When Are Inpatient and Emergency Dermatologic Consultations Appropriate?

Hershel Dobkin, MD; Timothy Blackwell, BS; Robin Ashinoff, MD

PRACTICE **POINTS**

- Primary inpatient teams should call patients' insurance companies to verify in-network dermatologists for eventual outpatient follow-up.
- Chronic skin problems (eg, psoriasis, hidradenitis suppurativa) are better cared for in an outpatient setting due to the necessity for follow-up reassessments.
- There remains a need to fill knowledge gaps for common inpatient dermatologic problems that do not necessitate consultations, such as morbilliform drug rash and other chronic and unchanged dermatoses.

There are limited clinical data concerning inpatient and emergency department (ED) dermatologic consultations. The indications for these consultations vary widely, but in one study (N=271), it was found that 21% of inpatient consultations were for contact dermatitis and 10% were for drug eruptions.[1] In the same study, 77% of patients who required a dermatology consultation eventually were given a different diagnosis or change in treatment after consultation. For example, of all consultations for suspected cellulitis, only 10% were confirmed after dermatology evaluation.[1]

Hospitalists and emergency physicians continue to struggle with the assessment of dermatologic conditions, often consulting dermatology whenever a patient has a "rash" or skin concern. Dermatology is still not emphasized in medical education and often is taught to most medical students in an abbreviated fashion, which results in physicians feeling ill-equipped to deal with any dermatologic condition—either mundane or potentially life-threatening. A study in 2016 showed that a monthly lecture series given to hospitalists over the course of 5 years did not improve diagnostic accuracy in patients who were admitted with skin manifestations.[2] This further shows that there is a need for dermatologic experts in the hospital.

We need to develop better guidelines for physicians in the ED and on inpatient units to guide them on appropriate use of dermatologic consultation outside the ambulatory office and the clinic. A 2013 study showed that patients often were discharged immediately after a dermatologic consultation, furthering our hypothesis that many inpatient consultations can be delayed until after discharge.[3]

In an era in which medical costs are soaring and there is constant surveillance for ways to reduce costs without impairing quality of care, limiting unnecessary specialty consultations should be embraced. In 2009, $1.8 billion in Medicare claims was paid for dermatology-related admissions.[3] A substantial savings to Medicare consulting fees for certain diagnoses, such as cellulitis or contact dermatitis, could be realized if patients were referred for outpatient assessment and treatment. In a study of 271 consultations, 54 patients also had a skin biopsy, which further increases dollars spent on inpatient care

Drs. Dobkin and Ashinoff are from Hackensack University Medical Center, New Jersey. Mr. Blackwell is from the Rowan University School of Osteopathic Medicine, Stratford, New Jersey.

The authors report no conflict of interest.

Correspondence: Hershel Dobkin, MD, Hackensack University Medical Center, 30 Prospect Ave, Hackensack, NJ 07601 (hersheldobkin@gmail.com).

