Dermatology visits account for a majority of dermatologic diagnoses: A representative sample of U.S. outpatient visits

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Given their prevalence, skin diseases are an important public health issue. In 2013, over 25% of the US population was impacted by dermatologic diseases, resulting in $75 billion in direct healthcare costs. Through 2010, non-dermatologists diagnosed a majority of skin diseases in outpatient settings. We sought to assess whether this was still true in 2016 and determine the most common dermatologic diagnoses seen in dermatology and non-dermatology practices. We assessed visits in the 2016 National Ambulatory Medical Care Survey, an annual representative survey of visits to U.S. outpatient physicians. We analyzed all diagnosis codes reported at visits with dermatologists and non-dermatologists to determine the most common dermatologic diagnoses. Observed visits were weighted to obtain a nationally representative estimate of all visits in the U.S. There were an estimated 49.9 million visits to dermatologists with 107 million dermatology diagnoses. In 2016, the top 5 dermatology diagnoses for non-dermatologists were unspecified dermatitis, rash and other nonspecific skin eruption, unspecified viral infection, unspecified external cause. The top 5 dermatology diagnoses for non-dermatologists were unspecified dermatitis, rash and other nonspecific skin eruption, unspecified viral infection, unspecified external cause. The top 5 dermatology diagnoses for non-dermatologists were unspecified dermatitis, rash and other nonspecific skin eruption, unspecified viral infection, unspecified external cause.

Characterizing risk factors for hospitalization for psoriasis patients

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Psoriasis is a chronic autoimmune disease with a large economic impact. The objective of this retrospective study was to characterize patients who are hospitalized for psoriasis, and differentiate features for patients with a single hospitalization from those who are hospitalized multiple times during the study period. Hospitalized psoriasis patients were identified from an inpatient database at a single academic institution. Differences between psoriasis patients with one hospitalization and those with multiple hospitalizations were characterized, as were differences between patients who were hospitalized primarily for psoriasis and those who were admitted primarily for other reasons. Patients with multiple hospitalizations had a longer mean Charlson comorbidity score (3.9 vs. 2.8, P < 0.05). They had a higher death rate during index hospitalization (7% vs. 2%) and a longer mean length of index hospitalization (15 days vs. 8 days), but these differences were not statistically significant. Patients who were primarily hospitalized for psoriasis had a mean Charlson comorbidity score (1.8 vs. 3.4, P < 0.05), shorter hospitalizations (4 days vs. 3.3 days, P < 0.05) and a lower death rate (0% vs. 4.7%, P < 0.05) than those hospitalized for other reasons. Patients with a primary discharge diagnosis of psoriasis also had a trend toward lower average income by zip code, though this value was not statistically significant. Our findings affirm the importance of regular dermatologic care for psoriasis patients in preventing hospitalizations. Dermatologists should be aware of the risk factors for hospitalization for psoriasis patients and work to mitigate them, as well as encourage patients to seek dermatologic care.

Evaluating clinical features and the presence of eosinophilia in pityriasis rubra pilaris

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Pityriasis rubra pilaris (PRP) is a rare disease presenting with orange to salmon-colored folliculocentric papules on the trunk and extremities, waxy palmoplantar keratoderma, and hypertkeratotic nails. PRP literature remains limited, and its pathogenesis remains unclear, often resulting in missed or delayed diagnosis. Further, although a case study found eosinophilia in a PRP patient, hematologic abnormalities have not been extensively examined, sparking the interest to evaluate for an association between eosinophilia and PRP to enhance diagnosis. PRP patients from 1980-2020 at Mass General Brigham were identified. Demographics, disease presentation, and laboratory and pathology data were recorded. This study was approved by the Brigham and Women's Hospital IRB. Student-test and chi-square analysis were conducted to evaluate for differences; p<0.05 was considered significant. 142 PRP patients were identified (55% male, 85% white); 82% were categorized as Type 1. 19.7% had eosinophilia. Age at onset more commonly was 20-39; although eosinophilia was 60.8±14.6 and 53.1±19.7, respectively (p=0.33). Presenting symptoms included pruritus (13%), ocular dryness (4%), and hair thinning (4%). Lesions were present in the extremities (77%), chest/thorax (7%), and head/face (18%). Eosinophils were included sparse superficial dermal perivascular lymphohistiocytic infiltrate (39%) and alternating ortho-para keratosis (37%). There were no significant differences in patient sex, race, disease presentation, or biopsy findings between the eosinophilia and non-eosinophilia cohorts. Eosinophilia did not correlate with age at presentation or age at diagnosis and therefore, the presence of peripheral or biopsy eosinophilia at diagnosis highlights an association that may suggest potential treatment strategies or help elucidate the underlying pathophysiology of this rare condition.

