Clinical Features	Proportion (%)					
	All	Western Engines	Asian Engines	SCOPUS	Pubmed& EMBASE	Pubmed/ MEDLINE
Lichenification	66%	66%	.	74%	82%	84%
Early onset disease	57%	58%	52%	54%	73%	78%
Ichthyosis/palmar hyperlinearity/keratosis pilar	38%	37%	44%	25%	15%	7%
White dermographism/delayed blanch	35%	35%	38%	27%	30%	17%
Urticaria	27%	27%	.	50%	30%	50%
Extensor involvment (lower limbs)	25%	25%	.	17%	8%	.
Papular lichenoid lesions	22%	26%	10%	16%	23%	26%
Photophobia	22%	26%	11%	11%	24%	11%
Dyshidrosis / pomphylox	14%	14%	.	12%	10%	7%
Knuckle dermatitis of hands	14%	21%	.	15%	24%	31%
Erythroderma	11%	11%	.	1%	2%	2%

Fig 1. Random-effects proportions of selected clinical characteristics occurring in atopic dermatitis overall and stratified by different regions are presented using a color-coded heat map (0% = dark green; 100% = dark red).

drugs developed for AD are studied in international studies across many regions. Yet, the results are pooled together, presuming homogeneity across regions. Our results suggest that such presumptions are problematic and that ethnic and regional differences should be considered when analyzing trial data.

We strongly recommend searching all of the abovementioned databases in SRs, especially those representing Asian and other non-English languages. Finally, clinicians should cautiously interpret SRs that were limited to English language and Western literature and recognize their potential biases and limited generalizability.

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REFERENCES

1. Cohen JF, Korevaar DA, Wang J, Spijker R, Bossuyt PM. Should we search Chinese biomedical databases when performing systematic reviews? *Syst Rev*. 2015;4:23.
2. Rice DB, Kloda LA, Levis B, Qi B, Kingsland E, Thombs BD. Are MEDLINE searches sufficient for systematic reviews and meta-analyses of the diagnostic accuracy of depression screening tools? A review of meta-analyses. *J Psychosom Res*. 2016;87:7-13.
3. Bramer WM, Rethlefsen ML, Kleijnen J, Franco OH. Optimal database combinations for literature searches in systematic reviews: a prospective exploratory study. *Syst Rev*. 2017;6:245.
4. Aagaard T, Lund H, Juhl C. Optimizing literature search in systematic reviews—are MEDLINE, EMBASE and CENTRAL enough for identifying effect studies within the area of musculoskeletal disorders? *BMC Med Res Methodol*. 2016;16:161.
5. Yew YW, Thyssen JP, Silverberg JI. A systematic review and meta-analysis of the regional and age-related differences of atopic dermatitis clinical characteristics. *J Am Acad Dermatol*. 2019;80(2):390-401.

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Prison malpractice litigation involving dermatologists: A cross-sectional analysis of dermatologic medical malpractice cases involving incarcerated patients during 1970-2018

To the Editor: Over 75% of dermatologists are projected to face malpractice litigation by the age of 65 years.[1] Moreover, 28.7% of malpractice claims against dermatologists during 2006-2015 were decided in favor of the plaintiff, with an average indemnity payment of $238,145.00 USD.[2] Although >1 in 110 Americans are incarcerated, limited information exists regarding malpractice litigation in the setting of dermatologic care for incarcerated patients.[3] Incarcerated patients experience unique exposures, and pharmacologic formularies are often

limited in prison settings.[4] Understanding the unique challenges involved in dermatologic care for patients in the prison setting is critical in identifying areas for quality improvement, safety initiatives, and education of prison medical staff. The goal of this study was to describe the characteristics of prison malpractice cases involving dermatologists.

This study was a cross-sectional analysis of the LexisNexis Academic legal database, which contains all prison lawsuit cases and source material from all 50 states since January 1970.[5] This data set was queried for prison, dermatologist, and other similar terms. Malpractice cases involving a dermatologist, reporting a final decision, and involving a dermatologic condition that occurred while the plaintiff was imprisoned were included. Monetary payouts were adjusted for inflation.[6] Descriptive statistics were performed in SAS 9.4 (SAS Institute, Cary, NC).

In total, 107 cases involving dermatologic prison malpractice were included in our analysis (median year 2011). Most incarcerated individuals were male (92.2%) with dermatologic conditions affecting the face, scalp, or neck (30.8%); whole body (24.0%); or a lower extremity (23.1%). The setting in which incarcerated individuals received health care was most commonly the prison (49.0%). Most cases won by the defendant were in northeastern prisons (36.5%, Table I). The most common rationale for litigation was delay in treatment (34.6%), and the most common reason for the decision in favor of the defendant was an inability to prove deliberate indifference (57.7%).

The most common symptoms in incarcerated patients filing dermatologic malpractice lawsuits were rashes (40.4%), lesions or discolored spots (21.2%), and pruritus (5.8%). Although most incarcerated patients were undiagnosed (31.7%), the most common diagnoses were skin and subcutaneous tissue infection (11.5%), atopic dermatitis (7.7%), scabies (5.8%), and psoriasis (5.8%). Although most incarcerated patients received no treatment (28.9%), the most common treatments in incarcerated patients seeking dermatologic care were topical corticosteroids (12.5%), topical antibiotics (11.5%), and Mohs micrographic surgery or surgical excision (10.6%).

