significantly more common in group B ($P = .033$). A nodular infiltration pattern was most common in group A (Fig 1, *E*; $P = .041$), but perivascular infiltration was the most common pattern in group B (Fig 1, *F*; $P = .040$). There were no significant differences between the immunophenotypic profiles in the 2 groups.

The present study demonstrated differences in clinical and pathologic features of primary and secondary cutaneous PTCL-NOS. Patients with secondary cutaneous PTCL-NOS had more extensive disease and a greater number of skin lesions than those with primary cutaneous disease. Cutaneous involvement in systemic PTCL-NOS suggests disease progression, consistent with the higher International Prognostic Index scores and the frequency of lymph node and other visceral involvement in secondary cutaneous PTCL-NOS. Skin lesions in primary cutaneous PTCL-NOS more commonly affected the head and neck area.

In conclusion, cutaneous PTCL-NOS had differences in clinicopathologic features depending on the primary tumor site. The present study would be helpful to differentiate cases of systemic PTCL-NOS from primary cutaneous PTCL-NOS.

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The Institutional Review Board at Asan Medical Center approved this study (2015-0263).

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Trends in scholarly productivity of dermatology faculty by academic status and gender

To the Editor: Gender differences in academic productivity and rank reportedly exist in many fields.[1] However, these disparities have not been assessed in dermatology. We used the Hirsch index (*h*-index), defined as the highest number (n) of an author's papers that are cited at least n number of times,[2] to assess academic productivity in dermatology. The *h*-index positively correlates with ascending academic rank in various other medical fields.

We performed a cross-sectional study of academic dermatologists listed on department websites identified through Electronic Residency Application Service. One hundred twenty US dermatology department websites were accessed between March 2017 and May 2017 to obtain information about dermatology faculty, including name, terminal degree, institutional affiliation, academic rank, and state. The author's gender was obtained from Google and biographies. *H*-indices and aggregate National Institutes of Health funding data from 1985 to 2016 were obtained from Scopus, which contains the largest citations database of peer-reviewed research dating back to 1970, and the National Institutes of Health Research Portfolio Online Reporting Tools, respectively. Career length was estimated as the difference between 2017 and the year of first publication. To normalize for career length, *m*-index was calculated by dividing the *h*-index by career length.[2] Inclusion criteria were professors with listed MD, MD and PhD, DO, and MBBS degrees. Exclusion criteria were nonclinical faculty, volunteer faculty, and joint faculty whose primary practice is not dermatology, or faculty without a unique Scopus profile. Statistical analysis was calculated using SPSS software (SPSS Inc, Chicago, IL). The Yale University Institutional Review Board exempted this study protocol.

We identified 685 profiles (Table I), of which women represented 63%, 50%, and 36% of academic

Table I. Descriptive characteristics of US academic dermatology professors*

Descriptive characteristics	Number (n = 685)	Percent	*h*-index			*P* value ANOVA
			Mean	SD	Median (IQR)	
Gender						<.001†
Male	316	46.1	12.56	12.68	8.5 (4-16)	
Female	369	53.9	7.48	9.41	4 (2-9)	
Academic position						<.001†
Assistant professor	364	53.1	5.08	6.21	3 (1-6)	
Associate professor	166	24.2	9.69	7.26	8 (4-13)	
Professor	155	22.6	21.12	15.49	17 (9-32)	
Degree						<.001†
MD/DO/MBBS	565	82.5	9.22	10.86	5 (2-12)	
MD and PhD	89	13.0	14.61	14.11	12 (5-19)	
MD and other degree	31	4.5	7.06	5.93	5 (2-11)	
NIH funding						<.001†
0	568	82.9	7.52	8.26	5 (2-10)	
1-10	74	10.8	17.82	14.03	14 (9-22)	
11-20	22	3.2	24.5	16.44	22.5 (17-37)	
>20	21	3.1	28.62	21.21	34 (7-48)	
US census division						.055
Midwest	158	23.1	9.28	10.8	5.5 (2-13)	
Northeast	197	28.8	10.5	11.57	7 (3-14)	
South	180	26.3	8.38	10.38	5 (2-10.5)	
West	146	21.3	11.51	12.48	7 (3-16)	
Puerto Rico	4	0.6	1.75	1.71	1.5 (0.5-3)	
Career length, years						<.001†
0-10	237	34.6	2.85	2.84	2 (1-4)	
11-20	213	31.1	8.86	6.57	7 (4-13)	
21-30	122	17.8	14.04	10.26	12 (6-19)	
>30	113	16.5	21.73	17.4	17 (8-32)	

