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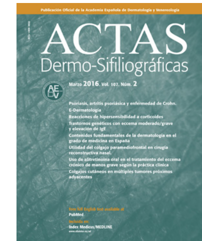

OPINION ARTICLE

Hospitalization of Dermatologic Patients: Why, When, and Where?☆

Hospitalización del paciente dermatológico, ¿dónde, cuándo y por qué?

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The activity of hospitals is divided into 4 areas: inpatient care, emergency department services, surgical procedures, and ambulatory care services. Traditionally, dermatologists work mainly with ambulatory patients[1–4] and in the operating theater.[5,6]

Today, the dermatologist's responsibility for patients who have been admitted to a hospital (inpatient dermatology) is increasingly limited to a consultative role. This decline in inpatient activity contrasts with the steady upward trend in other areas of dermatologic practice, such as surgical, cosmetic, and aesthetic procedures, which are increasingly associated with dermatologic practice. The number of inpatients in dermatology beds is declining in spite of an overall increase in the number of people being hospitalized for skin problems and in the healthcare cost associated with dermatologic inpatients.[7–9]

Why Are Dermatology Patients Admitted to Hospital?

Dermatologists are specialized in the care of the skin, hair, nails, and mucous membranes, and their training focuses on the diagnosis and treatment of skin conditions. This probably explains why research has shown that they are more skilled than other clinicians in the diagnosis and management of diseases affecting the skin and its appendages.[6,8,10–14]

Consultations regarding skin conditions account for up to 6% of office visits in the primary care setting, and as many as 25% of patients visiting a primary care physician have some kind of skin condition, although it may not be the reason for the visit.[8]

Numerous authors have highlighted the declining importance of the dermatologist's role in the care of inpatients admitted for dermatologic problems.[1,7,8,14,15] In 1997, Kirsner et al.[15] conducted a survey on the status of inpatient services in dermatology residency programs in the United States and compared their findings with data relating to 1982. Of the programs responding, 79% reported that they had reduced inpatient activity.

Almost half of the programs with dermatology beds in 1982 no longer had them in 1997, and the average number of patients they admitted for skin disorders fell from 119 in 1982 to 36.5 in 1997. The authors concluded that patients were still being admitted to hospital for skin diseases but were under the care of other specialists.

Several studies have shown that, when a cross consultation is requested to assess a patient with a skin condition (whether or not it is the reason for the admission), the dermatologist has a significant impact on the diagnosis and management of the disorder.[16–19] Lissy Hu et al.,[7] who studied the impact of dermatology consultations on the initial diagnosis made by the team in charge of the patient's care, found that treatment was modified in up to 95% of the patients and the diagnosis was changed in 45% after a dermatology consult. Their findings are in line with those

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of earlier studies, in which the percentage of diagnostic errors in dermatology patients hospitalized by other departments was between 30% and 80%.[16,19,20] Those authors also observed that the errors do not occur in rare skin diseases, but rather in toxicodermas, cellulitis, and allergic contact or stasis dermatitis,[7,18–21] all of which are conditions that may be difficult for other hospital specialists to recognize but which do not pose a diagnostic problem for dermatologists. Other studies show that dermatologists assessing patients with skin disease order fewer tests than other specialists, thereby reducing the number of explorations that generate unnecessary costs for the hospital and may be a source of patient discomfort.[22] All the authors agree on the benefit to dermatologic patients, including those in hospitals, of the involvement of a dermatologist, who can make a more accurate diagnosis and prescribe the most appropriate treatment more promptly. Furthermore, apart from its intrinsic advantages, early diagnosis also tends to reduce the cost of care.

