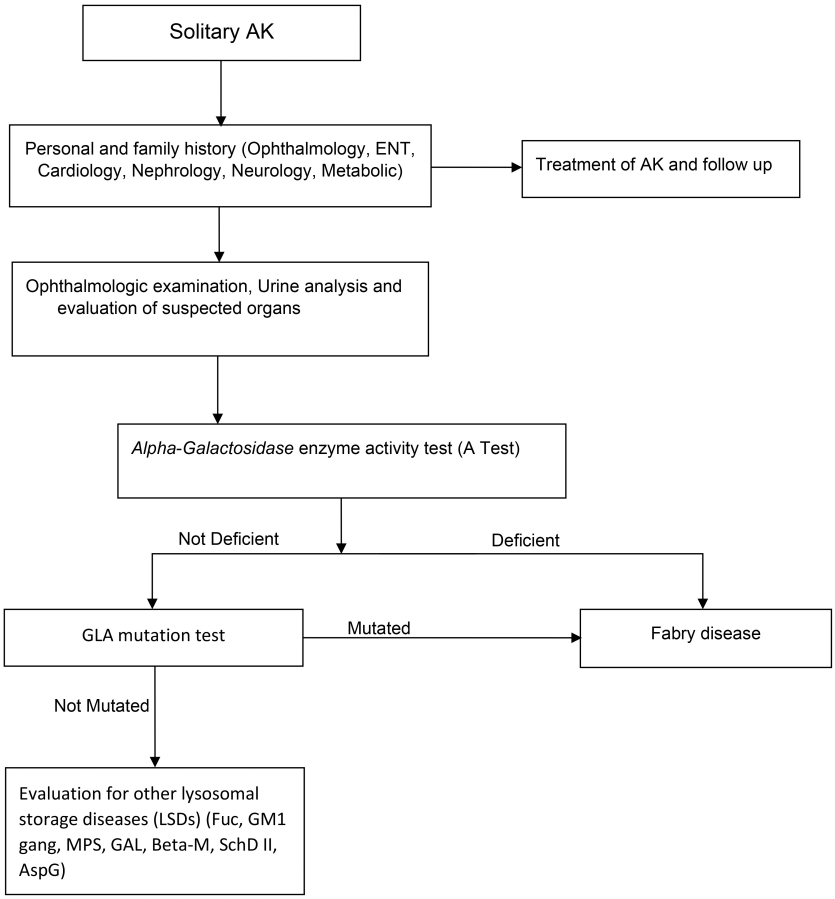

Figure 2 Approach to the patients with solitary angiokeratoma. Fuc, fucosidosis; GMI, gangliosidosis; MPS, mucopolysaccharidosis; GAL, galactosialidosis, Beta-M, beta-mannosidosis, SchD II, AspG (Schindler disease Type II)

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Impact of interpreter use on visit times in dermatology – A single-center retrospective cohort study

Dear Editor,

Patients with limited English proficiency experience improved health outcomes when medical interpreters are used.[1] Primary care setting studies have found that patients requiring medical interpreters have longer visit times than their counterparts.[2] Our study explores the impact of medical interpreter use on visit duration at our dermatology clinic.

A single-center retrospective cohort study was performed using Epic data on outpatient in-person (Michigan Medicine's Taubman Center Dermatology Clinic) and video visits (Michigan Medicine Dermatology) from October 2020 to April 2021. Total visit lengths (measured from time of check-in to check-out) of 100 interpreted and 7739 non-interpreted visits were analyzed. The time of check-in, check-out, or both were not always documented, resulting in implausibly short or extended visits. Visits shorter than 5 min and longer than 180 min were included as blank data points. Average total visit times were compared between interpreted and non-interpreted visits and between visits using different interpreting modalities (hospital-provided, phone, patient-provided, and video). Paired *t*-tests were used to assess statistical significance, with a p value <0.05.