ANOVA, Analysis of variance; *IQR*, interquartile ratio; *NIH*, National Institutes of Health; *SD*, standard deviation; *US*, United States.
*Stratified by gender, academic position, degree, National Institutes of Health funding, geography, and career length. The mean, standard deviation, and median with IQR of the *h*-index are shown. Univariate analyses are conducted using analyses of variance.
†$P < .05$.

Table II. Descriptive statistics of *h*-indices by academic title (assistant, associate, and full professor) and gender*

Index	Position	Female					Male					*P* value*
		N	Mean	SD	Median	IQR	N	Mean	SD	Median	IQR	
h-index	Assistant	230	4.27	6.08	3	1.00-6.00	134	6.47	6.20	5	2.00-9.25	.000†
	Associate	83	9.07	7.51	7	3.00-13.00	83	10.30	6.99	9	4.00-15.00	.101
	Full	56	18.32	13.71	15	8.00-25.75	99	22.71	16.26	19	11.00-32.00	.126
m-index	Assistant	230	0.41	0.32	0.33	0.20-0.56	134	0.47	0.35	0.43	0.20-0.70	.077
	Associate	83	0.51	0.38	0.41	0.21-0.75	83	0.53	0.32	0.45	0.28-0.75	.387
	Full	56	0.75	0.49	0.67	0.35-1.05	99	0.72	0.48	0.65	0.32-1.07	.784
Total		369					316					

*Assessed using the nonparametric Mann–Whitney *U* test.
†$P < .05$.

dermatologists at the assistant, associate, and full professor levels, respectively. In terms of *h*-indices, we found that mean *h*-indices for assistant, associate, and full professors increase with ascending position, thus validating the *h*-index as a bibliometric indicator for dermatology. Next, the *h*- and *m*-indices were analyzed by gender (Table II). Although female assistant professors had statistically significant lower *h*-indices (female 4.27, male 6.47), this difference became insignificant after adjusting for male assistant professors' longer average career length (female 9.9, male 14.4). There were no significant *h*- or *m*-index gender differences among associate and full professors. The overall lack of statistically significant

gender differences suggests similar levels of research productivity at each rank. Nevertheless, despite increasing numbers of women entering dermatology and more female professors at all levels,[1] there are still proportionately fewer female full professors.

The interpretation of these data is not straightforward. It could be attributed to factors such as shifting demographics in dermatology, academic culture, an increased preference for education-focused tracks, mentoring opportunities, and potential gender biases.[3,4] As more women enter the field of academic dermatology, it may be a matter of time before greater numbers of female assistant professors translate to greater numbers of senior female faculty. At the same time, implicit biases disfavoring female academic physicians have been suggested: women report greater difficulty in finding suitable mentors and a reduced sense of belonging in academia.[4]

In this first in-depth analysis of bibliometric indicators, we found that male and female professors of dermatology are achieving similar levels of academic productivity—yet there is lower female representation within the higher academic ranks. With greater numbers of female assistant professors, continuing to enable senior professors to serve as mentors with protected meeting times and mentoring awards may provide support.[5]

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Alopecia areata and poliosis: A retrospective analysis of 258 cases

To the Editor: It is not uncommon to observe white hairs regrown at previous patches of alopecia areata (AA) (Fig 1). However, studies of poliosis in AA are mostly limited to case reports about total or partial whitening with pigmented hair loss. In this study, we aimed to characterize AA patients with poliosis by comparing clinical parameters of AA cases with and without poliosis.

Medical records of 258 patients with AA who visited Wonju Severance Christian Hospital during March 2012-June 2017 were retrospectively assessed. Patients were subdivided into poliosis and

Fig 1. Poliosis in alopecia areata recovery. Multiple alopecia patches in occipital scalp are filled with white hairs.