Inpatient Dermatology Consultation Services in Hospital Institutions

Courtesy Dr. Dev Ram Sahni.

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RESIDENT **PEARL**

- When performing inpatient dermatology consultations, residents should focus on pre-rounding and must-ask questions of requesting providers as well as carrying an organized toolbox.

Inpatient dermatology plays a key role in the hospital system. Dermatology-related admissions are frequent, and the correct diagnosis and management of cutaneous conditions is crucial to improving patient outcomes and decreasing health care costs. As a dermatology resident, it can be challenging to perform inpatient consultations, especially early in residency. Focusing on pre-rounding and must-ask questions of requesting providers as well as carrying an organized toolbox will be invaluable for every dermatology resident.

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Inpatient dermatology consultation services are becoming increasingly prevalent in hospital institutions.[1-3] Although often underutilized as a consulting service, dermatology-related admissions cost hundreds of millions of dollars for the health care system.[1,2] Misdiagnosis, prolonged hospital stays, and incorrect treatment are common results of lack of involvement by a skin expert.[1-3] The importance of consultative inpatient dermatology cannot be understated. Accreditation Council for Graduate Medical Education requirements for proficiency in dermatology residency include exposure to inpatient dermatology, and it is our duty as residents to aid our colleagues in the management and treatment of cutaneous disease.

Although exposure to inpatient dermatology varies across residency programs, nearly every dermatology resident is bound to perform a consultation and be involved in the care of a hospitalized patient. At our program at the University of Utah (Salt Lake City), we have robust inpatient exposure, and after numerous hours spent on the forefront of inpatient dermatology, I have accrued a list of specific tips and techniques that have aided me as a resident clinician.

Pre-Rounding More Thoroughly

When I started as a postgraduate year 2 (PGY-2) on the inpatient dermatology rotation, I found myself perplexed. I had learned how to round in internal medicine but was unaccustomed to the nuances of specialty rounds. My list included calciphylaxis, small vessel vasculitis, cellulitis, stasis dermatitis, toxic epidermal necrolysis, and atypical mycobacterial infection. The first few days of service were undeniably difficult due to the daily consultations, complexity of admitted patients, and need for efficiency. I sometimes overlooked important laboratory test results, medication changes, and interdisciplinary discussions that prolonged rounding. As dermatologists, we are responsible for the largest organ of the body, and it is important to approach patients in a comprehensive manner. Pre-rounding should include reviewing interdisciplinary notes, laboratory values/results, and medications, and performing a focused skin examination with a review of systems during the encounter. Importantly, most electronic medical record systems offer an automated rounding sheet. In Epic (Epic Systems Corporation), I would use the bone marrow transplant rounding sheet, which includes laboratory test results, vitals, and medications. After printing out the rounding sheet, I would note important updates for each patient. Although pre-rounding and chart review requires time and effort, it aided me in providing elevated patient care and becoming more efficient during rounds. Over time I have come to strongly appreciate the term *dermatology hospitalist*. Cutaneous manifestations of systemic disease require thoughtful consideration and workup.

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New Patient Consultations: Must-Ask Questions

Holding the university inpatient pager can be stressful. At the University of Utah, we often carry 5 to 10 patients on our list and receive 3 to 4 new consultations a day, sometimes right before 5 PM. When receiving new consultations, it is important to obtain the whole story from the requesting provider. Some of the questions may seem obvious, but I am frequently reminded of the inefficiencies I encountered as a first-year dermatology resident. Remember to always be kind to your consulting colleagues. Dermatology is a difficult discipline, and describing rashes is no easy task. Here is my systematic approach to questions that should be asked of the requesting provider during each new patient consultation:

- What is the patient's name, room number, and medical record number?
- Is this patient getting admitted or admitted currently?
- Is the rash the reason for admission? (This can greatly help with triaging the urgency of evaluation.)
- Is the rash painful?
- Is this patient ill?
- How would you describe the rash?

When evaluating new patients, it is crucial to remember the morphology camps. Formulating a differential diagnosis on a complex patient can be difficult; however, remembering the morphology camps of acneiform, dermal, eczematous, erythematous, subcutaneous, vasculitic, vasculopathic, and vesiculobullous lesions can be extremely helpful. Additionally, it is crucial to perform a thorough and complete skin examination on every patient. When emphasizing the importance of this, I often am reminded of a humbling moment early in my training. Our team was consulted on a patient with cellulitis and stasis dermatitis. It was a busy day, and my examination was quick and focused on the lower and upper extremities, chest, and back. The patient improved from a cutaneous standpoint and was discharged. At follow-up the next week, one of my attending providers biopsied an atypical macule on the retroauricular region, which was found to be consistent with a stage 1A melanoma. Even on the longest and most tiring hospital days, it is important to perform a full-body skin examination on each patient. You may end up saving a life.

An Organized Toolbox: What to Carry

Similar to our ophthalmology colleagues who are seen carrying around a suitcase in the hospital, I highly recommend some form of a toolbox or bag for performing inpatient biopsies (Table). Carrying around an organized bag, albeit bulky and unfashionable, has saved me numerous trips back to clinic for unexpected complications including fixing leaky vessels, closing stubborn ulcers, and coordinating sedated biopsies in the operating room.

Inpatient Dermatology Toolbox
Absorbable gelatin powder (you never know when you will be unable to close a biopsy)
Bacterial, fungal, and viral swabs
Bandages
Biopsy kits
Formalin bottles
Gauze
Heat cautery
Lidocaine with epinephrine (bottle or prefilled syringes)
Michel medium
Needles (different gauges) and syringes
Petrolatum jelly
Punch tools (3–8 mm)
Saline bullets
Sutures (silk, polyglactin, and polypropylene)
Urine cups

Final Thoughts

As I near the completion of my residency journey, I hope these tips will aid budding and current dermatology residents at excelling as dermatology hospitalists during inpatient rotations. Dermatologists can make a profound impact on a variety of patients, especially when treating hospitalized patients on the clinical forefront. Our role extends beyond the skin, as cutaneous manifestations of internal disease are not uncommon.

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