Lessons learned from the inpatient dermatology consult service:

“How I approach consults”

Dr. Arturo R. Domínguez
Assistant Professor
University of Texas Southwestern Medical Center
Dallas, TX
Departments of Dermatology and Internal Medicine

I do not have any relevant relationships with industry

I will be discussing off-label use of medications
◆ 490 beds

◆ 862 beds

**Dermatology Consult Service**

- 4 affiliated hospitals
- Dermatology “Hospitalist” since 2012
  - 2 full-time attendings since July 2015
    - On-call 7 AM- 5 PM, M-Fri.
  - Rotating attendings:
    - 5 PM and weekends x 3 weeks per year

**Dermatology Consult Service**

- 3 Residents
  - 2 UTSW, Brook Army Medical Center-San Antonio

- 1 Physician Assistant (Clements)
  - Sees low-complexity without staffing

- Rotating medical students
UTSW Dermatology Consult Service

<table>
<thead>
<tr>
<th>Year</th>
<th>Initial Consults</th>
<th>Follow Ups</th>
<th>Total</th>
<th>% Follow Ups</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-2010</td>
<td>711</td>
<td>11</td>
<td>722</td>
<td>2%</td>
</tr>
<tr>
<td>2010-2011</td>
<td>781</td>
<td>59</td>
<td>840</td>
<td>7%</td>
</tr>
<tr>
<td>2011-2012</td>
<td>903</td>
<td>51</td>
<td>954</td>
<td>5%</td>
</tr>
<tr>
<td>2012-2013</td>
<td>984</td>
<td>762</td>
<td>1746</td>
<td>44%</td>
</tr>
<tr>
<td>2013-2014</td>
<td>1098</td>
<td>617</td>
<td>1715</td>
<td>36%</td>
</tr>
<tr>
<td>2014-2015</td>
<td>1245</td>
<td>829</td>
<td>2074</td>
<td>40%</td>
</tr>
</tbody>
</table>

- 2016: 1553 consults + 1041 subsequent = 2594 visits / 1700 beds

Answering the Consult

- Reason for admission:
  - 28 yo patient with abdominal pain
- Reason for consult: Rash?
- Always return the call:
  - What does the team say they are worried about, but what are they REALLY worried about
    - Primary dermatological condition reason for admission
    - Incidental finding?

Answering the consult

- Patient info: Name, MRN, Room,
- Service Team: Hospitalist, Surgery, Obs, Once
- 1st Call: Intern, PA, NP
- Second Call: Resident, Attending
- Attending:
- Cross-cover: Know cutoff times
- Unit:
  - Surgical vs Medical units
  - Burn units
Clues: Reason for admission

- Sepsis, shock
  - Neutrophilic dermatoses
  - Drug reactions (AGEP, DRESS, Anaphylactoid)
  - Generalized pustular psoriasis
  - Hemophagocytic lymphohistiocytosis

- Shortness of breath:
  - Neutrophilic dermatoses
  - Vasculitis
  - Drug reactions
  - Sarcoid

UTSW Dermatology Consult Service

Learning to triage

Resident Supervision and Triage

- Require residents to discuss every case:
  - Even at night
  - Opportunities for learning
    - Expect that resident can justify medical decision-making and triage:

- Cellulitis
  - Eczematous dermatitis
  - Vasculitis
  - Calciphylaxis
  - Psoriasis
  - Lipodermatosclerosis & other mimics

- Weakness:
  - Systemic vasculitis
  - Dermatomyositis
  - SLE

- Abdominal Pain/GI bleed/other GI badness:
  - HSP
2 AM ED page:
- 25-yo patient with a PMH of psoriasis here for worsening.
- What do you need to ask the ED?
  - History:
  - Vitals:
  - Exam:
- Do you go in?

7 AM ED page:
- 53 year old female with PMH of eczema x 2 years presenting for worsening of "itchy" rash that patient believes is an eczema flare.
- What do you need to ask the ED?
  - History:
  - Vitals:
  - Exam:
- Do you see the patient?
Resident Supervision and Triage

- Demonstrate that worst possible scenario has been considered
  - Can a delay in diagnosis or treatment harm the patient?
  - Is there something you can do NOW that would change management?
    - Atopic: Eczema herpeticum, infection, Staph-scalded skin
    - Chronic Sweets: Pulmonary involvement
    - Morbilliform rash: SCAR
    - Small vessel vasculitis: Renal and other systemic involvement

- Liability & Billing
  - “Right thing to do”: Professional responsibility
    - Patients followed in Dermatology
    - Derm-surgical complications
      - Involve fellows & Mohs attendings

- You make nighttime attendings come in?
  - Yes, patients with red flags
  - Encourage triaging skills with residents
  - Final decision is theirs to make
    - Consider giving feedback on “misses”

Red Flags

- Fever

- Mucosal involvement:
  - Erosions & cular symptoms, mouth pain, dysuria

- Blisters, generalized pustular rash

- Erythroderma

- Retiform purpura
Red Flags

- Clinically unstable patient:
  - Fever, hypotension, vasopressors, respiratory distress

- Immunosuppressed patient:
  - Neutropenic, advanced HIV, iatrogenic

Patient evaluation and initial consult note

PATIENT EVALUATION

- Initial chart review
  - Short and focused
  - Previous admissions/last clinic visit
  - Previous biopsies

PATIENT EVALUATION

- Full skin exam:
  - Incidental melanomas
  - HIV/AIDS: Thrush, leukoplakia, KS
  - Nutritional dermatoses
  - Incidental findings in patients with systemic disease
Consult Notes: Assessment & Plan