Cellulitis and other bacterial infections of the skin and its appendages are the reason for the majority of visits to emergency departments and inpatient admissions for skin conditions,[2,3,23–25] and studies have shown that they account for up to 70% of admissions related to dermatologic diseases.[26]A European study found that while only 7% of patients with cellulitis required hospitalization, inpatient care accounted for 83% of the total cost associated with treating the disease.[27] In the United States, inpatient admissions for infections of the skin and its appendages continue to increase as a percentage of total admissions,[28] possibly owing to the worldwide increase in bacterial resistance. In spite of this increase, the number of patients admitted under the care of a dermatologist continues to decline.

The authors of a database study[23] found that cross consultation with a dermatologist to assess patients with cellulitis was associated with an increase in the average length of stay (LOS) in hospital. They hypothesized that this increase could be the result of an initial diagnostic error and a poor response to the antibiotic treatment prescribed. In 33% of these cases the dermatologist consulted made an alternative diagnosis, such as lipodermatosclerosis or stasis dermatitis.

Since, as well as increasing morbidity and mortality, errors in diagnosing cellulitis prolong LOS in hospital it would be advantageous to make an effort to improve diagnostic accuracy and to distinguish cellulitis from its imitators.[29,30] This would also prevent unnecessary antibiotic treatment. Levell et al.[31] have proposed that a dermatologist should always be consulted when cellulitis is diagnosed, even when the patient does not require inpatient care.

These findings come from studies that analyzed data on cellulitis and bacterial infections of the skin, but there are many other dermatologic diseases that require inpatient admission and management by a dermatologist.

Another issue addressed by the authors of several articles about inpatient dermatology is the education of residents,[14,15] who, as future dermatologists, should received comprehensive training in all areas of the specialty. They are trained in the consulting room, in the operating theater, and in the emergency department. They should also receive training in the care of hospitalized patients.

On the basis of the data described above, we conclude that patients are still being hospitalized for skin diseases and that if dermatologists do not admit them, this responsibility will be taken on by other specialists.

For all these reasons, we believe that it is important that patients with skin conditions who require inpatient care for the management of their disease should be cared for in hospital by a dermatologist, that is, by the specialist best qualified to diagnose and treat their disease.

When Should a Patient Be Hospitalized for a Dermatologic Condition?

No admission criteria for dermatologic patients have been defined. Some authors, such as Ayyalaraju et al.[32] in a study of 2 inpatient units in Cardiff and Miami, have found that the main reasons for admission were the extensive nature and severity of the skin disease.

Generally speaking, any patient who, owing to the severity or extent of their lesions, requires inpatient care because the treatments and/or care they require cannot be provided in an outpatient setting or day-hospital could be admitted as a patient of the dermatology service. When the care of other specialists in the hospital is required because of the patient's general condition or comorbidities, they can be brought in to ensure that the patient receives the best medical care available.

Since one of the objectives of this article is to remind us that dermatology and hospitalization are terms that are currently somewhat distant from each other, it might be useful—for this purpose—to divide inpatients with skin diseases into 3 groups:

a) Patients who are ''always'' admitted by the dermatology unit rather than other departments: patients with purely dermatologic diseases (autoimmune blistering diseases, psoriasis, and atopic dermatitis) and patients undergoing dermatologic surgical procedures
b) Patients who may be admitted by dermatology units or other hospital departments: patients with cellulitis or bacterial infections, viral infections with cutaneous symptoms, vasculitis with systemic and cutaneous manifestations, etc.
c) Patients who are currently being admitted by other departments, who we think should be ''reclaimed'' by dermatologists: patients with chronic skin ulcers, vasculitis, etc.

We could also classify dermatology inpatients according to the origin of the admission. In dermatology, as in other medical and surgical specialties, patients are admitted to hospital from 3 sites: emergency departments, outpatient consultations, and surgical departments.

In this classification, we can group patients according to the site of service from which they were admitted and, because of their special characteristics, include a fourth group for patients aged under 18 years.

Admissions Related to Surgical Procedures

There are several reasons why patients undergoing surgical procedures are admitted: major surgery requiring monitoring of the surgical wound because of the risk of bleeding

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