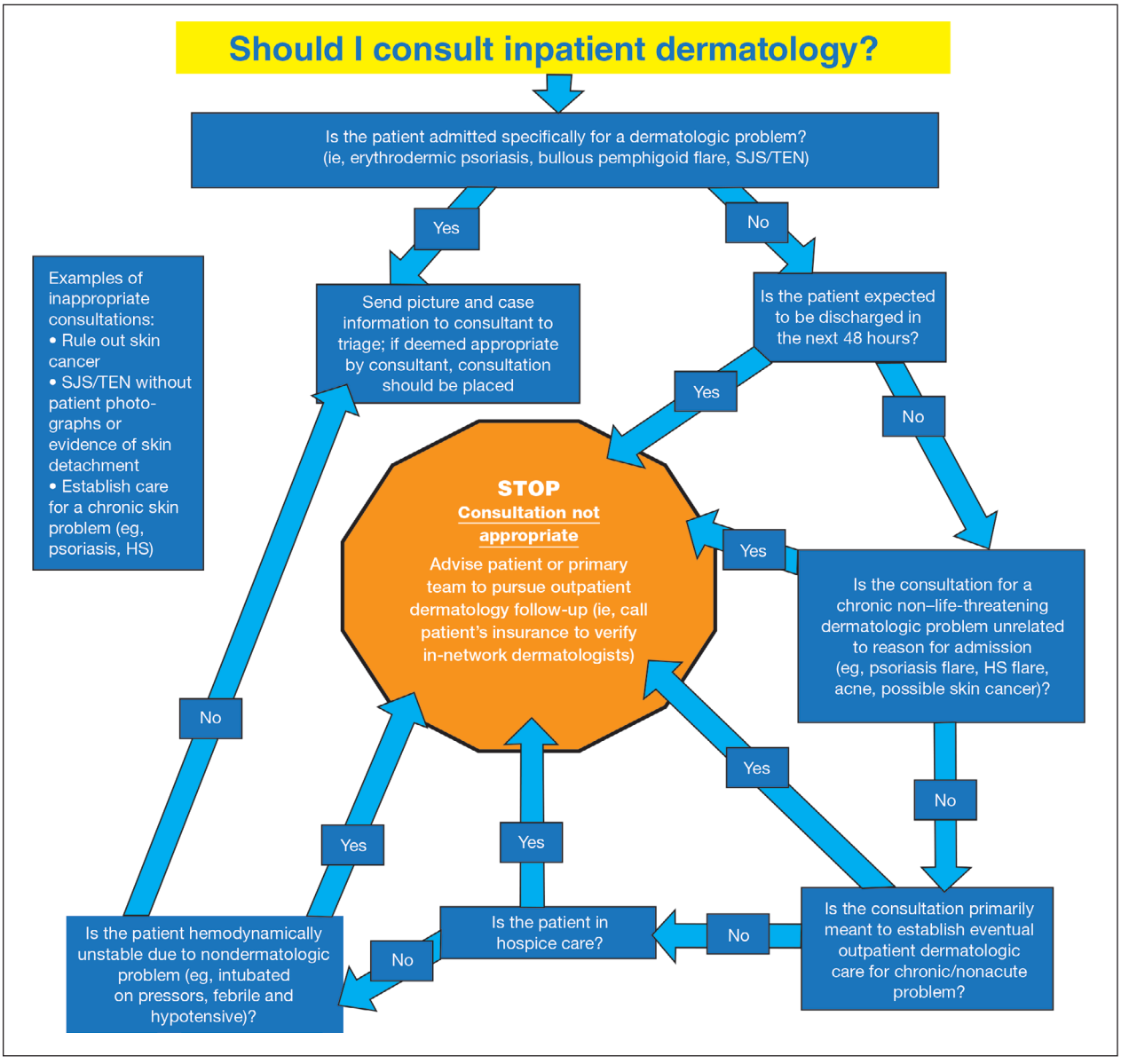
doi:10.12788/cutis.0492

and is (usually) something that can be performed in the outpatient setting.[1] In another study, the more common recommended treatments were topical corticosteroids and supportive educational measures for patients and hospital staff,[3] which further substantiates that most dermatology consultations are not truly emergent and can wait for outpatient consultation.

In addition, we are dealing with the COVID-19 pandemic in our hospitals and EDs. Many physicians, including dermatologists, would prefer to avoid unnecessary exposure to SARS-CoV-2 on inpatient units and in the ED. It certainly would be preferable to require consultants to come in to evaluate patients only when they truly need to be seen while in the hospital.

There also is limited dermatology training in other specialties, and the dermatology team can help fill this gap with educational programs and one-on-one teaching. Hospital teams have signaled this need, but there has been limited success with multiple teaching opportunities.[4]

We believe that this need for inpatient dermatology services can be filled with the newer subspecialty of hospital dermatology, which is not commonly present at most hospitals; a reason why the subspecialty has not been more popular is that there are few available data in the form of randomized clinical trials that can guide inpatient dermatologists with the care of rare hospital skin diseases.[5] Having a dermatologic hospitalist available



Inpatient dermatology consultation flowchart. HS indicates hidradenitis suppurativa; SJS, Stevens-Johnson syndrome; TEN, toxic edpidermal necrolysis.

might allow for patients to be seen more readily, which ultimately will save lives and health care dollars and would increase real-time teaching and education for house staff, nursing, and attendings at the bedside.

In a 2018 article,[6] it was postulated that quicker diagnosis of pseudocellulitis and initiation of antibiotics to treat this condition would save the US health care system $210 million annually. We believe that pseudocellulitis would be best evaluated by inpatient dermatology teams, thereby avoiding costly dermatologic consultations, at an average rate of $138.89.[6]

Morbilliform drug eruptions are among the most common skin conditions seen in the hospital; approximately 95% of cases are an uncomplicated reaction to a medication or virus. Data show that many of these consultations might be unnecessary.[7]

Our institution (Hackensack University Medical Center, New Jersey) is a tertiary hospital that also is connected with a major cancer center. Given this connection, skin eruptions due to chemotherapy and radiation are common. The treatment of drug eruptions, graft-vs-host disease, and other oncologic or drug-related eruptions should be within the scope of practice of our hospitalists, but these cases frequently involve dermatologic consultation.

We constructed a consultation flowchart (Figure) to help guide the triage of patients in need of dermatologic evaluation by inpatient teams and possibly to avoid unnecessary consultation fees. The manner in which this—or any flowchart or teaching aid—is conveyed to hospital personnel is critical so that these tools are not perceived as patronizing or confrontational. In our flowchart, we list emergent dermatologic conditions that we believe are appropriate for dermatology consultation including erythrodermic psoriasis, bullous pemphigoid flare, and Stevens-Johnson syndrome/toxic epidermal necrolysis.

We believe that the flowchart can educate inpatient medical teams about appropriate dermatology consultation. Use of the flowchart also may decrease unnecessary consultations, which ultimately will lower health care spending overall.

REFERENCES

1. Davila M, Christenson LJ, Sontheimer RD. Epidemiology and outcomes of dermatology in-patient consultations in a Midwestern U.S. university hospital. *Dermatol Online J*. 2010;16:12.
2. Beshay A, Liu M, Fox L, et al. Inpatient dermatology consultative programs: a continued need, tools for needs assessment for curriculum development, and a call for new methods of teaching. *J Am Acad Dermatol*. 2016;74:769-771. doi:10.1016/j.jaad.2015.11.017
3. Hu L, Haynes H, Ferrazza D, et al. Impact of specialist consultations on inpatient admissions for dermatology-specific and related DRGs. *J Gen Intern Med*. 2013;28:1477-1482. doi:10.1007/s11606-013-2440-2
4. Faletsky A, Han JJ, Mostaghimi A. Inpatient dermatology best practice strategies for educating and relaying findings to colleagues. *Curr Dermatol Rep*. 2020;9:256-260. doi:10.1007/s13671-020-00317-y
5. Fox LP. Hospital dermatology, introduction. *Semin Cutan Med Surg*. 2017;36:1-2. doi:10.12788/j.sder.2017.015
6. Li D, Xia FD, Khosravi H, et al. Outcomes of early dermatology consultation for inpatients diagnosed with cellulitis. *JAMA Dermatol*. 2018;154:537-543. doi:10.1001/jamadermatol.2017.6197
7. Biesbroeck LK, Shinohara MM. Inpatient consultative dermatology. *Med Clin North Am*. 2015;99:1349-1364. doi:10.1016/j.mcna.2015.06.004