**Table 2** COVID-19 vaccination-associated adverse events before and after propensity matching.

| AEs | HS ($n$ = 3418) | No HS ($n$ = 1 275 770) | RR or HR[a,b] | 95% CI | $P$ | HS ($n$ = 3416) | No HS ($n$ = 3416) | aRR or aHR[a,a] | 95% CI | $P$ |
|---|---|---|---|---|---|---|---|---|---|---|
| Acute AE (1 day), % ($n$/$N$) | ≤ 10[c] | 0.1 (742/1 275 770) | – | | – | ≤ 10[c] | ≤ 10[c] | – | | – |
| AESI, % ($n$/$N$)[d] | | | | | | | | | | |
| 30 days | ≤ 10[c] | 0.1 (1098/1 203 737) | – | | – | ≤ 10[c] | ≤ 10[c] | – | | – |
| 60 days | ≤ 10[c] | 0.2 (2095/1 203 737) | – | | – | ≤ 10[c] | ≤ 10[c] | – | | – |
| 90 days | 0.5 (15/2948) | 0.3 (3175/1 203 737) | 1.93[a] | 1.16–3.2 | 0.01 | 0.5 (15/2947) | 0.4 (11/3007) | 1.39[a] | 0.64–3.02 | 0.40 |
| All-cause hospitalization, % ($n$/$N$) | | | | | | | | | | |
| 30 days | 1 (33/3418) | 0.4 (5437/1 275 770) | 2.27[a] | 1.61–3.18 | < 0.001 | 1 (33/3416) | 1.1 (36/3416) | 0.92[a] | 0.57–1.47 | 0.72 |
| 60 days | 1.7 (57/3418) | 0.8 (9713/1 275 770) | 2.19[a] | 1.69–2.84 | < 0.001 | 1.7 (57/3416) | 1.7 (59/3416) | 0.97[a] | 0.67–1.39 | 0.85 |
| 90 days | 2.5 (86/3418) | 1.1 (13 586/1 275 770) | 2.36[a] | 1.92–2.91 | < 0.001 | 2.5 (86/3416) | 2.4 (82/3416) | 1.05[a] | 0.78–1.41 | 0.76 |
| COVID-19 breakthrough infection, % ($n$/$N$)[e] | | | | | | | | | | |
| 30 days | 0.5 (17/3129) | 0.2 (2538/1 228 713) | 2.34[b] | 1.45–3.77 | < 0.001 | 0.5 (17/3127) | 0.3 (11/3154) | 1.51[b] | 0.71–3.23 | 0.28 |
| 60 days | 0.6 (18/3129) | 0.3 (3147/1 228 713) | 1.82[b] | 1.14–2.89 | 0.01 | 0.6 (18/3127) | 0.3 (11/3154) | 1.60[b] | 0.75–3.38 | 0.22 |
| 90 days | 0.6 (20/3129) | 0.3 (3652/1 228 713) | 1.65[b] | 1.07–2.56 | 0.02 | 0.6 (20/3127) | 0.4 (14/3154) | 1.37[b] | 0.69–2.71 | 0.37 |

AESI, adverse event of special interest; aHR, adjusted hazard ratio; aRR, adjusted risk ratio; HR, hazard ratio; HS, hidradenitis suppurativa; RR, risk ratio. [a]RR/aRR was calculated for acute AE, AESI and all-cause hospitalization was calculated while [b]HR/aHR was calculated for COVID-19 breakthrough infection. [c]Results ≤ 10 had details obscured to protect patient privacy and thus analysis could not be performed. [d]Patients with a prior history of AESI were excluded from this analysis. [e]Patients with a prior history of COVID-19 infection were excluded from this analysis.

have existed. Further studies examining the influence of HS severity on outcomes and longer follow-up times are warranted.

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## Supporting Information

Additional Supporting Information may be found in the online version of this article:

**Data S1** Additional information.

## Comment on 'Effects of the COVID-19 pandemic on head lice and scabies infestation dynamics: a population-based study in France'

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Linked article: Launay T *et al. Clin Exp Dermatol* 2021; doi:10.1111/ced.15054.

Dear Editor,

We read with interest the article by Launay *et al.* published recently in *Clinical and Experimental Dermatology*.[1]

 

The authors reported that the rates of head lice and scabies in France decreased during the pandemic period compared with previous years, based on the comparison of the sales rates of topical head lice, topical scabies and ivermectin treatments during the COVID-19 pandemic period and previous years. The authors found that medication use was higher for head lice than for scabies. However, decrease in medication use does not directly reflect the decrease in the number of cases, which the authors state as a weak point of the study.

In the report, the authors stated that strict quarantine conditions in their country may have caused a decrease in the number of patients with head lice or scabies in parallel with the decrease in all hospital admissions, and that the closure of schools in this period and the ensuing summer vacation were the most important factors in the decrease in head lice cases. They also stated that for head lice, patients could not get treatments from hospitals during this period, but could buy topical antibiosis drugs over the counter from pharmacies. Apart from the reasons stated by the authors, we think that the fact that the patients received drugs directly from pharmacies following diagnosis via teledermatology methods such as WhatsApp for head lice, especially during the quarantine period, may also be a reason for this decrease, because in the survey study we conducted of dermatologists in Turkey during this period, we also found that the use of teledermatology methods by patients increased intensively during the pandemic.[2]

Launay *et al.* also stated that although the decrease was not as marked as for head lice at the beginning of the pandemic period, the rate of scabies also decreased significantly, and they suggested that this decrease was because the patients stayed at home under strict quarantine conditions. By contrast, both in our study[2] and in other studies in Turkey,[3] there was a significant increase in the rates of scabies compared with the number of all outpatient clinics, especially a few months after the onset of the pandemic. Kutlu *et al.*[4] periodically followed the rates of scabies patients during the pandemic period in Turkey, and observed a sudden increase in the incidence of scabies 2 months after the start of the pandemic.

Like other authors, we attributed the decrease in the number of applications to a healthcare provider to various reasons, and the fact that patients with scabies preferred to request treatment for severe itching at outpatient clinics despite the quarantine.[3–5] Although nearly 2 years have passed since the start of the pandemic, we observed a significant increase in the number of patients presenting with scabies once quarantine conditions were eased. The increase in referrals to tertiary outpatient clinics is probably due to resistance to topical drugs.

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### Deconstructing traditional dermatology mentorship paradigms in the digital age

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Linked articles: Hussain K *et al*. *Clin Exp Dermatol*. 2022; doi: 10.1111/ced.15071

Butt S, Butt H. *Clin Exp Dermatol*. 2022; doi: 10.1111/ced.15107

Dear Editor,
We enjoyed reading the recent article in *Clinical and Experimental Dermatology* by Hussain *et al*., in which the authors discuss the importance of mentorship for fostering clinical skills of dermatology trainees.[1] In reply, Butt and Butt insightfully explored the complexity of the mentor–mentee relationship, reminding us that mentors not only provide educational supervision, but also help trainees to navigate a diverse realm of adjacent topics, from personal development to systemic racism.[2] In context of the increasingly digital age ushered in by the pandemic,[3] we continue this conversation by critically re-evaluating traditional mentorship paradigms as they pertain to dermatology.

Society's collective adjustment to remote and hybrid workflows due to COVID-19 has upended typical face-to-face (F2F) arrangements between mentors and mentees. Instead, a new model of 'digital mentorship' has formed, characterized by mentor–mentee relationships developed