

no-show rates in minority patients and patients with Medicaid.^{4,5} Significant reductions in no-show rates with teledermatology suggest that televisits may help mitigate barriers to care and improve access for these patients.

Limitations of this study include its small sample size and single institution experience. However, this study provides early evidence that teledermatology may play an important role in mitigating no-show rates and improving access to our most vulnerable populations. Further investigation into the impact of telehealth on health inequity is vital to informing future policy making regarding continued insurance coverage of telemedicine moving forward.

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Funding: Supported by Harvard Catalyst, The Harvard Clinical and Translational Science Center (National Center for Advancing Translational Sciences, National Institutes of Health Award UL 1TR002541) and financial contributions from Harvard University and its affiliated academic health care centers. The content is solely the responsibility of the authors and does not necessarily represent the official views of Harvard Catalyst, Harvard University and its affiliated academic health care centers, or the National Institutes of Health.

Conflicts of interest: None declared.

IRB status: The institutional review board of the University of Massachusetts designated this study exempt from institutional review as a quality improvement project.

Reprints not available from the authors.

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REFERENCES

1. Kassamali B, Haddadi NS, Rashighi M, Cavanaugh-Hussey M, LaChance A. Telemedicine and the battle for health equity:

translating temporary regulatory orders into sustained policy change. *J Am Acad Dermatol*. 2020. <https://doi.org/10.1016/j.jaad.2020.08.016>.

2. Newswire PR. Telehealth claim lines increase 4,347 percent nationally from March 2019 to March 2020. Available at: <https://www.prnswire.com/news-releases/telehealth-claim-lines-increase-4-347-percent-nationally-from-march-2019-to-march-2020--301069182.html>. Accessed August 13, 2020.
3. Dantas LF, Fleck JL, Cyrino Oliveira FL, Hamacher S. No-shows in appointment scheduling - a systematic literature review. *Health Policy*. 2018;122:412-421.
4. Syed ST, Gerber BS, Sharp LK. Traveling towards disease: transportation barriers to health care access. *J Community Health*. 2013;38:976-993.
5. Sharp DJ, Hamilton W. Non-attendance at general practices and outpatient clinics. *BMJ*. 2001;323:1081-1082.

<https://doi.org/10.1016/j.jaad.2020.09.019>

Cross-sectional survey examining skin picking and hair pulling disorders during the COVID-19 pandemic



To the Editor: Body-focused repetitive behaviors (BFRBs) include repetitive hair pulling (trichotillomania), nail biting, and skin picking (excoriation disorder). The ritualized behaviors are distinct and classified among obsessive-compulsive and related disorders in the Diagnostic and Statistical Manual of Mental Disorders. BFRBs can cause distress, visible damage, and lead to social impairment.

Societal changes from the COVID-19 pandemic present a unique challenge to those with BFRBs. Individuals with BFRBs have high baseline levels of anxiety and report a correlation between anxiety and symptom severity.¹ Rapid implementation of changes to daily life, including COVID-19 social distancing directives, have the potential to compound the increased social isolation already experienced by those with BFRBs.¹

We created a survey to examine how changes during the COVID-19 pandemic have affected those with BFRBs, including symptom severity and access to treatment.

This study was exempted by the University of Minnesota Institutional Review Board. An online survey link was shared among BFRB Facebook groups and in a newsletter sent to consumers of a BFRB awareness device (HabitAware, Minneapolis, MN). Responses were collected between July 1 and July 31, 2020. Participants who indicated hair-focused BFRBs completed a modified Massachusetts General Hospital Hairpulling Scale and those with skin-focused BFRBs completed a modified Skin Picking Scale-Revised comparing symptoms before and during the