Wrong-site surgery in medicine and dermatology: Analysis of data from the Joint Commission and from the Patient Safety Authority of Pennsylvania

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Wrong-site surgery procedures (WSS) are patient safety events which are underreported and may result in patient harm. WSS are typically grouped to include wrong-site, wrong-side, wrong-person and wrong-procedure errors. Despite the attention given to these preventable errors by professional organizations and development of the Universal Protocol, WSS still occur and reliable data on their frequency is lacking. We analyzed publicly available data on WSS from the Joint Commission (JC) and from the Patient Safety Authority (PSA) of Pennsylvania. JC data is national and all specialty with most reported voluntarily. From 2005-18 there were 231 JC WSS cases and 228 PSA WSS cases. Of the 231 JC WSS cases 223 were wrong-site, 40 wrong-procedure and 16 wrong-patient. Pennsylvania is among a small group of states which legally mandate the reporting of all safety events including near misses. According to PSA from 2015-2019 there were 368 WSS reported from 178 licensed facilities, excluding private offices. Dermatology accounted for 9 (2%) of the 368 cases, 8 of which were wrong-site and one wrong-side. Of the 9 procedures, 2 were biopsies, 4 excisions, 2 Mohs and 1 curettage. Five involved the head with 1 each from the chest/thorax, upper extremity, and spine and 1 unspecified. Root causes of WSS identified by both the JC and PSA were accuracy and verification issues in procedure scheduling, failure to follow the three-part Universal Protocol and organizational safety culture issues. Additional strategies for dermatology include accurate biopsy site identification utilizing high-quality scanning and close-up photographs and specific and consistent anatomic designations. In conclusion WSS data may not reflect their absolute frequency. Health care facilities should conduct additional analysis of WSS for improving the occurrence of WSS.

Demographic and clinical factors associated with patient-reported remission in psoriatic arthritis

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Remission of remission in psoriatic arthritis (PsA) is a key goal for patients and clinicians, yet definitions of remission may vary. Treat-to-target initiatives in PsA have utilized multi-domain measures such as Minimal Disease Activity that incorporate the status of joints, skin, and function. The goal of this study is to identify factors associated with patient-reported PsA remission. National Psoriasis Foundation conducted a survey within a random stratified sample of 1,570 individuals with psoriatic disease in the United States. Participants provided demographics and were asked about a provider diagnosis of psoriasis, PsA, or both. All reported remission on the PsA Global Quality of Life (PsAQoL). PsA remission was assessed using the Psoriatic Arthritis Impact of Disease-9 (PsAID-9) questionnaire. Participants provided information on treatments and quality of life (QoL). Multivariate analysis was performed on 1,501 cases of 2012-2020 QoL data. Significant results included an association of biologic medications with improved PsAQoL scores. It was less impactful on the PsA Global QoL scale, and psoriasis remission. Factors not associated with PsA remission included age, sex, BMI, and biologic use. These results indicate that patient-reported PsA remission is not solely associated with PsA severity, but encompasses other factors such as race, achievement of skin remission, and quality of life.