In-person interpreted visits were 10 min longer than non-interpreted visits ($p = 0.004$), and interpreted video visits ($n = 12$)

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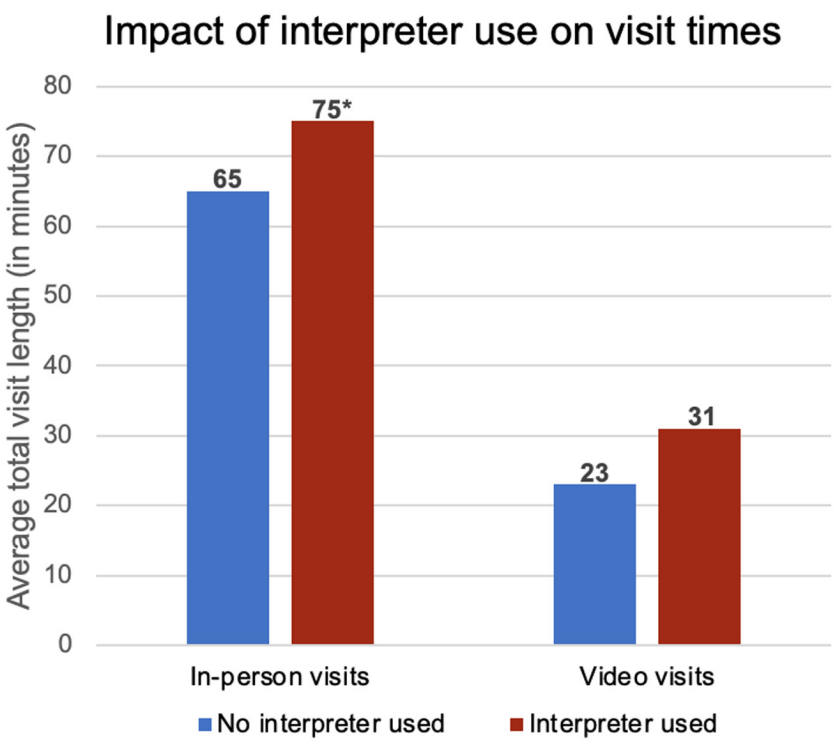

Figure 1 Average total visit times for in-person and video visits using interpreters and those not using interpreters. *All in-person visits utilizing an interpreter (n = 88) were analyzed including those in which interpreting modality was not specified

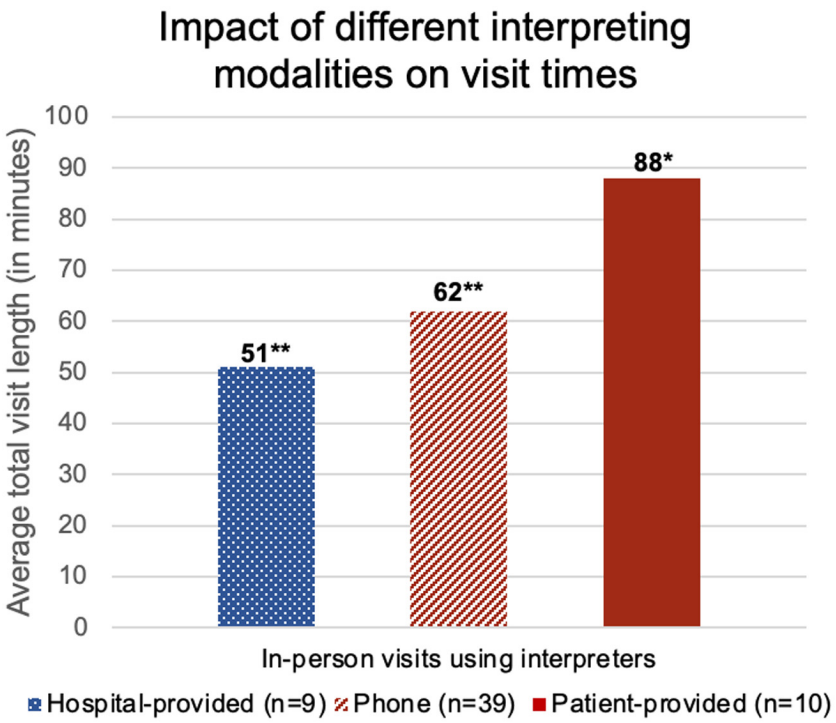

Figure 2 Average total visit length for visits using different interpreter modalities. Interpreted visits without a documented interpreting modality were excluded from this analysis. *Patient-provided interpreters include patients' family members and friends. **No statistically significant difference in average total visit length was detected between phone and hospital-provided interpreting modalities

