Table I. Procedure characteristics and recurrence data for melanoma in situ treated with staged excision

	Body site	Cleared on first stage (%)	Average stages to clear	Recurrences (%)
Total	339	275 (81.1)	1.26	3 (0.9)
Head & neck	170	123 (72.0)	1.41	1 (0.6)
Nose	13	11 (84.6)	1.23	0
Ear	12	9 (75)	1.25	0
Periocular	11	5 (45.5)	1.82	0
Scalp	14	11 (78.6)	1.29	0
Other head & neck	120	87 (72.5)	1.43	1 (0.8)
Trunk	53	49 (92.5)	1.08	0
Upper extremities	56	47 (83.9)	1.2	0
Lower extremities	41	38 (92.7)	1.07	0
Hands & feet	19	17 (89.5)	1.11	2 (10.5)

A total of 275 (81.1%) of cases were cleared on the first stage, 5 mm from clinically visible tumor. For all sites, the average number of stages needed to obtain clear margins was 1.26. Cases on the head and neck were less likely to be cleared at 5 mm, with 72.0% of cases cleared on the first stage compared to 89.3% for all other sites ($P < .001$). Patients 70 years and older required an average of 1.37 stages to clear tumor, compared to 1.20 for the rest of the cohort ($P = .023$). There were 3 (0.9%) recurrences, all occurring within 1 year of initial staged excision. Two of the recurrences were on the hands/feet, and one was on the head/neck (Table 1). Three cases were upstaged after the central debulking procedure, with 2 upstaged to T1a (ear and periocular) and 1 case upstaged to T2a (other head and neck). The patient who was upstaged to T2a underwent sentinel node biopsy, the results of which were negative for metastatic disease. At the time of publication, none of the 3 patients with upstaged cases had evidence of recurrent or metastatic disease.

Staged excision techniques are an effective treatment for MIS, resulting in higher clearance rates and lower recurrence rates when compared to wide local excision.[2-5] A significant number of our tumors had subclinical extension requiring larger margins than the 5-mm margins recommended for excision of MIS, especially on the head and neck and in elderly patients. Although more data are needed to generate formalized recommendations regarding staged excision of MIS, data from our single-center study support the growing body of literature suggesting that this is a superior treatment compared to standard excision.

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Use of a dermatology-specific discharge form to improve outpatient follow-up after inpatient dermatology consultation

To the Editor: Inpatient dermatology consultations have been shown to be associated with decreased 1-year readmission rates for patients with inflammatory skin conditions.[1] We anecdotally identified

Table I. Impact of dermatologic consultations on diagnoses and management

Consults (*N* = 100)	Final diagnosis, No. (%)	Change from original diagnosis (n/N)	Change in management (n/N)
Blistering disorder	6 (6)	6/6	6/6
Drug eruption	24 (24)	18/24	20/24
Psoriasis	8 (8)	5/8	7/8
Dermatitis*	21 (21)	15/21	18/21
Cutaneous malignancy	9 (9)	4/9	9/9
Fungal infection	4 (4)	4/4	4/4
Cellulitis	7 (7)	1/7	2/7
Vasculitis	4 (4)	3/4	4/4
Furunculosis	4 (4)	2/4	3/4
Connective tissue disease	3 (3)	3/3	2/3
Viral exanthem	10 (10)	8/10	8/10
Total, n/N (%)		69/100 (69)	83/100 (83)

No., Number.
*Dermatitis includes eczematous dermatitis, contact dermatitis, stasis dermatitis, and seborrheic dermatitis.