**APSO Format:**

- **Assessment:** Explanation of why we may favor a diagnosis or a specific treatment
  - Favor Cellulitis rather than stasis dermatitis due to unilaterality, pain on palpation, ill-defined erythema
  - Start empiric methylprednisolone for probable Sweet’s syndrome given patient’s rash, cough, shortness of breath

**Justify need for admission and goals for discharge**
- Erythroderma: Electrolyte abnormalities, AKI, high output cardiac failure
- Pemphigus Vulgaris: Tolerating PO, healing blisters, decreasing rate of blister formation, wound care plan

**Specific recommendations in bullet point format**
- If you really want team to do it then be specific!
  - Avoid terms like consider, instead say:
    - Start Triamcinolone 0.1% bid, 454 grams
    - Start Hydrophilic ointment
    - Start Cetirizine 10 mg po bid
    - Recommend against Debridement (PG, calciphylaxis, SJS)
Why don’t they listen?

- Why don’t they listen to us:
  - Teams don’t always read notes
    - Adherence associated with shorter length of stay and earlier clinical improvement (ID consult study)
  - Treatment vs diagnosis & lab workup:
    - 88% vs 72%
  - Call and give recommendations or find rounding room

Elodie et al 2009

Why don’t they listen: Solutions

- Enter orders
  - Hospitalist vs Teaching service: Know the culture
  - Expediting care in the ED and on admission:
    - Delays result in morbidity, extended hospitalization
    - Joint commission requirements and guidelines:
      - Time to antibiotics for pneumonia, thrombolytics & angiogram for CVA and ACS
      - Derm meds?

Entering Orders

- Topical steroids and other topical meds
  - Ensures promptness and correct form & amount
- Wound care orders: wet-wraps, PG, Calciphylaxis
- Subcutaneous biologics in hospital
  - Prescribe outpatient and have family bring
- Let team know that you did it verbally or in your note

Entering Orders

- Entering labs can be very helpful
  - IIF, ELISA for Pemphigus and Pemphigoid antibodies
  - Genetic testing
Entering Orders: Order sets

- Wet-wraps, SJS care
- Discuss with hospital committees, nursing leadership, pharmacy, IT, wound care

Entering Orders:

**3 DERMATOLOGY WET WRAP**

**Medication:**

- Topical
  - Hydrocortisone (1%) ointment
  - Tramul, Tretinoin (Acne Treatment)
- Hydrophilic ointment
  - Dupixtumab (Eczema Treatment)

**Communication Orders for Wet Wrap Administration**

- Medication Applied Weekly
- Review of patient care plan
- Review of patient's allergies
- Review of patient's medication list

**Side effects:**

- Reddening
- Rash
- Swelling

**Precautions:**

- Avoid application on broken skin
- Avoid application on irritated skin

**Chronic Wound Care Instructions:**

- Patient should sit on a chair with aloe vera gel for 5-10 minutes to reduce pain.
- Do not use topical ointments or creams on the affected area.
- Regularly clean the wound with mild soap and water.
- Avoid exposing the wound to direct sunlight.
- Apply moist dressings to keep the wound moist.
- Change dressings as needed.
- Monitor wound for any signs of infection.

**Subsequent visits and notes**

- Encourage patient to keep the wound clean and dry.
- Monitor wound healing progress.
- Provide appropriate wound care instructions.

Build relationships

- Get to know your colleagues
  - Hospitalists, Infectious Diseases, Rheumatology, Allergy Immunology, Burns/Plastics, Ophthalmology
- Lectures, teaching, rotating residents and fellows

UTSW Dermatology Consult Service

Subsequent visits and notes
Follow-up visits and progress notes

- Evolution of a clinical presentation
  - Our initial impression isn’t always correct

- Adherence with and treatment and diagnostic recommendations

- Tracking a patient’s response to treatment

65 yo woman with a history of MDS with recurrent atypical PG/Sweet’s syndrome admitted with fever, hypotension, worsening abdominal wound
Follow-up visits and progress notes

- Treated with IV pulse systemic steroids with recommended taper
- Noted to be improving. Dermatology signed off. Wound Care consult
- General surgery consult for debridement

Follow-up visits and progress notes

- Examples of patients needing daily follow-up visits:
  - Derm-specific conditions including:
    - Severe drug reactions
    - Autoimmune blistering diseases
    - Erythroderma
    - Atopic Dermatitis or eczematous flare

- "Chart-checking" might be enough in stable patients
  - Labs: Eosinophilia, LFTs
  - Change in clinical status

Follow-up visits and progress notes

- Minimize copy-paste

Follow-up visits and progress notes

- Monitoring for side effects from medications:
  - IV acyclovir and nephrotoxicity

- Justification for continued hospitalization
  - Goals & Requirements prior discharge
  - Sign-off!

- Demonstrates engagement and that you care!
Between Residents
Between Attendings
- Others don’t do it as often as you do
- If -> then scenarios
- Consider chart review on all weekend patients on Monday

One-hour weekly conference:
- Review clinical images & biopsies from previous week
  - Multi-headed scope
  - Screen/television for over-flow

Biopsy result notes:
- Preliminary: Pending stains
- Interpretation and recommendations

22 yo with treatment refractory Macrophage Activation syndrome/HLH
Discharge and follow-up

- Include DC recommendations in progress note in case patient discharged unexpectedly
- Medications, formulation, amount, refills (BE SPECIFIC)
  - Awareness of patient's coverage and insurance status
- Follow-up interval
- Decrease readmissions

Summary

- If you build it they will come
- Learn to triage
- Consider worst possible scenario
- Be specific with your recommendations
- Don’t be shy about entering orders
- Always communicate
  - Teams, covering physicians, residents
- Follow-up (demonstrate engagement)

References