were 8 min longer than non-interpreted video visits (p = 0.008) (Figure 1). The average visit time for visits utilizing patient-provided interpreters (n = 10) was 26 and 37 min longer than visits using phone (n = 39) (p = 0.0495) and hospital-provided interpreters (n = 9) (p = 0.01), respectively (Figure 2). There was no statistically significant difference in the visit duration between visits utilizing phone and hospital-provided interpreters (p = 0.17) (Figure 2).

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All visits were longer when utilizing interpreters. For in-person visits, it is unclear how much of this time is provider-facing time, as the total visit length we analyzed includes time spent in the waiting room, with the medical assistant, in the exam room, and with providers. In contrast, video visit duration represents the majority of the provider-facing time. Comparing interpreting modalities, in-person visits using phone and hospital-provided interpreters were comparable in duration but significantly shorter than visits using patient-provided interpreters. Video visits utilizing interpreters had the shortest duration since no time is spent in waiting and exam rooms.

Study limitations include having a small sample of interpreted visits and lack of real-time measurements of visit duration, visit content information (number and severity of medical concerns addressed), and patient satisfaction measures. Also, the generalizability of our findings to other dermatology practices is unclear.

Our study supports the need for extended visits when utilizing interpreters. Ways to accommodate extended visits include scheduling patients at the end of clinic, avoiding scheduling multiple visits requiring interpreters on a given day, or increasing the allotted visit time. If medically appropriate, video visits are a reasonable alternative to in-person visits for individuals requiring interpreters, especially given the ongoing COVID-19 pandemic. Our study supports using professionally trained interpreters, which is the standard of care at Michigan Medicine. To minimize clinic flow disruptions, steps should be taken to address the need for extended visits when using interpreters.

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Ulcerated cutaneous lesions in type 1 lepra reaction healing with morpheaform scarring: an unusual presentation

Dear Editor,

A 39-year-old female presented to the leprosy clinic with a 2-week history of reddish skin lesions over the body and pain along the medial aspect of the left elbow associated with fever, arthralgia, and generalized weakness.

Examination revealed multiple erythematous, edematous papules, and plaques of variable sizes distributed over the face, trunk, and upper and lower limbs with involvement of palms and soles (Figure 1a). Plaques over the arms showed 'inverted saucer' morphology with multiple well-defined punched out ulcers over the surface and loss of temperature sensation (Figure 1b). Sensory examination of the remainder of the lesions and of the hands and feet was normal. Left ulnar and bilateral radial cutaneous nerves were enlarged with tenderness in the former. There was no evidence of malnutrition or immunosuppression in the patient. A diagnosis of mid-borderline leprosy with acute severe type I reaction was made. Slit skin smear was positive for acid-fast bacilli, and skin biopsy result was consistent with the diagnosis. All routine investigations were within normal limits. WHO-multidrug therapy comprising monthly supervised doses of rifampicin 600 mg and clofazimine 300 mg and daily administered dapsone 100 mg and clofazimine 50 mg was started along with prednisolone at 1 mg/kg/day. At 1 month follow-up, erythema and edema had decreased with the resolution of neuritis. The ulcerated lesions, however, had healed with severe scarring causing partial restriction of movement at the elbow joint (Figure 2a). The scarring had a striking morpheaform appearance and on dermoscopy revealed whitish amorphous structureless areas, chrysalis-like structures with

Figure 1 (a) Erythematous, edematous papules, and plaques present over the face, neck, and ear. (b) Annular plaque with multiple well-defined ulcers present over the medial aspect of the left elbow

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