the fact that even cell fragments may still label with specific antibodies, even if they are no longer cyto logically recognizable. This distinction is not only important for sustaining a correct clinical diagnosis, but also for determining antiviral dosing, which differs between VZV and HSV infections. HSV and VZV immunolabeling on smears requires about 30 minutes of laboratory time and is therefore very convenient for routine testing and even in emergency settings.

Since our initial publication in 1995 until this point in time, this test has been routinely performed with great satisfaction. We strongly support the other authors in confirming that the Tzanck smear with histochemical and IHC staining still represents an easily performed, highly sensitive and specific, cost-effective, and rapid test that is useful in a number of clinical settings encountered in the dermatologist’s daily practice. When continuing training young dermatologists to correctly sample a smear, the Tzanck test is heading the right way.

Arjen F. Nikkels, MD, PhD, a and Gérald E. Piérard, MD, PhDb
From the Departments of Dermatology a and Dermatopathology, b Centre Hospitalier Universitaire du Sart Tilman, University of Liége, Liége, Belgium

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Reprint requests: Arjen F. Nikkels, MD, PhD, Department of Dermatology, CHU du Sart Tilman, Bld du Rectorat, B4000, Liége, Belgium

E-mail: af.nikkels@chu.ulg.ac.be

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Hospitalist dermatology

To the Editor: We read with interest the article in the February 2009 issue of the Journal by Helms et al entitled “Hospital consultations: Time to address an unmet need?” We agree that inpatient dermatology consultations are a necessary part of dermatology residency programs and practice. Unfortunately, managed care and time and practice constraints have pushed dermatologists almost completely out of the hospital. In addition, patients admitted to the hospital are generally much sicker than they were in the past. Their hospital courses are more complex and the complications (including dermatologic) resulting from these hospitalizations are more severe. These changes have not only led to an increase in the responsibilities of the dermatologist providing consultation to hospitalized patients with skin disease, but they have also shifted some of the care of said patients to nondermatologist physicians and ancillary personnel unskilled in the unique requirements of patients with severe skin disease and/or the cutaneous signs of internal disease and their treatment.

According the American Academy of Dermatology 2007 Practice Profile Survey (unpublished data, courtesy of Jack Resneck, Jr, MD), of the 1139 survey respondents actively involved in patient care (representing a 35% response rate), 44% perform hospital consultations, with 30% of dermatologists spending ≤1 hour per week in the hospital and only 14% spending >1 hour per week in the hospital. These data support the findings of Helms et al that most dermatologists do not perform inpatient consultations, and that those that do find the time required to do so prohibitive.

Another issue still to be addressed is one of workforce. At academic centers, inpatient dermatology consultations are typically supervised by dermatology faculty working in monthly shifts as part of his or her academic appointment to the institution. In the private practice sector, the dermatologist who performs dermatology consultations does so at the end of a busy and often tiring work day. However, the fact remains that hospitalized patients require dermatologic evaluation and care, whether their skin disease is the reason for the hospitalization (eg, erythodermic psoriasis) or it develops as a result of another condition for which the patient is hospitalized (eg, cutaneous lesions of a disseminated fungal infection in a neutropenic patient after a hematopoietic stem cell transplant).

To address these issues, we propose a “dermatology hospitalist” model, to be modeled after the internal medicine hospitalist movement that was initiated by Robert Wachter, MD, in the mid-1990s. Other hospitalist models, including surgery and neurology hospitalist programs, have recently been developed and are beginning to demonstrate
feasibility, advances in quality improvement, and
enhanced patient care. The dermatology hospitalist
model would be similar, whereby an individual
dermatologist or fixed rotation of a dedicated group
of dermatologists (usually as a consultant, rather than
as a primary admitting team) attends to hospitalized
patients with skin disease. This arrangement facili-
tates continuity of care for patients who are either
frequently admitted with skin manifestations of sys-
temic illnesses or have a severe primary cutaneous
disease that requires hospitalization. These physi-
cians, whose skill set is focused on hospital-based
medicine, are more knowledgeable about the rapidly
changing medical literature, new medications used,
and idiosyncrasies that arise in managing patients
with complicated skin disorders in the hospital. They
also have the knowledge of “how to get it done” in
their respective hospitals. This translates into a higher
standard of care for patients through more timely and
accurate diagnoses and skillful hands-on treatment.
There is also the additional benefit of dermatologic
education of medical students, house staff, and con-
sulting colleagues, especially in the academic setting.
Furthermore, it is often in the inpatient setting that
emerging diseases or new cutaneous manifestations
do not think that dermatology is
“serious medicine.”

In addition to identifying ourselves as “dermatology
hospitalists,” we have created The Society of
Dermatology Hospitalists (SDH), which is open to all
dermatologists interested in inpatient care. Our mission statement reads as follows: “The goal of
the society is to strive to develop the highest standards of clinical care of hospitalized patients with skin disease by promoting clinical expertise, fostering research, and
furthering education in the management of hospital-
ized patients with cutaneous disease. These elements
will be integrated to further our understanding of
dermatologic disease, as well as to advance the knowl-
edge used to diagnose and treat hospitalized patients
with complex skin diseases.” Our group is committed
to gathering data, sharing ideas, and developing treat-
ment algorithms that will improve the quality of care for
hospitalized patients with skin disease.

While we are well aware that the hospitalist der-
matology model will not fit all dermatology practice
models, and we realize that there will be unique challenges to implementing this type of practice in
areas and/or communities underserved by dermatol-
gists, we feel that it is a reasonable starting point from
which we can begin tackling some of the issues stated
earlier and in the article by Helms et al.

Lindy P. Fox, MD,a Jonathan Cotliar, MD, b Lauren
Hughey, MD, c Daniela Krosbinsky, MD, d and
Kanade Shinkai, MD, PhD e

Departments of Dermatology at the University of
California, San Francisco,a San Francisco, California; the University of Alabama, Birmingham, c
Birmingham, Alabama; and Massachusetts General Hospital, d Boston, Massachusetts; and the
Division of Dermatology, e David Geffen School of
Medicine at UCLA, Los Angeles, California

All authors are Dermatology Hospitalists and are
founding members of The Society of Dermatology
Hospitalists.

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Correspondence to: Lindy P. Fox, MD, Department
of Dermatology, University of California, San
Francisco, 1701 Divisadero St, Box 0316, San
Francisco, CA, 94143-0316

E-mail: foxli@derm.ucsf.edu

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