Table I. Demographics and clinical presentation of the cohort

Variable	All patients (N = 180)	Cutaneous LE (n = 136)	Dermatomyositis (n = 44)	*P* value
Sex, n (%)*				.56
Female	146 (81%)	109 (80%)	37 (84%)	
Male	34 (19%)	27 (20%)	7 (16%)	
Age at evaluation, y†				.03
Mean (SD)	50 (16)	48 (17)	54 (15)	
Min/max	(20, 88)	(20, 88)	(20, 84)	
Ethnicity, n (%)‡				.72
Hispanic/Latino	18 (10%)	15 (11%)	3 (7%)	
Not Hispanic/Latino	151 (84%)	112 (82%)	39 (89%)	
Unknown	11 (6%)	9 (7%)	2 (5%)	
Race, n (%)‡				>.99
White	145 (81%)	108 (79%)	37 (84%)	
Black or African American	1 (1%)	1 (1%)	0 (0%)	
Asian	7 (4%)	6 (4%)	1 (2%)	
American Indian and Alaska Native	3 (2%)	2 (1%)	1 (2%)	
Native Hawaiian and other Pacific Islander	1 (1%)	1 (1%)	0 (0%)	
Other	13 (7%)	10 (7%)	3 (7%)	
Unknown	10 (6%)	8 (6%)	2 (5%)	
Medication§				
Hydroxychloroquine‡	179 (99%)	135 (99%)	44 (100%)	>.99
Chloroquine‡	7 (4%)	6 (4%)	1 (2%)	>.99
Previous exposure to antimalarial, n (%)*	26 (14%)	21 (15%)	5 (11%)	.50
Concomitant immunosuppression, n (%)*	68 (38%)	35 (26%)	33 (75%)	<.001
Drug reaction‡	7 (4%)	5 (4%)	2 (5%)	.68
Drug reaction (controlling for concomitant immunosuppression)‖				.83

The cutaneous LE group was composed of 92 patients with discoid LE, 25 with subacute cutaneous LE, 3 with LE tumidus, and 16 with acute cutaneous LE. The dermatomyositis group consisted of 7 patients with clinically amyopathic dermatomyositis and 37 with classic dermatomyositis.

LE, Lupus erythematosus; *SD*, standard deviation.

*Chi-square test used.

†*t* Test used.

‡Fisher exact test used.

§Six patients who were first treated with chloroquine and were switched to hydroxychloroquine because of gastrointestinal upset, tinnitus, or a national shortage of chloroquine. Only 1 patient was treated with chloroquine exclusively.

‖Cochran-Mantel-Haenzsel test used.

Reprints not available from the authors.

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REFERENCES

1. Femia AN, Vleugels RA, Callen JP. Cutaneous dermatomyositis: an updated review of treatment options and internal associations. *Am J Clin Dermatol*. 2013;14(4):291-313.
2. Anyanwu CO, Chansky PB, Feng R, Carr K, Okawa J, Werth VP. The systemic management of cutaneous dermatomyositis: results of a stepwise strategy. *Int J Womens Dermatol*. 2017;3(4):189-194.
3. Pelle MT, Callen JP. Adverse cutaneous reactions to hydroxychloroquine are more common in patients with dermatomyositis than in patients with cutaneous lupus erythematosus. *Arch Dermatol*. 2002;138(9):1231-1233.
4. Wolstencroft PW, Casciola-rosen L, Fiorentino DF. Association between autoantibody phenotype and cutaneous adverse reactions to hydroxychloroquine in dermatomyositis. *JAMA Dermatol*. 2018;154(10):1199-1203.
5. Matsuda T, Ly NTM, Kambe N, et al. Early cutaneous eruptions after oral hydroxychloroquine in a lupus erythematosus patient: a case report and review of the published work. *J Dermatol*. 2018;45(3):344-348.

