A diagnosis of secondary pulmonary alveolar proteinosis (PAP) was made and oral PSL was discontinued. The patient was successfully treated with whole lung lavage and followed up thereafter without relapse of the skin lesions.

SS is characterized by fever, polymorphonuclear neutrophilic leucocytosis and multiple, raised, painful erythematous plaques with superficial small pustules on the face and limbs, often in patients with immunological disorders, haematological disorders and internal malignancies.[1,2] Subcutaneous SS causes neutrophilic infiltration extending to the subcutaneous fat affecting the lobules, septae or both, and the subcutaneous type is associated with haematological disorders.[3] Our patient developed subcutaneous induration with tenderness limited to one leg, mimicking cellulitis. Histopathology revealed infiltration of neutrophils in the hypodermis and subcutaneous tissues. White blood cell count was not elevated, which was considered to be due to the patient's MDS.

Idiopathic PAP occurs as a result of autoantibodies against GM-CSF, whereas secondary PAP may result from functional impairment of the GM-CSF receptor on alveolar macrophages and/or an abnormal signal transduction pathway after interaction of GM-CSF and its receptor in association with haematological disorders, immunosuppressive drugs, dust inhalation, acute silicosis or certain chronic infections.[4,5] Although the exact pathogenesis of secondary PAP associated with haematological malignancy remains unknown, alveolar macrophages derived from malignant clones may be defective or have an abnormal GM-CSF transduction pathway. Therapy for secondary PAP mainly depends on the treatment used for the underlying disease. We diagnosed our patient with secondary PAP, based on the negative staining for antibodies against GM-CSF, the lung CT findings, the milky bronchoalveolar lavage fluids containing PAS-positive granules and the presence of MDS.

To our knowledge, this is the first report of subcutaneous SS in association with MDS, in a patient who subsequently developed secondary PAP.

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How dermatology will change in the post-COVID-19 ('POST-CORONA') era

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COVID-19 has forced a sea change in the practice of dermatology across the world in 2020. Some changes enforced upon us will continue in the long term after the current pandemic and consequent deployment of many dermatologists to internal medicine ends. While attention is currently focused upon managing the pandemic and its immediate impact of COVID-19 upon dermatology departments,[1] it would be instructive to consider the ways in which dermatology (and medicine more broadly) will change in the 'POST-CORONA' era.

P ublic health will rightly be prioritized; in dermatology, this may include measures to reduce skin cancer as well as possible hand dermatitis from personal protective equipment. ***O***wnership of health conditions will be forced to pass from physicians to patients, with greater emphasis on patient self-education, monitoring and alerting. ***S***taff wellbeing will have to be prioritized to boost morale and allow a sustainable workforce. ***T***elephone (and video) consultations for many conditions will no longer be an aspiration, but the default. ***C***onferences and other meetings will increasingly take place virtually.[2] ***O***utsourcing of work to both other healthcare professionals and artificial intelligence resources will occur owing to pressures on the already depleted medical workforce. ***R***emote working within medicine will become an established and an accepted mode of working. ***O***pportunists (with different motives) will exploit the disruption to conventional outpatient care and the explosion of technology. ***N***eoplasms (at least in the short term) will be prioritized above inflammatory work, in part due to the backlog created by COVID-19. ***A***pps will be increasingly used by patients and medical professionals during the temporary pause in regular clinical activity,dermatologists will need to find a means of validating and working with these to make sure

they conform to guidelines[3,4] and will help optimize health care.

This list of changes is not exhaustive but we believe is inevitable. During moments of reflection, perhaps while in enforced self-isolation, dermatologists may wish to consider how these changes will feature and can be best managed for the benefit of our patients when the dark cloud of COVID-19 begins to pass.

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Provider comfort, knowledge and attitudes in treating psychocutaneous diseases in dermatology, psychiatry and family medicine

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Psychocutaneous diseases can be challenging to manage, as they impinge on the boundaries between dermatology and psychiatry. We sought to compare the current attitudes, perceptions and comfort level of dermatologists, psychiatrists and family medicine physicians in treating psychocutaneous diseases.

An anonymous survey focusing on comfort level, referral practices and residency preparation in treating specific psychocutaneous diseases was sent to physicians in dermatology, psychiatry and family medicine practices (Data File S1).

Statistical analyses were performed using Stata (v15.1; StataCorp., College Station, TX, USA). Pearson χ^2 test and Fisher exact test (for expected cell counts > 5 or < 5, respectively) were conducted to compare the differences across the three specialties. Demographic data of participants are depicted in Table 1.

The majority of dermatologists felt comfortable and knowledgeable in treating patients with psychogenic pruritus, trichotillomania and delusions of parasitosis (DOP; Table 2). However, only 36–42% of dermatologists thought that these conditions were best treated by them, with slightly over half of dermatologists stating that trichotillomania and DOP were best treated by psychiatrists, and the vast majority of psychiatrists and family physicians stating that trichotillomania and DOP were best treated by psychiatrists. This is perhaps due to the comorbid psychiatric conditions associated with trichotillomania and DOP that contribute to persistence of these conditions and complicate treatment. Patients with psychocutaneous disease can require extended appointment times to fully address their disease and build the physician–patient relationship, which could be a barrier in a busy dermatology practice.

Our results suggest that overall psychiatrists feel very comfortable treating trichotillomania and DOP and less comfortable treating psychogenic pruritus. All three specialties felt that psychiatrists are the best providers to treat trichotillomania and DOP. However, a recent study stated that 65% of psychiatrists reported referring patients with a psychocutaneous disease to a dermatologist at least twice a month.[1] This may be because psychiatrists may wish to seek another opinion as to not miss a nonpsychogenic dermatological disorder. Patients can often be reluctant to seek psychiatric care, which could be potential barrier to getting appropriate care.

Our study highlights several gaps in knowledge for each speciality and the potential usefulness of a collaborative care model, in which the expertise of both dermatologists and psychiatrists is utilized, with support from the family medicine physician. There are several examples in place for psychodermatology clinics, where dermatologists and psychiatrists may see the patient together or during back-to-back appointments with support from clinical psychologists, if available.[2] While these have shown promising results as a collaborative care model, payment, availability and follow-up are still barriers.[3]

If access to an integrated clinic is not available, further educational efforts may help providers fill in the speciality-specific gaps in knowledge. This can be pursued in a variety of ways through increased training in residency, continuing medical educational courses, asynchronous web-based modules or individualized training. Although our study suggests that many psychocutaneous diseases can be managed by a dermatologist, more complicated or treatment-resistant cases should warrant a psychiatry referral and possibly involve a trained psychotherapist (or