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How well prepared are dermatologists redeployed to COVID-19 wards?

Dear Editor,

Since December 2019, the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic has been posing a serious challenge for the national health systems of numerous countries, such as Italy or the United States (US).[1]

The massive patient influx has led to shortages not only in vital medical supplies but also in medical personnel, resulting in health authorities taking emergency initiatives so as to face the consequences of this public health crisis.[1] Among these initiatives is the recruitment of doctors of specialties other than internal medicine or anesthesiology and, in some cases, even of medical students.[1-2] Such actions, although necessary and evident in critical times, can be a cause of concern for numerous physicians who are suddenly redeployed to COVID-19 wards yet lack even the basic intensive care training.[2]

As far as the structure of the dermatologic medical specialist training is concerned, there are certainly differences among the different countries and even among residency programs in the same country: some residency programs include a general medicine common trunk of variable duration, while others are constituted solely of a full-time dermatology training.[3] It is therefore a reasonable concern up to which extent a skin physician without contact with a minimum critical care training during the last years of his career could perform adequately in the special emergency conditions and the complex cases of respiratory failure, such as the ones encountered frequently in the overworked COVID-19 wards.[2]

In light of the recent developments, it is important to reflect not only on the content of the postgraduate dermatology curriculum of the various residency programs but also on the nature of the specialty of dermatology overall. The expansion of dermatology toward surgical and aesthetic fields over the last years as well as the overlap of areas of our specialty with other medical specialties, such as infectious diseases or rheumatology, have gradually resulted in the fragmentation of medical dermatology and its gradual absorption into other subspecialties of internal medicine.[4] Oncologists managing melanoma cases or rheumatologists handling individual patients with systemic scleroderma are examples reflecting the general framework that contributes to the lack of familiarity of many dermatologists with basic aspects of internal medicine.[5] When dermatologists are gradually deprived—either willingly or unwillingly—of their privilege to be involved in the complex medical care of patients suffering from primarily mucocutaneous diseases who manifest variable systemic complications, it is normal to expect that their knowledge in the field of critical care medicine is even less well-founded.

The idea of providing dermatologists, throughout their careers, continuous access to the updated necessary knowledge so as to independently manage intensive care patients is not realistic. It is, however, essential that the residency programs as well as the dermatological societies encourage skin physicians to be actively involved in the management of systemic complications of complex dermatologic diseases. A suggested approach would be, for instance, endorsing the participation in regular educational opportunities that involve an interdisciplinary interaction with other medical specialties, or including a short rotation in the emergency department during the residency training. This would allow dermatologists to be gradually able to repress the inner emotional barrier that impedes them from assuming responsibility for such patients and to manage to rise to the occasion when confronted with certain types of internal medicine problems.[5] As dermatologists, we should protect and preserve our right to be the primary care providers for patients with complex mucocutaneous diseases, and it is essential to acquire the sufficient competence in the principles of internal medicine that allows our involvement in the management of their challenging systemic complications. This process could definitely enhance our preparedness when it comes to handling critical situations or even—up to some point—participating actively as front-line physicians in times of extreme need, such as the currently ongoing SARS-CoV-2 pandemic or future difficult periods.

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Letter to the editor: *de novo* Koebner phenomenon

Dear Editor,

It was with great interest that we read the case report "Isolated annular atrophic lichen planus of the mammary areola" by Ozbagcivan *et al.*[1] in the June 2019 edition of this journal.

The authors have reported the case of a 35-year-old woman with a solitary lesion of annular atrophic lichen planus on the mammary areola without any known history of prior cutaneous or mucosal lichen planus. The patient has a history of breastfeeding her child, and the authors have proposed that the lesion may be resultant of unknown trauma during breastfeeding resulting in Koebner phenomenon.[1]

The Koebner phenomenon is defined as the development of isomorphic pathologic lesions in the traumatized uninvolved skin of patients who have cutaneous diseases, and these new lesions are clinically and histologically identical to those in the diseased skin. *De novo* Koebner phenomenon without prior skin lesions does not fall under the scope of the definition of the original phenomenon described by Heinrich Koebner.[2,3] As the patient in the case report had no prior history of skin lesions suggestive of lichen planus, the lesion on the areola cannot be termed 'isomorphic'. The authors have postulated that the patient might have had an obscure form of lichen planus in the past, probably asymptomatic oral reticulate lichen planus. However, the morphology of oral lichen planus is distinct from cutaneous lichen planus.

The best and most frequently used disease model for description and study of Koebner phenomenon is psoriasis. Heinrich Koebner in his original report too described the phenomenon in psoriasis.[2] Induction of lesions of psoriasis over a site of tattooing in a patient without prior psoriatic lesions has been described.[4] Recent literature suggests that Koebner phenomenon may occur in patients without preexisting skin conditions and therefore may pre-date the appearance of skin disease.[3] We propose that such cases may be termed '*de novo* Koebner phenomenon'. The case by Ozbagcivan *et al.*[1] may be an example of such *de novo* Koebner phenomenon, but further follow-up of the patient may be needed to look for development of more lesions over sites of trauma, or if this was an isolated occurrence in her. Also, although the 'all or none phenomenon' was once accepted for Koebner phenomenon, it has been demonstrated that all trauma need not necessarily produce lesions in susceptible individuals.[5] Hence, it may not be possible to conclude with absolute certainty that this particular case was indeed due to Koebner phenomenon.

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H syndrome with a possibly new immunological phenotype

Dear Editor,

H syndrome is an autosomal recessive histiocytic disorder associated with mutations in SLC29A3 gene which encodes the human equilibrative nucleoside transporter 3 (hENT3).[1] This multisystem disorder is characterized by hyperpigmentation with overlying hypertrichosis which appears bilaterally and symmetrically, mainly on the medial aspect of the thighs. In addition, there are other common clinical features in the disorder such as hepatosplenomegaly, heart anomalies, hearing loss, hypogonadism, short stature, hyperglycemia, hallux valgus, and flexion contractures of fingers and toes.[2,3] Here we report a patient with a possibly new phenotype of H syndrome. This is the first report of a patient with H syndrome and an autoimmune phenomenon, idiopathic thrombocytopenic purpura (ITP).

A 26-year-old man with known sensorineural hearing loss and born to a nonconsanguineous marriage was referred to an outpatient dermatology clinic with cutaneous lesions. The lesions consisted of hyperpigmented patches with overlying hypertrichosis located at the inner aspects of both thighs and the anterior aspect of the thorax. These lesions were first presented as abnormal hair growth over these sites around his puberty years (about 13 years prior) and progressed gradually over time to indurated hyperpigmented lesions. In addition, the patient had a history of several migratory lesions on other parts of the skin which were absent at the time of examination