Urgent care in dermatology: first year experience of an academic clinic

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To the Editor:

Access to timely care remains a significant barrier for patients suffering from dermatologic conditions, with patients waiting upward of an average of 33 days for new appointments [1]. Since most skin conditions become more common with age, there will be more patients seeking care as the population ages [2]. These patients are often initially evaluated by nonspecialists, such as primary care providers or emergency physicians and their skin conditions are less likely to be diagnosed accurately compared to initial evaluation by a trained dermatologist [3]. This can lead to prolonged patient suffering and unnecessary use of antibiotics [4,5]. This gap in the healthcare continuum provides an opportunity to increase access and quality of care for dermatologic complaints. A couple of other institutions have successfully adopted dermatology urgent care models [6,7]. We implemented a dermatology urgent care clinic (UCC) at Washington University in St. Louis and assessed the first year of operation in terms of feasibility and accessibility.

Following approval by the Washington University Institutional Review Board, a retrospective single-site chart review was performed on all visits from the weekly clinic's first year of establishment, from July 2021 to July 2022. Data were organized and analyzed using a secure electronic database (REDCap®).

In total, 628 patients were seen with the highest representation from White (57%) and female (64%) patients (**Table 1**). Most patients who visited the clinic had private insurance (68%) and a primary care physician (86%). Half of the visits were referred by another provider, most commonly primary care (52%). Rashes (60%) were often diagnosed as eczematous dermatitis with a suspected allergic contact component and growths (20%) were often determined to be precancerous (**Table 2**). The median duration of symptoms was three months, with the shortest duration of three days. Only 25% of cases were recurrent issues. Of the patients included, 57% were prescribed medications, most frequently topical corticosteroids and less frequently antibiotics or oral corticosteroids; 20% received a biopsy. A follow-up dermatology appointment was scheduled for 48% of patients.

Dermatology UCCs can provide improved access to necessary specialized care. The UCC resembled our institution's general dermatology clinic during the same time frame regarding distribution of race/ethnicity, gender, and insurance status.

Although the median duration of symptoms of three months suggests that the clinic was unable to address concerns urgently, the wide range of duration of symptoms from three days to 50 years suggests that other factors such as the patient's impression of urgency may confound this data. The UCC served a higher percentage of White patients (57%) compared to the general population in St. Louis City (46.3%) [8]. Only 12.6% of patients seen were on Medicaid compared to 24% of people on Medicaid in the city of St. Louis, suggesting the clinic did not serve many patients from a low socioeconomic stratum [8]. From this experience of opening the UCC we learned there is a need to better advertise the existence of this clinic to patients with social and structural access barriers and that it would be beneficial to open similar centers in low-income areas.

Potential conflicts of interest

The authors declare no conflicts of interest.

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Table 1. *Demographics and insurance status of 628 total patients seen at urgent care clinic.*

Characteristic	Value
Age at visit, mean (range)	48 years (12–95 years)
Race/ethnicity, N (%)	
White or caucasian	357 (57)
Black or African American	198 (32)
Asian or Pacific Islander	41 (7)
Gender Identity, N (%)	
Female	400 (64)
Male	226 (36)
Other [a]	2 (0.3)
Insurance status, N (%)	
Private	429 (68)
Public [b]	190 (30)
None	9 (1)
Primary care, N (%)	
Established	538 (86)
None	90 (14)
Referred by, N(%)	
Primary care	164 (52)
Dermatology	54 (17)
Other [c]	43 (14)

Urgent care	21 (7)
Emergency department	10 (3)

[a] 1 transgender female, 1 nonbinary person.
[b] 111 Medicare, 79 Medicaid.
[c] Obstetrics-gynecology, oncology, rheumatology, allergy, and infectious disease.

Table 2. *Clinical presentation and interventions performed during urgent care clinic visits.*

Category	Finding	N (%) or value
Chief complaint, N (%)		
	Rash	378 (60)
	Growth	123 (20)
	Other[d, e]	127 (20)
Symptoms, N (%)		
	Itching	259 (40)
	Pain	128 (20)
	Change	85 (14)
	Bleeding	39 (6)
	Other	92 (15)
	Asymptomatic[f]	126 (20)
Duration, median (range)		3 months (3 days–50 years)
Recurrent issue, N (%)[g]		156 (25)
Biopsy performed		124 (20)
Labs ordered[h]		34 (5)

Procedure performed[i]	57 (9)
Medications prescribed	358 (57)
Follow-up scheduled	302 (48)

[d] Including nail changes, hair loss, or cysts.
[e] Common diagnoses included dermatitis, seborrheic keratosis, actinic keratosis, acne, folliculitis, hidradenitis suppurativa, squamous cell carcinoma, basal cell carcinoma, verruca vulgaris, pityriasis rosea, and post-inflammatory hyperpigmentation.
[f] Including drainage, swelling, or discoloration.
[g] Previously resolved then relapsed.
[h] Included KOH, HSV/VZV, CBC/CMP, RPR
[i] 31 liquid nitrogen, 17 intralesional kenalog, 10 other (incision & drainage, paring).