

Palliative Care: Utilization Patterns in Inpatient Dermatology

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PRACTICE POINTS

- Although severe dermatologic disease negatively impacts patients' quality of life, palliative care may be underutilized in this population.
- Palliative care should be an integral part of caring for patients who are admitted to the hospital with serious dermatologic illnesses.

Palliative care (PC) focuses on improving the quality of life of patients with serious illnesses. The use of PC in the field of dermatology is limited despite the presence of severe disease. In this cross-sectional study of inpatient dermatology consultations, we aimed to evaluate PC utilization among patients hospitalized with select severe dermatologic diseases. Our results suggest that PC may be underutilized when caring for patients with serious skin diseases. Palliative care should be an integral part of caring for patients with serious illnesses, and further research characterizing ways this can be accomplished by dermatologists is needed.

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Palliative care (PC) is a field of medicine that focuses on improving quality of life by managing physical symptoms as well as mental and spiritual well-being in patients with severe illnesses.^{1,2} Despite cases of severe dermatologic disease, the use of PC in the field of dermatology is limited, often leaving patients with a range of unmet needs.^{2,3} In one study that explored PC in patients with melanoma, only one-third of patients with advanced melanoma had a PC consultation.⁴ Reasons behind the lack of utilization of PC in dermatology include time constraints and limited training in addressing the complex

psychosocial needs of patients with severe dermatologic illnesses.¹ We conducted a retrospective, cross-sectional, single-institution study of specific inpatient dermatology consultations over a 5-year period to describe PC utilization among patients who were hospitalized with select severe dermatologic diseases.

Methods

A retrospective, cross-sectional study of inpatient dermatology consultations over a 5-year period (October 2016 to October 2021) was performed at Atrium Health Wake Forest Baptist Medical Center (Winston-Salem, North Carolina). Patients' medical records were reviewed if they had one of the following diseases: bullous pemphigoid, calciphylaxis, cutaneous T-cell lymphoma (CTCL), drug reaction with eosinophilia and systemic symptoms (DRESS) syndrome, erythrodermic psoriasis, graft-vs-host disease, pemphigus vulgaris (PV), purpura fulminans, pyoderma gangrenosum, and Stevens-Johnson syndrome/toxic epidermal necrolysis. These diseases were selected for inclusion because they have been associated with a documented increase in inpatient mortality and have been described in the published literature on PC in dermatology.² This study was reviewed and approved by the Wake Forest University institutional review board.

Use of PC consultative services along with other associated consultative care (ie, recreation therapy [RT], acute pain management, pastoral care) was assessed for each patient. Recreation therapy included specific interventions such as music therapy, arts/craft therapy, pet therapy, and other services with the goal of improving patient cognitive, emotional, and social function. For patients with a completed PC consultation, goals for PC intervention were recorded.

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Results

The total study sample included 193 inpatient dermatology consultations. The mean age of the patients was 58.9 years (range, 2–100 years); 66.8% (129/193) were White and 28.5% (55/193) were Black (Table). Palliative care was consulted in 5.7% of cases, with consultations being requested by the primary care team. Reasons for PC consultation included assessment of the patient's goals of care (4.1% [8/193]), pain management (3.6% [7/193]), non-pain symptom management (2.6% [5/193]), psychosocial support (1.6% [3/193]), and transitions of care (1.0% [2/193]). The average length of patients' hospital stay prior to PC consultation was 11.5 days (range, 1–32 days). Acute pain management was the reason for consultation in 15.0% of cases (29/193), RT in 21.8% (42/193), and pastoral care in 13.5% (26/193) of cases. Patients with calciphylaxis received the most PC and pain consultations, but fewer than half received these services. Patients with calciphylaxis, PV, purpura fulminans, and CTCL received a higher percentage of PC consultations than the overall cohort, while patients with calciphylaxis, DRESS syndrome, PV, and pyoderma gangrenosum received relatively more pain consultations than the overall cohort (Figure).

Comment

Clinical practice guidelines for quality PC stress the importance of specialists being familiar with these services and the ability to involve PC as part of the treatment plan to achieve better care for patients with serious illnesses.⁵ Our results demonstrated low rates of PC consultation services for dermatology patients, which supports the existing literature and suggests that PC may be highly underutilized in inpatient settings for patients with serious skin diseases. Use of PC was infrequent and was initiated relatively late in the course of hospital admission, which can negatively impact a patient's well-being and care experience and can increase the care burden on their caregivers and families.²

Our results suggest a discrepancy in the frequency of formal PC and other palliative consultative services used for dermatologic diseases, with non-PC services including RT, acute pain management, and pastoral care more likely to be utilized. Impacting this finding may be that RT, pastoral care, and acute pain management are provided by nonphysician providers at our institution, not attending faculty staffing PC services. Patients with calciphylaxis were more likely to have PC consultations, potentially due to medicine providers' familiarity with its morbidity and mortality, as it is commonly associated with end-stage renal disease. Similarly, internal medicine providers may be more familiar with pain classically associated with PG and PV and may be more likely to engage pain experts. Some diseases with notable morbidity and potential mortality were under-represented including SJS/TEN, erythrodermic psoriasis, CTCL, and GVHD.

