

enabling clinicians to counsel their patients adequately. Furthermore, in light of the apparent increased mortality in various ethnic groups,^{5,6} combined with the potential under-reporting of ethnicity in the published COVID-19 dermatological literature,⁷ a register would ensure that key risk factors are not overlooked. In the absence of this information, it seems prudent to thoroughly assess all patients due to commence, and those currently undergoing, immune checkpoint therapy, for coronavirus risk factors and symptoms, complemented by early and rigorous SARS-CoV-2 PCR testing where clinically indicated and available.

J. Kurzhals,¹ P. Terheyden¹ and E. A. Langan^{1,2} 

¹Department of Dermatology, University of Lübeck, Lübeck, Germany and ²Centre for Dermatological Science, University of Manchester, Manchester, UK

E-mail: ewan.langan@uksh.de

Conflict of interest: JK reports no conflict of interest. PT has received speaker's honoraria from Bristol-Myers Squibb, Novartis and Roche, consultant's honoraria from Bristol-Myers Squibb, Merck, Novartis, Sanofi and Roche, and travel support from Bristol-Myers Squibb, Pierre-Fabre and Roche. EAL has received speakers' honoraria, travel support and/or participated in Advisory Boards for Sun Pharma, CureVac, BMS and Novartis.

Accepted for publication 3 July 2020

References

- 1 Wu Z, McGoogan JM. Characteristics of and important lessons from the coronavirus disease 2019 (COVID-19) outbreak in China: summary of a report of 72314 cases from the Chinese Center for Disease Control and Prevention. *JAMA* 2019.
- 2 Liang W, Guan W, Chen R *et al.* Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China. *Lancet Oncol* 2020; **21**: 335–7.
- 3 Lee LYW, Cazier JB, Starkey T *et al.* COVID-19 mortality in patients with cancer on chemotherapy or other anticancer treatments: a prospective cohort study. *Lancet* 2020; **395**: 1919–26.
- 4 Bersanelli M. Controversies about COVID-19 and anticancer treatment with immune checkpoint inhibitors. *Immunotherapy* 2020; **12**: 269–73.
- 5 Niedzwiedz CL, O'Donnell CA, Jani BD *et al.* Ethnic and socioeconomic differences in SARS-CoV-2 infection: prospective cohort study using UK Biobank. *BMC Med* 2020; **18**: 160.
- 6 de Lusignan S, Dorward J, Correa A *et al.* Risk factors for SARS-CoV-2 among patients in the Oxford Royal College of General Practitioners Research and Surveillance Centre primary care network: a cross-sectional study. *Lancet Infect Dis* 2020; **6**: e18606. <https://doi.org/10.2196/18606>
- 7 Lester JC, Jia JL, Zhang L *et al.* Absence of skin of colour images in publications of COVID-19 skin manifestations. *Br J Dermatol* 2020.

Patient perceptions of Mohs micrographic surgery during the COVID-19 pandemic and lessons for the next outbreak

doi: 10.1111/ced.14423

Understanding patient experiences of healthcare systems during the pandemic is important to help strategize for future similar events. We operated a reduced Mohs micrographic surgery (MMS) service during the pandemic by rationalizing patients by tumour type, age, comorbidities and patient choice. We sought to establish patient expectations and concerns of attending for MMS by conducting a survey of those attending surgery over a 7-week period from 24 April 2020. The results are particularly relevant when re-establishing services in preparation for an expected upsurge of routine activity (including surgical procedures) or 'second spike' of COVID-19 cases later this year.

Although patients who may not have attended surgery were not surveyed, 37% of patients had at least one risk factor for COVID-19 and 27% were over the age of 70 years. Furthermore, we also had a high response rate of 96% (151 responses) reflecting an accurate representation of patient experiences.

Of the survey respondents, 52% were male and 48% female and the majority (98%) white. The age range was 30–89 years and the majority (91%) described their health status as good to excellent.

Our main findings were that the overwhelming majority of patients (82%) were relieved to have surgery. Nearly half (47%) had been worried the hospital would cancel their surgery. Only 17% considered cancelling due to concerns about contracting coronavirus, transmitting to household/family members, or taking public transport, although 54% were anxious about using public transport to attend their appointment. The overwhelming majority (80%) stated they would normally have used public transport if there was not an ongoing pandemic, but only 45% actually did.