Table I. Demographics, therapy, and dermatologic care

Category	
Age, y, mean (SD)	32.5 ± 12.4
Diagnosis, n	
Formal BFRB diagnosis	460
No formal BFRB diagnosis, excluded	25
Location, n (%)	
United States	342 (74.3)
Outside of the United States	118 (25.7)
Race, ethnicity, or origin, n (%)	
Asian or Pacific Islander	15 (3.3)
Black or African American	7 (1.5)
Hispanic or Latino	15 (3.3)
Middle Eastern or North African	4 (0.9)
White	411 (89.3)
Other race, ethnicity, or origin	8 (1.7)
Gender/gender identity, n (%)	
Transgender	11 (2.4)
Nonbinary	9 (2.0)
Genderqueer*	5 (1.1)
Female	457 (99.3)
Male	13 (2.8)
Chose not to disclose	1 (0.2)
BFRB classification, n (%)	
Repetitive skin picking	133 (28.9)
Repetitive hair pulling	181 (39.3)
Both	141 (30.7)
Other BFRB	5 (1.1)
Self-rated impact of COVID on BFRB, n (%)	
Improved	60 (13.0)
No change	81 (17.6)
Worsened	309 (67.2)
No answer	10 (2.2)
BFRB therapy, n (%)	
Active treatment for BFRB before COVID	145 (31.5)
Interruption to active treatment because of COVID	55 (37.9)
No active treatment for BFRB before COVID	315 (68.5)
Desire to start therapy since COVID	127 (40.3)
Dermatologic care, n (%)	
History of dermatologic care	249 (54.1)
History of dermatologic care for BFRB	55 (12.0)

*Genderqueer is as a term for self-identification and includes those who have a gender identity that does not align with sex assigned at birth. For more information, see the American Academy of Dermatology Lesbian, Gay, Bisexual, Transgender, and Queer Sexual and Gender Minority Expert Resource Group position statement on Sexual and Gender Minority Health in Dermatology, available at <https://server.aad.org/Forms/Policies/Uploads/PS/PS-Sexual%20and%20Gender%20Minority%20Health%20in%20Dermatology.pdf?>

pandemic.^{2,3} Paired-samples t tests were used to compare means.

A total of 460 individuals with a self-reported BFRB diagnosis completed the survey (Table I). Skin

picking was reported by 133 (28.9%) participants, hair pulling was reported by 181 (39.3%) participants, and 141 (30.7%) participants reported both. A majority (67.2%) reported increased BFRB symptoms during COVID-19. Of the 145 (31.5%) participants receiving active treatment for BFRBs, 55 (37.9%) experienced an interruption in therapy because of COVID-19. Those with skin picking disorders reported a significant (2.2) increase on the modified Skin Picking Scale-Revised ($P = .00$). Participants with hair pulling disorders reported a 1.6 point increase on the Massachusetts General Hospital Hairpulling Scale ($P = .01$; Table II).

For those with BFRBs, the COVID-19 pandemic has led to increased symptoms. Although this study was limited by modification of standardized scales and its self-reported survey design, it suggests that anticipated psychologic effects of the pandemic are, in fact, materializing. Respondents with both skin and hair BFRBs reported increased distress and functional impairment.

BFRBs are psychiatric disorders with dermatologic manifestations. While only 12.0% of those surveyed in our study reported seeing a dermatologist for their BFRB before COVID-19, the rapid spread of telemedicine may change that. Dermatologists should be aware that those with BFRBs may be experiencing increased skin picking and hairpulling during COVID-19. Proactive outreach to existing patients with BFRBs may be helpful.

Although there are no treatments for BFRBs approved by the US Food and Drug Administration, treatment options include serotonin reuptake inhibitors, N-acetylcysteine, behavioral therapies, and wearable devices.^{4,5} In addition, many health systems have expanded telemedicine capabilities. In the context of lessened geographic and social barriers (eg, appearance stigma), patients with BFRBs may have greater access to treatment. Thus, it is more important than ever for dermatologists to consider BFRBs in their differential diagnosis and management.

We acknowledge the members of the body-focused repetitive behaviors social media community who helped disseminate the survey.

