Access to dermatology services at free medical clinics: A nationwide cross-sectional survey

To the Editor: Free or low-cost medical clinics provide health care to more than 15 million Americans.[1] The American Academy of Dermatology SPOTme skin cancer screening campaign recommends that uninsured participants with suspicious lesions identified at screenings follow up at these clinics for dermatologic care.[2] Recent data from SPOTme show that 12% of screening participants with lesions suggestive of melanoma lacked health insurance.[3] However, free or low-cost clinics often lack specialty services.[4] This study sought to determine access to dermatology services at free or low-cost clinics in the United States.

With use of the National Association of Free and Charitable Clinics database, which is recommended by SPOTme for uninsured screening participants to seek follow-up care, a simple, random sample of 357 of the total of 1280 clinics was selected. Clinics that, by their name, were obviously not medical (ie, dental or podiatric) were excluded. Data collection consisted of a 10-item survey administered by telephone from April to August 2018. This study was reviewed by the Augusta University Institutional Review Board and designated as not human subjects research.

The results are summarized in Table I. Of the 357 clinics called, 137 (38%) did not answer after 3 attempts over 2 weeks and 62 (17%) were closed or did not provide medical services. Of the remaining 158 clinics, 54 (34%) declined to participate in the survey and 104 (29% of all the clinics called [66% of eligible clinics]) participated. Of the 104 participating clinics, 29 (28%) did not offer dermatology services or referrals, 58 (56%) referred patients to local dermatology practices for presumably discounted care, and 17 (16%) had board-certified dermatologists periodically available on site. At the free clinics with dermatology services on site, the average wait time was 21.6 days (standard deviation, 20.7 days). On-site dermatology services included biopsy services (available at 88% of the clinics), pathology services (available at 82%), and surgical excision services (available at 59%).

At the 58 free clinics that refer patients to outside dermatology practices, the average volume of referrals was 1.9 per month (standard deviation, 3.9 per month). Contact information was provided by the free clinics for 13 referral dermatology practices, which were contacted to assess their willingness to accept referrals from free clinics. Of those 13 practices, 12 indicated that they accept these referrals, with 7 requiring patients to complete financial need paperwork or pay an upfront fee.

Table I. Clinic characteristics

Variable	Value
Clinics sampled (N = 357)	
No response after 3 calls, n (%)	137 (38.4%)
Closed or not health clinics, n (%)	62 (17.4%)
Participated in the survey, n (%)	104 (29.1%)
Declined to participate in the survey, n (%)	54 (15.1%)
Clinics participating in survey (n = 104)	
Do not offer dermatology services, n (%)	29 (27.9%)
Refer out to dermatology practices, n (%)	58 (55.8%)
Have dermatology services on site, n (%)	17 (16.4%)
Clinics providing dermatology services (n = 17)	
Skin biopsy available, n (%), n (%)	15 (88.2%)
Pathology services available, n (%)	14 (82.3%)
Surgical excision available, n (%)	10 (58.8%)
Average wait time, d (SD)	21.6 (20.8)
Clinics that refer to an outside dermatologist (n = 58)	
Average monthly referrals (SD)	1.9 (3.9)
Referral clinics contacted (n = 13)	
Accepted referrals from free clinic, n (%)	12 (92.3%)
Required copay or demonstrated financial need, n (%)	7 (53.9%)

SD, Standard deviation.

On the basis of our study, more than half of the free or low-cost clinics listed in the database endorsed by SPOTme are unresponsive, are closed, or do not offer medical services. At the remaining clinics, on-site access to dermatology services is limited. The most common mechanism for providing dermatologic care is through referral to outside dermatology practices, many of which accept these referrals but also require some payment for services.

The primary limitation of this study is the low response rate, which was largely due to an inability to reach some sampled clinics despite repeated attempts or was due to clinic closure. The sampled clinics were selected from a single database recommended by SPOTme, and use of an alternative database or random sample might yield different results. Finally, the survey administered by the investigators was not validated.

Given the barriers to accessing dermatologic care at free or low-cost medical clinics, programs such as SPOTme may consider alternative strategies, such as maintaining an independent list of free clinics offering dermatology services or directly referring to local dermatologists who are willing to see screenees without insurance and

willing to provide follow-up care for uninsured screening participants with suspicious lesions identified at screening events. Centralized follow-up tracking protocols and transportation incentives[5] may also enhance access to follow-up care.

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Eosinophilic dermatosis of hematologic malignancy: A retrospective cohort of 37 patients from an Italian center

To the Editor: Eosinophilic dermatosis of hematologic malignancy (EDHM) is a nonspecific skin disease that is primarily associated with chronic lymphocytic leukemia.[1-3] Despite being a common disease in the hematology setting, often misdiagnosed as an "exaggerated reaction to mosquito bites,"[2] there is a shortage of dermatology-oriented reports. We report on a retrospective case series of EDHM carried out in our department between November 2014 and January 2017. The main results are listed in Table I.

We identified 37 patients on the basis of the proposed EDHM diagnosis criteria, which include: 1) a known history of oncohematologic disease; 2) recurrent episodes of papules, nodules, urticarial plaques, or blisters with intense pruritus; 3) eosinophilic infiltration upon histopathology; and 4) the exclusion of other causes of tissue eosinophilia.[1] The majority suffered from indolent B cell disorders, primarily B cell chronic lymphocytic leukemia (51%) and various types of B cell non-Hodgkin lymphomas (30%), whereas acute leukemia was observed in 4 patients (10%). At the time of EDHM onset, only a minority of them (25%) underwent chemotherapy because of active/progressive disease.

The eruption was widespread, albeit mostly occurring on the lower limbs (90%) and upper limbs (79%). However, more than half of the cases had lesions on the trunk, and 25% of patients reported painful lesions on the face, scalp, and neck.

Most of the patients presented with pruritic erythematous papules, plaques, and nodules with a smooth surface and color ranging from slightly pink to bright red, or more cyanotic hues. In one third of cases, tense blisters resembling bullous pemphigoid (BP) were evident, especially on the legs (Fig 1, *A*).

Skin specimens revealed variably dense, mainly perivascular lymphohistiocytic and eosinophilic infiltrates in the papillary and mid-dermis in most cases (80%), extending to the reticular dermis and subcutaneous fat in 20% of cases. In 2 cases, the histologic features resembled those of Wells syndrome, revealing numerous eosinophils with flame figures in the reticular dermis. Dermoepidermal detachment was observed in 10 cases, raising the suspicion of BP. In these cases, direct immunofluorescence was negative. No relevant epidermal changes were found, except for spongiosis in 2 specimens (Fig 1, *B*).

Almost all patients showed some clinical benefit with the proposed treatment; most patients were treated with systemic steroids either with or without concomitant topical steroids. A minority of patients achieved clinical improvement with other regimens, including doxycycline with or without nicotinamide and ultraviolet A1 light phototherapy. The overall response rate was 93%. However, in many cases (63%) the response was short-lived, and the patients relapsed.

Our study shows that EDHM potentially occurs in a wide range of hematologic cancers, with