



Fig 2. Allergic contact dermatitis. A classic distribution of a rash due to garlic allergen involving the nondominant hand.



Fig 3. Allergic contact dermatitis in a patient allergic to gold and medicaments.

patient pantomimed holding a paint tray with his left hand lodged against his periumbilical region while using a paintbrush to dip into the tray. The lubricant substance in the tray would splash over the edge onto his left hand and the clothing over his abdomen. The patch testing result was positive for lanolin, relevant to the lubricant and to the medication used to treat the dermatitis.

When using pantomime, prompt the patient by saying, “Let’s pretend” or “Show me,” referring to the use of an object. Statements such as “How do you use this?” should be avoided because they may confuse the patient and make the process awkward. It may be helpful to hand any object to the patient that approximates the size of the item he or she is pretending to handle. Pantomiming can be very helpful in understanding unusual patterns of dermatitis.

Pantomiming can be a powerful diagnostic modality that allows the physician to observe how patients may interact with various products to better diagnose ACD.

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Funding sources: None.

Conflicts of interest: None disclosed.

IRB approval status: Reviewed and approved by the Sparta IRB (STUDY20191228).

Reprints not available from the authors.

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REFERENCES

1. Broadbent R. History of Pantomime. Alexandria, VA: International Business Publications; 2018.
2. Lausberg H, Kazzar P, Heekeren HR, Wartenburger I. Pantomiming tool use with an imaginary tool in hand as compared to demonstration with tool in hand specifically modulates the left middle and superior temporal gyri. *Cortex*. 2015;71:1-14.
3. McGovern TW, Alstroemeria L. (Peruvian lily). *Am J Contact Dermat*. 1999;10(3):172-176.
4. Hughes TM, Varma S, Stone NM. Occupational contact dermatitis from a garlic and herb mixture. *Contact Dermatit*. 2002;47(1):48.

<https://doi.org/10.1016/j.jaad.2020.01.027>

Depression screening at visits for acne in the United States, 2005-2016



To the Editor: Acne is associated with mental health problems, including low self-esteem, depression, and suicidality.^{1,2} Thus, screening for depressive symptoms may be beneficial among this population. However, it is unclear how often physicians in routine practice screen individuals with acne for depression.

The purpose of this study was to examine rates of depression screening at visits for acne in the United States using data from the National Ambulatory Medical Care Survey (NAMCS, 2005-2016) and the National Hospital Ambulatory Medical Care Survey (NHAMCS, 2005-2011), which sample visits to non-federally employed, office-based physicians and outpatient departments, respectively.³ Because the prevalence of acne decreases with age, we limited our sample to visits for individuals ages 10 through 40 years. Visits for acne were identified using International Classification of Disease—9th Revision code 706.1 and International Classification of Disease—10th Revision codes L70.0 and L70.9. We were unable to compare screening rates at new versus follow-up visits due to sample size limitations.

Table I. Depression screening rates at visits for acne and visits for other reasons*

Visit type	Weighted %	95% CI	P value
Acne visits	1.2	0.7-1.9	—
Primary care	2.2	1.2-3.9	.011
Dermatology	0.6	0.2-1.5	
Other visits	2.7	2.3-3.1	—
Primary care	2.8	2.4-3.2	<.001
Dermatology	0.0	0.0-0.1	

CI, Confidence interval.

*Percentages are weighted to national estimates. P values represent chi-square tests between physician specialty and depression screening.

We estimated the overall rates of depression screening at visits for acne, which in the NAMCS/NHAMCS is defined as follows: “The assessment of whether the patient has signs or symptoms of depression and may involve the administration of a standard questionnaire to assess whether a patient is experiencing symptoms of depression.” Additionally, among visits for acne, we analyzed whether rates differed between primary care physicians (PCPs) and dermatologists. We also performed multivariable logistic regression to further determine associations between physician specialty and depression screening and adjusted for sex, age, and region, each of which is independently associated with depression and suicide. Analyses accounted for the complex sampling design and used sampling weights to generate nationally representative estimates. All analyses were conducted using Stata 16 (StataCorp, College Station, TX).

There were an estimated 67.9 million visits for acne between 2005 and 2016. Overall, 62.1% of visits were to dermatologists, and 33.1% of visits were to PCPs. Depression screening was performed at 1.2% of acne visits and was less common among dermatologists (0.6%) than among PCPs (2.2%). Depression screening at visits with dermatologists was more common at acne visits compared with visits for all other reasons (Table I). In a multivariable logistic regression model, dermatologists were less likely than PCPs to screen for depression at visits for acne (Table II).

In this study of nationally representative outpatient visits in the United States, rates of depression screening at visits for acne were extremely low, despite known associations with depression and suicidality. Depression screening was less common at visits with dermatologists than nondermatologists, suggesting there may be an opportunity for dermatologists to improve the care of patients with acne by more often screening for depression symptoms.

Table II. Results from multivariable logistic regression model among visits for acne

Specialty	aOR	95% CI
Primary care (reference)	—	—
Dermatology	0.28	0.09-0.88
Sex		
Male	1.16	0.51-2.63
Age, y		
10-19 (reference)	—	—
20-29	1.43	0.55-3.72
30-40	0.45	0.07-3.13
US region		
Northeast (reference)	—	—
Midwest	0.14	0.02-0.81
South	0.17	0.03-1.09
West	0.93	0.30-2.82

aOR, Adjusted odds ratio; CI, confidence interval.