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Table II. Modified Skin Picking Scale-Revised and modified Massachusetts General Hospital Hairpulling Scale scores before and after COVID

Scale and score	Pre-COVID mean	COVID mean	Mean difference	P value
SPS-R (modified) scale item (0-4)				
Overall urge	1.8	2.2	0.4	.00
Intensity of urges	1.8	2.3	0.4	.00
Time spent picking skin	1.6	1.9	0.3	.00
Control over skin picking behavior	2.1	2.5	0.3	.00
Emotional distress from skin picking	1.7	1.9	0.2	.02
Social impairment caused by skin picking	1.1	1.2	0.2	.05
Social avoidance behavior	0.8	1.0	0.2	.00
Physical damage to skin from skin picking	1.6	1.7	0.2	.00
Total modified SPS-R (max 32)	12.5	14.7	2.2	.00
MGH-HPS (modified) scale item (0-4)				
Frequency of urges	2.2	2.6	0.4	.00
Intensity of urges	2.3	2.6	0.4	.00
Ability to control the urges	2.0	2.3	0.2	.02
Frequency of hairpulling	1.8	2.0	0.3	.01
Control over hairpulling	2.9	3.0	0.1	1.03
Associated distress	2.3	2.5	0.2	.02
Total modified MGH-HPS (max 24)	13.5	15.1	1.6	.01

MGH-HPS, Massachusetts General Hospital Hair Pulling Scale; SPS-R, Skin Picking Scale-Revised.

Funding sources: None.

IRB approval status: Approved by the Institutional Review Board of the University of Minnesota.

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Conflicts of interest

Ms Idnani is the cofounder and president of HabitAware. HabitAware did not provide any funding for this study. The remaining authors have no disclosures.

REFERENCES

- Keuthen NJ, Deckersbach T, Wilhelm S, et al. Repetitive skin-picking in a student population and comparison with a sample of self-injurious skin-pickers. *Psychosomatics*. 2000;41:210-215.
- Keuthen NJ, O'Sullivan RL, Ricciardi JN, et al. The Massachusetts General Hospital (MGH) Hairpulling Scale: 1. Development and factor analyses. *Psychother Psychosom*. 1995;64:141-145.
- Snorrason I, Ólafsson RP, Flessner CA, Keuthen NJ, Franklin ME, Woods DW. The Skin Picking Scale-Revised: factor structure and psychometric properties. *J Obsessive Compuls Relat Disord*. 2012;1:133-137.
- Sani G, Gualtieri I, Paolini M, et al. Drug treatment of trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, and nail-biting (onychophagia). *Curr Neuropharmacol*. 2019;17:775-786.
- Himle JA, Perlman DM, Lokers LM. Prototype awareness enhancing and monitoring device for trichotillomania. *Behav Res Ther*. 2008;46:1187-1191.

<https://doi.org/10.1016/j.jaad.2020.11.011>

A surge in the incidence of telogen effluvium in minority predominant communities heavily impacted by COVID-19



To the Editor: In March 2020, New York City (NYC) experienced a surge of coronavirus infections, becoming the epicenter of the global pandemic. Low-income, communities of color were the hardest hit, with morbidity and mortality far outweighing that of more affluent white areas.¹ Our dermatology departments operate out of 2 safety net hospitals in Brooklyn and Manhattan serving racially diverse neighborhoods that experienced some of the highest death rates in NYC.² Beginning in July, we began to notice an abrupt uptick in cases of hair shedding in our clinics. The timeframe, approximately 3 to 4 months after the shelter in place directive in NYC, correlates with the expected onset of telogen effluvium (TE).

To quantify the incidence of TE, a retrospective analysis was performed whereby all patients diagnosed with the condition were extracted from among the total patients evaluated by dermatology (SlicerDicer; EPIC, Verona, WI). Between November 1, 2019 and February 29, 2020, an average of 7.5 cases of TE were identified every 2 months—an incidence of 0.4% (Fig 1). This rate remained stable through June 2020 with an incidence of 0.5%. However, in July and August, 43 patients with TE were identified, corresponding to an incidence of 2.3%—a >400% increase in incidence (Fig 1). The