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Post–nail procedure analgesia: A randomized control pilot study

To the Editor: For success in nail surgery, proper anesthesia is essential. Postoperative pain after nail surgery is a common complication. Lidocaine is the most widely used anesthetic in nail surgery because of its safety profile and faster onset of action.[1]

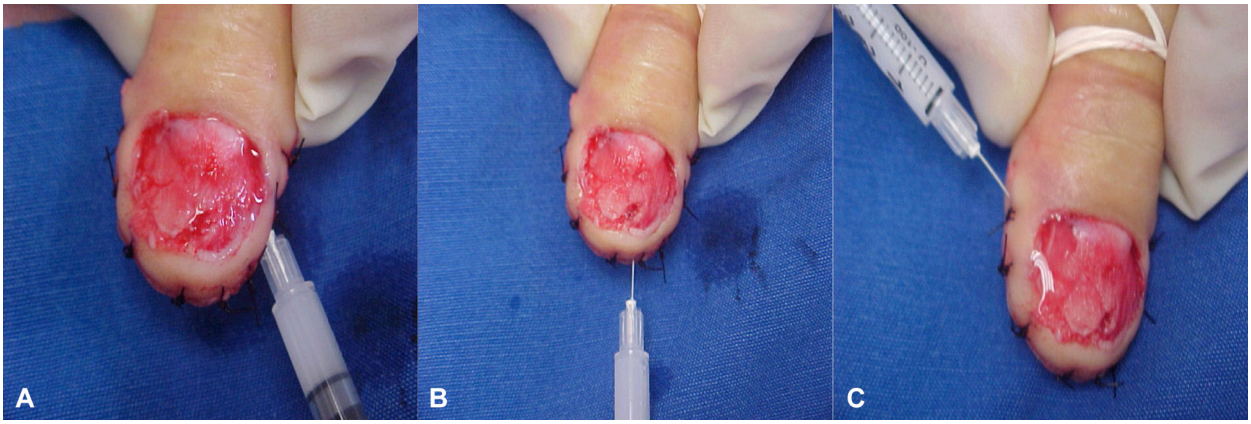

Fig 1. Injection of antipain solution into the surgical wound after the surgery. **A-C**, Ropivacaine (0.5 mL) and triamcinolone (10 mg/mL [0.5 ml]) were injected into the surgical wound after the nail surgery.

Table I. General characteristics of patients included in the study

	Group with antipain solution				Group without antipain solution			
Patient No.	**Sex**	**Location**	**Age, y**	**VAS**	**Sex**	**Location**	**Age, y**	**VAS**
1	Female	BT	55	2	Female	BT	43	7
2	Female	BT	48	2	Female	BT	53	8
3	Male	BT	60	0	Female	BT	55	8
4	Female	BT	42	1	Female	BT	39	9
5	Male	BT	61	3	Female	BT	59	7
6	Female	BT	56	2	Male	BT	49	8
7	Female	BT	43	3	Male	BT	62	9
8	Female	FH	52	3	Female	FH	60	7

BT, Big toe; *FH*, first finger of hand; *VAS*, visual analogue scale.

However, the duration of its analgesic effect is around 60 minutes, after which the patient experiences pain and discomfort. Ropivacaine, because of its short onset and prolonged duration of action (up to 20 hours), represents an ideal anesthetic, with the advantage of delaying pain in the postsurgery period.[2] Steroids in combination with long-lasting anesthetic agents are effective in avoiding the delayed pain in nail surgery.[3] The objective of this study was to use a visual analogue scale (VAS) to compare after-procedure pain in patients treated with antipain solution with that in patients without pain solution in the postoperative period of nail surgery.

This open-label, randomized, controlled trial was performed (from January 2017 to January 2018) at the Hospital do Servidor Público Municipal de São Paulo in São Paulo, Brazil. All patients signed an informed consent form, and the ethical committee approved this study. A total of 16 patients with transverse overcurvature of the nail, all of them with bone spicule of the dorsal part of distal phalanx confirmed by radiograph, were included.