Although the NAMCS/NHAMCS may not capture all screening for depression, such as patient intake forms that are not documented by the physician, given the low rates of observed screening, increased screening rates would likely reduce the mental health morbidity among individuals with acne. A lack of knowledge regarding appropriate referrals and treatment of mental health comorbidities among dermatologists may contribute to underscreening. Furthermore, it may lead to delayed treatment after positive depression screening results. Screening measures, such as the PHQ-2 (Patient Health Questionnaire-2),⁴ and subsequent action plans for appropriate referral may be used by dermatologists to better address mental health problems among individuals with acne.⁵

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Funding sources: Dr Barbieri is supported by the National Institute of Arthritis and Musculoskeletal and Skin Diseases of the National Institutes of Health under award number T32-AR-007465 and receives partial salary support through a Pfizer fellowship grant to the Trustees of the University of Pennsylvania.

Conflicts of interest: None disclosed.

IRB approval status: Not applicable.

Reprints not available from the authors.

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REFERENCES

1. Dalgard F, Gieler U, Holm JO, Bjertness E, Hauser S. Self-esteem and body satisfaction among late adolescents with acne: results from a population survey. *J Am Acad Dermatol*. 2008; 59(5):746-751.
2. Vallerand IA, Lewinson RT, Parsons LM, et al. Risk of depression among patients with acne in the U.K.: a population-based cohort study. *Br J Dermatol*. 2018;178(3):e194-e195.
3. Centers for Disease Control and Prevention. Ambulatory health care data. Available at: <https://www.cdc.gov/nchs/ahcd/index.htm>; 2019. Accessed November 5, 2019.
4. McDonald K, Shelley A, Jafferany M. The PHQ-2 in dermatology—standardized screening for depression and suicidal ideation. *JAMA Dermatol*. 2018;154(2):139-141.
5. Gaufin M, Hess R, Hopkins ZH, Biber JE, Secrest AM. Practical screening for depression in dermatology: using technology to improve care. [e-pub ahead of print]. *Br J Dermatol*. <https://doi.org/10.1111/bjd.18514>.

<https://doi.org/10.1016/j.jaad.2019.12.076>

Association between bullous pemphigoid and ischemic heart diseases: A systematic review and meta-analysis



To the Editor: Bullous pemphigoid (BP), the most common autoimmune bullous disease affecting the elderly, is associated with several comorbidities and high mortality.^{1,2} Previous meta-analyses have reported a significant association between BP and thrombotic complications such as stroke and venous thromboembolism.^{3,4} In addition to stroke, ischemic heart diseases (IHDs) are a leading cause of death in older people. In this study, we performed a systematic review and meta-analysis to investigate the association between BP and IHDs.

We systematically searched the PubMed, Embase, Web of Science, and Cochrane Library databases for all relevant studies published before October 13, 2019, and included case-control studies investigating the IHDs prevalence in patients with BP and controls. Search keywords were “bullous pemphigoid” in combination with “ischemic heart diseases,” “angina,” “myocardial infarction,” “acute coronary syndrome,” or “coronary artery diseases.” We excluded articles that (1) were conference abstracts, case series, or reviews; (2) enrolled patients based on diagnosis codes in databases without definite diagnostic items of BP or IHDs; and (3) lacked evaluable data. Study quality was evaluated using the Newcastle-Ottawa scale.

A random-effects model was used for the meta-analysis. Odds ratios and the corresponding 95% confidence intervals were used for pooled analysis. Heterogeneity across studies was assessed using χ^2 and I^2 statistics, and the risk of publication bias was evaluated using the Egger test. All analyses were performed using Comprehensive Meta-analysis version 3 software (Biostat, Englewood, NJ).

The systematic review initially identified 89 studies, of which 11 case-control studies that met the inclusion criteria were eligible for qualitative synthesis. After the exclusion of studies with indefinite diagnostic criteria for cases, 8 studies involving 814 patients with BP and 5147 controls were included in the final quantitative analysis. Table 1 presents the basic characteristics of these selected studies. The meta-analysis (Fig 1) revealed that the odds of IHDs was nonsignificantly higher in patients with BP than in controls (odds ratio, 1.153; 95% confidence interval, 0.938-1.418; $P = .176$). The heterogeneity across studies ($I^2 = 0.000\%$) and publication bias ($P = .38614$) were also nonsignificant. A leave-one-out sensitivity analysis confirmed the robustness of our findings.

In contrast to the well-established association of BP with stroke or thrombotic events, the possible correlation of BP with cardiovascular diseases was proposed on the basis of the hypercoagulable and inflammatory state noted in patients with BP.² Furthermore, only a few case series without matched controls have reported the possibility of an association between BP and cardiovascular diseases, particularly hypertension; however, other studies conducted in different populations have reported conflicting results.^{1,2} Our results demonstrated only a nonsignificant trend for the association of BP with IHD.

The limitations of this study include the lack of information on the chronology of onset for both BP and IHDs and on the influence of medications or other comorbidities of BP on IHDs as well as the exclusion of studies that enrolled patients based on codes in databases.

In conclusion, our meta-analysis revealed no significant association between BP and IHDs.

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