lesions have been reported. Hunt and Koziatek reported a case of COVID-19 presenting

Figure 1 Red–purple papules on the dorsal aspect of fingers bilaterally. In addition to diffused erythema in the subungual area of the right thumb.

with fever and morbilliform rash as the primary presenting symptoms,[3] while Joob and Wiwanitkit reported a case of COVID-19 presenting initially with a petechial skin rash.[4]

We report two further cases of COVID-19 presenting with cutaneous lesions, specifically, chilblain-like lesions, which have not been reported previously, to our knowledge.

Both patients were women (Patient 1 was 27 and Patient 2 was 35 years old) and were previously healthy. They presented to the Dermatology clinic in Qattar with the chief complaint of a skin rash.

Physical examination revealed red–purple papules on the dorsal aspect of the fingers on both hands. Additionally, Patient 2 had diffused erythema in the subungual area of her right thumb (Fig. 1). The medical and drug history for both patients were unremarkable. Both patients reported recent travel to the UK, necessitating screening for COVID-19. Reverse transcriptase (RT)-PCR confirmed COVID-19 in both patients. Full blood count and complete metabolic profile were normal. Chest radiographs were clear of clinically detectable pathology. Skin biopsy was not performed.

Figure 2 Red–purple papules on the dorsum of the right ring finger.

We diagnosed the patients as having COVID-19-related lesions, with ischaemia considered to be the underlying process (Fig. 2).

The pathological characteristics of COVID-19 were evaluated in lung, blood vessel, skin and other organs by Yao *et al.*, using minimally invasive autopsies. Degeneration and necrosis of parenchymal cells and formation of hyaline thrombi in small vessels were observed in lung and other organs.[5] This could be the underlying pathology in our cases and could explain the clustering of cases of acral ischaemia reported in patients with COVID-19 in Italy.[5] Mazzotta and Troccoli reported a few dozen cases, initially presenting with red–purple papules on the feet and hands, which either evolved into haemorrhagic bullae or developed a blackish crust; however, laboratory tests of the reported cases were only available for two cases, both of which were confirmed by RT-PCR to be infected with COVID-19.[6]

In conclusion, we report the occurrences of red–purple papules on acral areas in two asymptomatic patients who were both confirmed by RT-PCR to be infected with COVID-19. Both these cases and the earlier cases reported from Italy[5] could be similar, but unfortunately not all the cases in the earlier study were tested for COVID-19. Acral ischaemic lesions may be a rare presentation of a symptomatic COVID-19, and this possibility should be kept in mind by dermatologists receiving referrals of such cases.

A. Alramthan[1,2] and W. Aldaraji[2]
[1]*Department of Dermatology, Al-Amiri Hospital, Kuwait City, Kuwait and* [2]*Department of Dermatology, Quttainah Medical Centre, Kuwait City, Kuwait*
E-mail: anwaar.alramthan@gmail.com
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Secure communication conduits during COVID-19 lockdown

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We commend Jakhar *et al.* in *Clinical and Experimental Dermatology*, which highlighted the virtues of instant messaging tools such as WhatsApp during the COVID-19 crisis.[1] While WhatsApp's advantages include being highly intuitive, widely used and accessible, there are concerns among clinicians about its use, as well as that of other commercially available communications apps. These include the loss of anonymity to patients, the need to reveal their personal telephone number, and questions over privacy and data security. In their paper, the authors overlooked a variety of freely accessible secure healthcare apps. For patients and physicians within the UK National Health Service (NHS), Nye[2] is freely available, facilitating real-time telephone and video consultations from any computer or smartphone without the need to reveal the clinician's personal details. From the personal perspective of the senior author (F. R. Ali), working during a time of enforced social distancing, the resolution afforded by Nye is helpful to diagnose many common inflammatory dermatoses, and the user interface is intuitive to patients and clinicians of all ages. Freely available apps that facilitate (among other functions) secure patient–clinician and clinician–clinician interactions without storing images on clinicians' photostreams include MySkinSelfie,[3] Hospify,[4] Pando and AccuRx, and others also exist. We encourage clinicians to consider such bespoke medical apps, made with consideration of data security and confidentiality at their core.

S. M. Black[1] and F. R. Ali[2]
[1]*Medical Sciences Division, University of Oxford, Oxford, UK and* [2]*Vernova Healthcare Community Interest Company, Macclesfield, UK*
E-mail: f.r.ali.01@cantab.net
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