A Dermatology Hospitalist Team's Response to the Inpatient Consult Flowchart

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To the Editor:

We read with interest the *Cutis* article by Dobkin et al[1] (*Cutis*. 2022;109:218-220) regarding guidelines for inpatient and emergency department dermatology consultations. We agree with the authors that dermatology training is lacking in other medical specialties, which makes it challenging for teams to assess the appropriateness of a dermatology consultation in the inpatient setting. Inpatient dermatology consultation can be utilized in a hospital system to aid in rapid and accurate diagnosis, avoid inappropriate therapies, and decrease length of stay[2] and readmission rates[3] while providing education to the primary teams. This is precisely why in many instances the availability of inpatient dermatology consultation is so important because nondermatologists often are unable to determine whether a rash is life-threatening, benign, or something in between. From the perspective of dermatology hospitalists, there is room for improvement in the flowchart Dobkin et al[1] presented to guide inpatient dermatology consultation.

To have a productive relationship with our internal medicine, surgery, pediatrics, psychiatry, and other hospital-based colleagues, we must keep an open mind when a consultation is received. We feel that the flowchart proposed by Dobkin et al[1] presents too narrow a viewpoint on the utility of inpatient dermatology. It rests on assertions that other teams will be able to determine the appropriate dermatologic diagnosis without involving a dermatologist, which often is not the case.

We disagree with several recommendations in the flowchart, the first being the assertion that patients who are "hemodynamically unstable due to [a] nondermatologic problem (eg, intubated on pressors, febrile, and hypotensive)" are not appropriate for inpatient dermatology consultation.[1] Although dermatologists do not commonly encounter patients with critical illness in the outpatient clinic, dermatology consultation can be extremely helpful and even lifesaving in the inpatient setting. It is unrealistic to expect the primary teams to know whether cutaneous manifestations potentially could be related to the patient's overall clinical picture. On the contrary, we would encourage the primary team in charge of a hemodynamically unstable patient to consult dermatology at the first sign of an unexplained rash. Take for example an acutely ill patient who develops retiform purpura. There are well-established dermatology guidelines for the workup of retiform purpura,[4] including prompt biopsy and assessment of broad, potentially life-threatening differential diagnoses from calciphylaxis to angioinvasive fungal infection. In this scenario, the dermatology consultant may render the correct diagnosis and recommend immediate treatment that could be lifesaving.

Secondly, we do not agree with the recommendation that a patient in hospice care is not appropriate for inpatient dermatology consultation. Patients receiving hospice or palliative care have high rates of potentially symptomatic cutaneous diseases,[5] including intertrigo and dermatitis—comprising stasis, seborrheic, and contact dermatitis.[6] Although aggressive intervention for asymptomatic benign or malignant skin conditions may not be in line with their goals of care, an inpatient dermatology consultation can reduce symptoms and improve quality of life. This population also is one that is unlikely to be able to attend an outpatient dermatology clinic appointment and therefore are good candidates for inpatient consultation.

Lastly, we want to highlight the difference between a stable chronic dermatologic disease and an acute flare that may occur while a patient is hospitalized, regardless of whether it is the reason for admission. For example, a patient with psoriasis affecting limited body surface area who is hospitalized for a myocardial infarction is not appropriate for a dermatology consultation. However, if that same patient develops erythroderma while they

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are hospitalized for cardiac monitoring, it would certainly be appropriate for dermatology to be consulted. Additionally, there are times when a chronic skin disease is the reason for hospitalization; dermatology, although technically a consulting service, would be the primary decision-maker for the patient's care in this situation. In these scenarios, it is important for the patient to be able to establish care for long-term outpatient management of their condition; however, it is prudent to involve dermatology while the patient is acutely hospitalized to guide their treatment plan until they are able to see a dermatologist after discharge.

In conclusion, we believe that hospital dermatology is a valuable tool that can be utilized in many different scenarios. Although there are certainly situations more appropriate for outpatient dermatology referral, we would caution against overly simplified algorithms that could discourage valuable inpatient dermatology consultations. It often is worth a conversation with your dermatology consultant (when available at an institution) to determine the best course of action for each patient. Additionally, we recognize the need for more formalized guidelines on when to pursue inpatient dermatology consultation. We are members of the Society of Dermatology Hospitalists and encourage readers to reference their website, which provides additional resources on inpatient dermatology (https://societydermatologyhospitalists.com/inpatient-dermatology-literature/).

REFERENCES

1. Dobkin H, Blackwell T, Ashinoff R. When are inpatient and emergency dermatologic consultations appropriate? *Cutis*. 2022;109:218-220. doi:10.12788/cutis.0492
2. Ko LN, Garza-Mayers AC, St John J, et al. Effect of dermatology consultation on outcomes for patients with presumed cellulitis: a randomized clinical trial. *JAMA Dermatol*. 2018;154:529-536. doi:10.1001/jamadermatol.2017.6196
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. Georgesen C, Fox LP, Harp J. Retiform purpura: a diagnostic approach. *J Am Acad Dermatol*. 2020;82:783-796. doi:10.1016/j.jaad.2019.07.112
5. Pisano C, Paladichuk H, Keeling B. Dermatology in palliative medicine [published online October 14, 2021]. *BMJ Support Palliat Care*. doi:10.1136/bmjspcare-2021-003342
6. Barnabé C, Daeninck P. "Beauty is only skin deep": prevalence of dermatologic disease on a palliative care unit. *J Pain Symptom Manage*. 2005;29:419-422. doi:10.1016/j.jpainsymman.2004.08.009

Authors' Response

We appreciate the letter in response to our commentary on the appropriateness of inpatient dermatology consultations. It is the continued refining and re-evaluation of concepts such as these that allow our field to grow and improve knowledge and patient care.

We sought to provide a nonpatronizing yet simple consultation flowchart that would help guide triage of patients in need or not in need of dermatologic evaluation by the inpatient teams. Understandably, the impressions of our flowchart have been variable based on different readers' medical backgrounds and experiences. It is certainly possible that our flowchart lacked certain exceptions and oversimplified certain concepts, and we welcome further refining of this flowchart to better guide inpatient dermatology consultations.

We do, however, disagree that the primary team would not know whether a patient is intubated in the intensive care unit for a dermatology reason. If the patient is in such a status, it would be pertinent for the primary team to conduct a timely workup that could include consultations until a diagnosis is made. We were not implying that every dermatology consultation in the intensive care unit is unwarranted, especially if it can lead to a primary dermatologic diagnosis. We do believe that a thorough history could elicit an allergy or other chronic skin condition that could save resources and spending within a hospital. Likewise, psoriasis comes in many different presentations, and although we do not believe a consultation for chronic psoriatic plaques is appropriate in the hospital, it is absolutely appropriate for a patient who is erythrodermic from any cause.

Our flowchart was intended to be the first step to providing education on when consultations are appropriate, and further refinement will be necessary.

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