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COVID-19 pandemic-related impact on two-week wait window for clinic visits in dermatology departments—results of pre-visit image referrals

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To the Editor:

The COVID-19 pandemic has led to several changes in the approach of triaging patients in two-week wait (2WW) skin cancer clinics. These measures were taken to safely address the new skin lesion referrals in U.K.'s National Health Services during the pandemic [1]. Where appropriate, hospitals and dermatology teams continued to aim to deliver remote telephone clinics for outpatient appointments for the duration of the COVID-19 outbreak, to reduce patients coming into the hospital, and support safe practice and infection control [2]. These 2WW skin cancer referrals from general practitioners (GP) along with relevant images were sent to our service via the standard NHS national electronic Referral Service (e-RS). These were taken either by the patients themselves or by the GP. Of note, there was no availability of dermatoscopic images. Thereafter, the patient would be booked into a 2WW skin cancer telephone

clinic where the clinician would review the images and discuss with the patient diagnosis and appropriate management.

The aim of the audit was to evaluate: 1) completeness of referrals with available image(s) to be reviewed alongside the GP referral on first clinic consultation; 2) quality of images sufficient for diagnosis; and 3) the financial impact of the new pathway.

A total of 213 consecutive new 2WW cancer referrals were audited between May 13, 2020 and July 27, 2020. Of these, 31 (14.6%) did not have any images attached, 173 (81.2%) had images provided by the patient, and 9 (4.2%) included images taken by the GP. Of the referrals with provided images (N=182), 76 (42%) were of sufficient quality to make a diagnosis, and 106 (58%) were not. The breakdown of the outcomes is outlined in **Table 1**.

Our hospital specialist service arranged 9.5 extra ad-hoc clinics to meet the added demand for follow up face-to-face appointments required to make the diagnosis (N=125). The financial costs of the new 2WW telephone pathway were calculated and

Table 1. Summary of outcomes of audited 2WW cancer referrals (n=213)

Clinical outcome	Patients with sufficient quality images	Patients with no sufficient quality of images	Patients with no available images
Follow up	28	94	26
Biopsy	33	8	1
Discharge	15	3	3
Patient did not attend	0	1	1
Sum	76 (35.7%)	106 (49.7%)	31 (14.6%)

compared with the previous face-to-face 2WW pre-COVID pathway. There was an excess of \$10,299.87 (£7,426) by adding the cost of those patients who required a face-to-face follow up appointment following initial review of their images (N=94). The cost of the new pathway was \$256.60 (£185) per consultation adding an extra cost of \$49.75 (£35.87) per patient compared to pre-COVID fees.

In summary, images sent for 2WW telephone clinics during the COVID-19 pandemic lockdown period were mainly taken, and sent by patients. On the day of consultation, 15% of referrals did not have any images. More than half of the available images were not sufficient to make a diagnosis. Almost three of 5 patients required a further face-to-face consultation following telephone consultation. Poor image quality creates a barrier to initial telephone consultation in 2WW clinics. This in turn had a significant impact both on time- and cost-efficiency on diagnosis and management of skin patients.

Since the results of this audit, our skin cancer pathway was changed back to the pre-COVID set up from the end of August 2020, despite two

consecutive governmental-implemented full lockdowns as it was not sustainable both financially and in terms of clinic capacity. Namely, all suspected skin cancer referrals now receive a face-to-face appointment within two weeks from family physician's referral to our rapid access service. We have adapted our clinics to work in a COVID-safe environment. The patients complete a telephone COVID-screening questionnaire the day before their appointment. Thereafter, only the referred patient is allowed to enter the hospital after temperature check at the entrance, without allowing any friends or relatives with them unless patients are capable of only limited self-care or confined to bed or chair more than 50% of waking hours. The clinicians are using personal protective equipment (PPE) in clinic rooms with graded three filter face pieces (FFP3) and all the surfaces of the rooms are cleaned between each patient.

Potential conflicts of interest

The authors declare no conflicts of interest.

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