Of the 3 cases decided in favor of the plaintiff, the payout ranged $766,042.21-$2,384,136.45 (median $989,034.54, Table II). Two cases involved male defendants and 2 cases took place in the Northeast. The rationales for these lawsuits included foot amputation due to misdiagnosis of ichthyosis as a severe fungal infection, metastasis due to failure to biopsy a primary cutaneous melanoma on the nose, and radiodermatitis due to improper radiation procedures.

Table I. Characteristics of prison malpractice cases won by defendants (n = 104)

Characteristic	Prison malpractice cases won by defendant, N = 104, n (%)
Location	
Northeast	38 (36.54)
South	31 (29.81)
Midwest	19 (18.27)
West	16 (15.38)
Lawsuit reason	
Delay in treatment	36 (34.62)
Failure to treat fully, leading to continued suffering	31 (29.81)
Wrong treatment or off-label use	9 (8.65)
Side effect of dermatologic medication	8 (7.69)
Failure to biopsy or diagnose	6 (5.77)
Misdiagnosis	5 (4.81)
Failure to prevent disease	3 (2.88)
Dermatologic side effect of medication	3 (2.88)
Failure to obtain informed consent	3 (2.88)
Decision reason	
No deliberate indifference	60 (57.69)
Statute of limitations	17 (16.35)
Unable to prove negligence	11 (10.58)
Procedural issue	9 (8.65)
No impact	5 (4.81)
Standard of care was followed	2 (1.92)
Setting	
Prison	51 (49.04)
Veterans Affairs	26 (25.00)
Nonacademic hospital	11 (10.58)
Army hospital	9 (8.65)
University hospital	4 (3.85)
Private practice	3 (2.88)
Sex	
Male	95 (92.23)
Female	8 (7.77)
Site	
Face, scalp, or neck	32 (30.77)
Whole body	25 (24.04)
Leg or foot	24 (23.08)
Unspecified	8 (7.69)
Arm or hand	7 (6.73)
Genitals	4 (3.85)
Trunk or back	4 (3.85)

This study highlights the unique characteristics of dermatologic malpractice in the prison setting. Most patients in this study were undiagnosed by prison medical staff and not treated by dermatologists, which highlights the importance of available dermatology referrals and second opinions for

Table II. Prison malpractice cases won by plaintiff (N = 3)

Year	Sex	Location	Payout, USD	Reason for lawsuit	Setting	Site
1990	Male	Northeast	$989,034.54	Misdiagnosis of fungal infection as ichthyosis, leading to eventual amputation	Prison	Foot
2008	Male	Northeast	$2,384,136.45	Did not biopsy, leading to metastasis of cutaneous melanoma	Veterans Affairs	Nose
2013	Female	South	$766,042.21	Improper procedures followed for radiation, leading to radiodermatitis	Nonacademic Hospital	Head

Payout is adjusted for inflation to July 2018. The rationale for the decision for all cases won by the plaintiff was negligence.

unclear cases. Limitations of this study include the inability to evaluate cases settled outside of court and variation in the level of detail provided by proceedings of different jurisdictions. Close collaboration of dermatologists with prison medical staff might minimize malpractice risk for incarcerated patients and providers, lead to greater access to dermatologists, and ultimately improve clinical outcomes.

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REFERENCES

1. Jena AB, Seabury S, Lakdawalla D, Chandra A. Malpractice risk according to physician specialty. *N Engl J Med*. 2011;365(7):629-636.
2. Kornmehl H, Singh S, Adler BL, Wolf AE, Bochner DA, Armstrong AW. Characteristics of medical liability claims against dermatologists from 1991 through 2015. *JAMA Dermatol*. 2018;154(2):160.
3. Glaze LE, Kaeble D. Correctional populations in the United States, 2013. https://www.bjs.gov/content/pub/pdf/cpus13.pdf; 2014. Accessed August 17 2018.
4. Coury C, Kelly B. Prison dermatology. *J Correct Health Care*. 2012;18(4):302-308.
5. Medical Malpractice. LexisNexis Academic Legal Database. http://www.lexisnexis.com/documents/academic/academic_migration/LexisNexisAcademicUserGuide-1.pdf; 2018.
6. Bureau of Labor Statistics. Consumer price index inflation calculator. Databases, tables, and calculators by subject. https://www.bls.gov/data/inflation_calculator.htm.

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Pressure alopecia in pediatric and adult patients: Clinical and trichoscopic findings in 12 cases

To the Editor: Pressure alopecia (PA) is an infrequent form of hair loss due to ischemic changes to the scalp. It affects adults and children as a complication of prolonged head immobilization during surgery or hospitalization.[1,2] PA occurs as a localized alopecic area, usually overlying scalp prominences. It is generally transient. We reviewed the records of patients with PA who were seen for dermatologic consultation in our hospital during the period from 2010 to 2017. We present what to our knowledge is the largest series in the literature investigating trichoscopy of PA (N = 12) (Table I).

On clinical examination, the early acute phase of PA shows erythema and sometimes ulceration. Skin necrosis, loss of adnexal structures, and cicatricial outcome may occur, depending on the severity and duration of pressure or operative time and on patients' characteristics. The diagnosis can be challenging when a transient decrease of papillary blood supply to the hair bulb induces anagen effluvium[3] but the skin integrity is maintained. The clinical history and location of alopecia shed light on the diagnosis in mild cases.

In our series, hospitalization and head immobilization were not the only causes of PA because subcutaneous masses and trauma shared the same hypoxic pathogenesis, similarly to pressure ulcers. In addition to the scalp (vertex and occipital region), the beard was a possible location of PA.

On trichoscopy, our patients with PA presented with dystrophic hairs and yellow and black dots