Patient Demographics and Dermatologic Diagnosis (N=193)

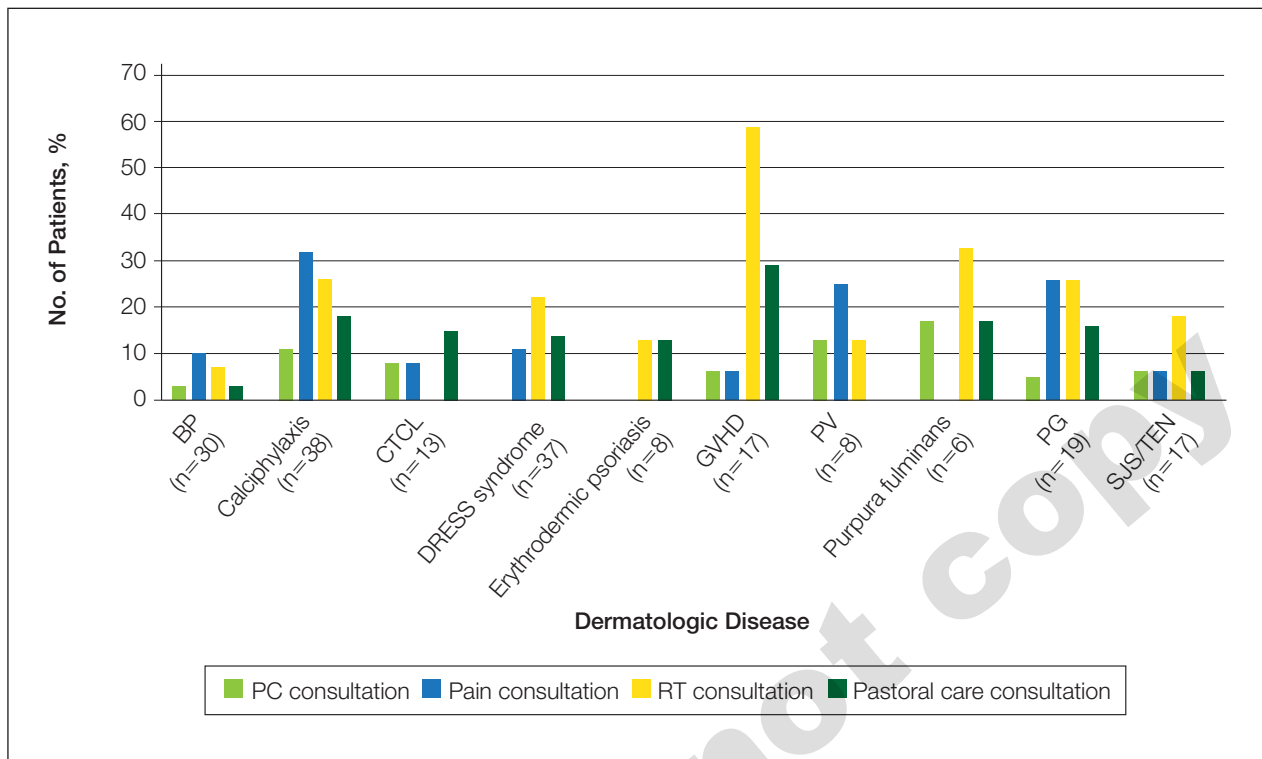
Characteristic	Inpatient dermatology consultations
Mean age (range), y	58.9 (2–100)
Race/ethnicity, n (%)	
White	129 (66.8)
Black	55 (28.5)
Hispanic	3 (1.6)
Other	3 (1.6)
Unspecified	3 (1.6)
Dermatologic diseases, n (%)	
Calciphylaxis	38 (19.7)
DRESS syndrome	37 (19.2)
Bullous pemphigoid	30 (15.5)
Pyoderma gangrenosum	19 (9.8)
Graft-vs-host disease	17 (8.8)
SJS/TEN	17 (8.8)
CTCL	13 (6.7)
Pemphigus vulgaris	8 (4.1)
Erythrodermic psoriasis	8 (4.1)
Purpura fulminans	6 (3.1)

Abbreviations: CTCL, cutaneous T-cell lymphoma; DRESS, drug reaction with eosinophilia and systemic symptoms; SJS/TEN, Stevens-Johnson syndrome/toxic epidermal necrolysis.

Limitations of our study included examination of data from a single institution, as well as the small sample sizes in specific subgroups, which prevented us from making comparisons between diseases. The cross-sectional design also limited our ability to control for confounding variables.

Conclusion

We urge dermatology consultation services to advocate for patients with serious skin diseases and include PC consultation as part of their recommendations to primary care teams. Further research should characterize the specific needs of patients that may be addressed by PC services and explore ways dermatologists and



Percentage of patients within each disease entity who received palliative care (PC), acute pain management, recreation therapy (RT), or pastoral care consultations during hospitalization. BP indicates bullous pemphigoid; CTCL, cutaneous T-cell lymphoma; DRESS, drug reaction with eosinophilia and systemic symptoms; GVHD, graft-vs-host disease; PG, pyoderma gangrenosum; PV, pemphigus vulgaris; SJS/TEN, Stevens-Johnson syndrome/toxic epidermal necrolysis.

others can identify and provide specialty care to hospitalized patients.

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