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Editorial

The four-day advantage and its challenges

In the review article of this issue of the Hong Kong Journal of Dermatology & Venereology, the authors shared with us four cases in which the dermatologist contributed greatly in the diagnosis and management of in-patients suffering from conditions with skin manifestations. In case 1, the initial diagnosis of cellulitis was acute contact dermatitis; in case 2 who was initially diagnosed as cellulitis was found to be erythema nodosum; in cases 3 and 4, clinically suspected necrotizing fasciitis on initial presentation was finally diagnosed as bullous erysipelas. These four cases share at least one thing in common: the dermatologists were summoned to see and give input to the diagnosis and management at least four days after the initial presentation. To the attending dermatologist, this four-day time lag may be an advantage as well as a challenge when contributing to the management of the patient concerned.

There is no qualitative data available but with the scarcity of dermatologists and further scarcity of dermatology focused in medical dermatology (some say the medical dermatologist is a dying breed), we have good reasons to believe this four-day time lag (if not more than four days) is a common occurrence in hospitals. With this time lag, rashes will have completely developed (e.g. initial banal redness will become nodular if it is a panniculitis; red macules will become purplish, raised papules if it is vasculitis; non-specific erythema on the left side chest wall will become vesicular if it is herpes zoster), the pattern of generalization will be complete and be more revealing (e.g. Stevens-Johnson syndrome on the face instead of erythema multiforme which is more acral; some rickettsial disease will have developed more definite palmo-plantar macules instead of the initially non-descript macules), laboratory results will be available and we will also be able to see their serial trend (e.g. disproportionately high eosinophil in pre-pemphigoid; low haemoglobin, white blood cell and platelets in Ebstein-Barr virus associated haemophagocytic syndrome; impaired liver function test in hypersensitivity syndrome) and last but not least, the dermatologists will be able to witness the response to the initial treatment given by colleagues in the hospital (e.g. amoxicillin/clavulanate failed; topical anti-fungal did not help; debridement made it worse). In that sense, the four-day time lag gives the dermatologist an advantage in contributing to the diagnosis and management to the referred patient.

On the other hand, the four-day time lag could pose as a challenge to the dermatologist in many ways. The earlier signs in the progression of a condition may have disappeared (e.g. in scarlet fever only peeling is left which is indistinguishable from the exanthems of many causes; in pyoderma gangrenosum, the painful dusky plaque may have turned into non-descript ulcers), earlier events forgotten (e.g. whether there were upper respiratory tract infection symptoms before the rash; whether the rash began before or after taking the prescription by the family doctor; whether the now generalized rash started on the arm or the face). Despite of the lack of first-hand information, expectations on the dermatologist are high: they are expected to give an instantaneous diagnosis, suggest treatments with immediate effects. There is an immense pressure on the dermatologist.

There is no easy way to survive dermatology consultations in hospitals. The dermatologist must read widely beyond dermatology journals: the British Medical Journal is a must (a recent example is an article on PVL positive *Staphylococcus aureus* skin infections), and one must also read Communicable Diseases Watch, a Centre for Health Protection online publication, and much more. The dermatologist must think beyond the context of the skin, knowing that for the same manifestation, e.g. psoriasiform plaques, in the context of the hospital consultation may be due to many other underlying causes, e.g. disseminated infections. Liaising with the referring doctor is many a time a key to success: he or she may already have a suspected diagnosis in mind, only waiting for you to verify. On the other hand, after having gathered all the necessary information from the patient and relatives, as well as from our referring colleagues and case notes, think afresh from the very beginning of the story, putting aside all the pre-conceptions that may affect your own independent judgment.

Last but not least, let's not forget that one's own ego has no place in patient management. In case of doubt do not hesitate to ask the opinion of our colleagues.

After having prepared ourselves, the experience of giving a dermatology consultation service to in-patients will be more exciting than watching an episode of the latest BBC Sherlock Holmes series. We function almost like Sherlock Holmes himself when attending to our patients and not just as a bystander.

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