Patients were given proximal block anesthesia with lidocaine 2%, varying from 1.5 to 3.0 mL according the digit's size. A tourniquet was applied. In all cases, the bone spicule of dorsal part of the distal phalanx was isolated and removed by using a nail nipper. In 8 patients, an antipain solution (1 mL of the solution containing 0.5 mL of ropivacaine and 0.5 mL of triamcinolone) was injected into the surgical wound after the surgical procedure (Fig 1, *A* to *C*). In the other 8 patients no solution was applied. For pain, both groups were prescribed either paracetamol or metamizol. Follow-up and assessment using the VAS were applied after 48 hours, when the dressing was removed. On the VAS scale, a score of 0 represented no pain and a score of 10 represented the worst pain that the patient ever had. Patients treated with the antipain solution had a VAS of 2 (± 1.07), compared with 7.88 (± 0.84) in the nontreated group (Tables I and II).

Table II. Statistical analysis of patients involved in the study

Variable	Group with antipain solution (n = 8)	Group without antipain solution (n = 8)	*P* value
Sex, n (%)			.715
Female	6 (50)	6 (50)	
Male	2 (50)	2 (50)	
Mean age, y (range)	53 (42-61)	54 (39-62)	.925
Average VAS score (SD)	2 (±1.07)	7.88 (±0.84)	<.001

For categoric variables, the chi-square test was performed. A paired *t* test was used for numeric variables. There were no statistic differences with regard to age, sex, or site of nail surgery. VAS analysis was statistically significant with <0.001.

Infiltrative anesthesia is the most-used anesthetic procedure for nail surgery. Ropivacaine (an amide anesthetic) gives analgesia for around 8 hours, and triamcinolone decreases the postoperative inflammatory process. However, this type of long-acting anesthetic masks pain due to postoperative complications (compartment syndrome, infections, and ischemia).[4] Although ropivacaine's most common side effect is vasoconstriction, it is no stronger a vasoconstrictor than lidocaine and it is safe to use.[5] The triamcinolone that we used had a concentration of 20 mg/mL and was diluted in 3 parts saline (a 5-mg/mL solution); only 0.5 mL was added with 0.5 mL of long-acting anesthetic. We do not recommend higher doses of steroids, especially with the pinky finger and when doing this procedure in children.

In conclusion, the antipain solution decreases pain after nail surgery. The marked reduction in the patient's pain, as well as the easy application and low profile of side effects of this analgesic technique, warrant its consideration for inclusion in daily practice.

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REFERENCES

1. Jellinek NJ, Velez NF. Nail surgery: best way to obtain effective anesthesia. *Dermatol Clin*. 2015;33:265-271.
2. Keramidas EG, Rodopoulou SG. Ropivacaine versus lidocaine in digital nerve blocks: a prospective study. *Plast Reconstr Surg*. 2007;119:2148-2152.
3. Salasche SJ, Peters VJ. Tips on nail surgery. *Cutis*. 1985;35:428-431, 435-438.
4. Vinycomb TI, Sahhar LJ. Comparison of local anesthetics for digital nerve blocks: a systematic review. *J Hand Surg Am*. 2014;39:744-751.e5.
5. Gherardini G, Samuelson U, Jernbeck J, Aberg B, Sjostrand N. Comparison of vascular effects of ropivacaine and lidocaine on isolated rings of human arteries. *Acta Anaesthesiol Scand*. 1995;39:765-768.

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Atopic dermatitis is associated with increased hospitalization in US children

To the Editor: Childhood atopic dermatitis (AD) is associated with severe flares and comorbid atopic, mental health, and infectious disorders,[1] which may increase hospitalization risk. A previous study found increased hospitalization in US adults with AD, which were costly.[2] We sought to determine whether childhood AD is associated with increased hospitalizations in the United States; this has important ramifications for risk stratification and resource allocation. We hypothesized that childhood AD was associated with increased hospitalizations.

The 1997-2017 National Health Interview Survey, a US population–based household survey (N = 251,555) was analyzed. One child per household was randomly selected. The 1-year prevalence of AD was determined on the basis of response to the question During the past 12 months, has your child had eczema or any kind of skin allergy? Caregiver report of eczema and skin allergy in children was previously validated.[3] Number of overnight hospitalizations was determined on the basis of response to the question How many different times did your child stay in any hospital overnight or longer during the past 12 months? This study was approved by the institutional review board at Northwestern University.