Less than a quarter were concerned they would contract COVID-19 in hospital and 30% were concerned about transmitting to household/family members. Only 19% were concerned about the ability to social distance in hospital. Despite these concerns, patients still attended for MMS.

To our knowledge, this is the first study exploring patient perceptions of MMS during the pandemic. Patients overwhelmingly appreciated having MMS treatment in a safe environment. There were some COVID-19-related concerns; however, patients felt that attending their appointment was more important. Relatively few patients were concerned about being able to socially distance in hospital; this may reflect our strong infection-control measures¹ and effective communication, including a nurse-led consultation prior to the appointment. During this consultation, patients were given information about

infection-control measures and had the opportunity to ask questions. The main limitation is we surveyed patients who actually attended hospital for surgery, although a third of patients had COVID-19 risk factors and over a quarter were over 70 years old.

In conclusion, it is clear that patients strongly appreciated continued MMS services during the pandemic and continuation of surgery helps reduce treatment delays and backlogs. Our key lessons for any future pandemic or second wave are that MMS services should continue to run with patients prioritized based on clinical judgement and limiting risks. Effective patient communication is vital prior to surgery to prepare patients and alleviate their concerns. Finally, it is important that multiple infection-control measures are implemented to reduce transmission. We can and should strive to continue to deliver high-quality care and reduce associated risks to provide the best outcomes for patients. This will be critical in any second wave or future pandemics.

P. Nicholson,¹  F. R. Ali,¹  R. Patalay,¹ E. Craythorne¹ and R. Mallipeddi¹

¹*Dermatological Surgery & Laser Unit, St John's Institute of Dermatology, Guy's & St Thomas' NHS Foundation Trust, London, UK*

E-mail: raj.mallipeddi@gstt.nhs.uk

Conflict of interest: the authors declare that they have no conflicts of interest.

Accepted for publication 13 August 2020

Reference

- Nicholson P, Ali FR, Mallipeddi R. Impact of COVID-19 on Mohs micrographic surgery: UK-wide survey and recommendations for practice. *Clin Exp Dermatol* 2020. <https://doi.org/10.1111/ced.14356>

Recognizable vascular skin manifestations of SARS-CoV-2 (COVID-19) infection are uncommon in patients with darker skin phototypes

doi: 10.1111/ced.14421

Reported cutaneous manifestations of SARS-Cov-2 infection include maculopapular rash, urticarial rash, varicelliform or vesicular lesions, petechiae/purpura, livedoid/necrotic lesions, chilblain-like lesions ('COVID toes'), erythema multiforme-like lesions¹ and aphthous ulcers.² These cutaneous manifestations have been mostly reported from countries with populations of lighter skin

Table 1 Details of the patients possible COVID-19-related cutaneous features included in the study.

Patient	Age, years	Sex	Lesion morphology/ diagnosis	Site(s)	Duration	Severity of COVID-19 symptoms	Comorbidities	Other relevant features/comments
1	54	F	Weals	Limbs	2 days	Mild	None	No prior history of weals. The patient also reported a burning sensation over the palms and soles
2	24	M	Desquamation	Palms and soles	4 days	Mild	AML	Desquamation started just after resolution of fever
3	59	F	Weals	Limbs, trunk	7 days	Mild	DM	No prior history of weals
4	31	M	Petechiae	Trunk	3 days	Severe	CML	–
5	19	M	Purpura	Arms and legs	4–5 h	Moderate	None	No thrombocytopenia. Patient died after 1 day of admission
6	40	M	Purpura	Periumbilical area and flank	7 days	Severe	Acute on chronic liver failure	Thrombocytopenia
7	50	F	Chilblain-like	Toes of both feet	15 days	Mild	DM	Lower limb ischaemia as documented by Doppler ultrasonography
8	55	M	Weals	Arms	Acute onset for 7 days ^a	Mild	Chronic kidney disease, hypothyroidism	–
9	28	M	Minor aphthous ulcers	Oral cavity	4 days	Mild	None	No prior history of recurrent oral aphthosis
10	39	M	Macular erythematous rash	Face, trunk	3 days	Mild	DM, hypertension	Occurred in the resolving phase

AML, acute myeloid leukaemia; CML, chronic myeloid leukaemia; DM, diabetes mellitus; ^apatient already had a 2-year history of chronic weals, but the acute episode, lasting for 7 days, correlated temporally with his COVID-19 diagnosis.