Table II. Demographic and intervention factors and follow-up appointment success rates

Subgroup	Consults, No.*	Completed follow-up, No. (%)	RR (95% CI)	*P* value
Sex				
Female	57	27 (47.3)	1.38 (0.76-2.49)	.29
Male	43	14 (32.6)	1 [Reference]	…
Age, y				
≥65	59	24 (40.6)	1.32 (0.64-2.47)	.12
<65	41	15 (36.6)	1 [Reference]	…
Dermatology Consult Discharge Form				
Yes	53	32 (60.4)	2.25 (1.18-4.28)†	.004
No	47	10 (21.1)	1 [Reference]	
Condition				
Acute on chronic	30	18 (60)	2.11 (1.29-3.46)	.003
Acute	70	22 (31.4)	1 [Reference]	…

CI, Confidence interval; *No.*, number; *RR*, risk ratio.
*Total consults (N = 100).
†Log-binomial regression model after adjustment for age and sex.

noncompliance with postdischarge follow-up appointments with consulting dermatologists as a cause of poor outcomes among patients hospitalized for inflammatory skin conditions. To address this area of unmet need, we performed a resident-led quality improvement project that assessed the effect of implementing a dermatology-specific discharge form on compliance with postdischarge dermatology appointments.

Dermatology consult patients who were previously noncompliant with postdischarge appointments were contacted by telephone to identify barriers to follow-up. Some reasons reported included lack of understanding of their inpatient skin diagnoses and the need for long-term outpatient management, discontinuation of the inpatient dermatologic treatment regimen upon discharge, and confusion about how and where to follow-up. Many patients believed that they only needed to follow-up with their primary care physician, suggesting suboptimal communication regarding dermatologic care upon hospital discharge.

These responses were used to develop a dermatology-specific discharge form, which was to be completed by the consulting dermatologist and included with the hospital discharge summary. The form was designed to educate consult patients about their dermatologic condition(s) and treatment plan and provide detailed follow-up instructions.

The dermatology-specific discharge form was given to 53 consult patients upon discharge in 2017. Follow-up appointments were made before discharge in reserved slots on the consult resident's continuity clinic schedule, and the appointment information was included on the discharge form. The study used data from 47 consult patients before the implementation of the dermatology-specific discharge form as historical controls. All patients

included were otherwise given the hospital's standard discharge summary. Follow-up compliance rates for keeping appointments were compared over the 1-year periods before and after the implementation.

Of the 100 consults included, 57.0% were women with a mean age of 63.3 (standard deviation, 19.7) years. In line with previous studies,[2,3] our consultations had a significant impact on the inpatient management of skin conditions, changing the diagnosis and treatment plan in 69% and 83% of cases, respectively (Table I). Multivariate regression analysis showed that patients given the dermatology-specific discharge form were more likely to follow-up compared with consult patients before this implementation (60.4% vs 21.2%; risk ratio, 2.25; 95% confidence interval, 1.18-4.28; $P = .004$). Patients with an acute flare of a chronic condition (compared with an acute new condition) were also more likely to follow-up (risk ratio, 2.11; $P = .003$), whereas there was no statistically significant difference in follow-up rates based on age or sex (Table II).

Improved outpatient follow-up compliance rates with use of a dermatology-specific discharge form may be due to improved accuracy and specificity of dermatology information provided to patients upon discharge. One possible contributing factor is that the form is designed to be completed by the consulting dermatologist, as one study found that the accuracy rate of dermatology documentation in hospital discharge summaries completed by nondermatologists was only 54.5%.[4]

The study is limited by its retrospective nature and generalizability given the implementation at a single community-based academic medical center. Although patients in the intervention group had reduced all-cause 30-day hospital readmission rates (6.9% vs 9.2%, $P = .03$), it is beyond the scope of this study to correlate this with the higher rates of clinic follow-up. Future studies evaluating use of a dermatology-specific discharge form as a mechanism for reducing readmission rates of inflammatory skin conditions are warranted.

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Outcome and clinicophenotypical features of acute lymphoblastic leukemia/lymphoblastic lymphoma with cutaneous involvement: A multicenter case series

To the Editor: Cutaneous involvement by acute lymphoblastic leukemia/lymphoblastic lymphoma (ALL/LBL) is very uncommon. Current knowledge of this situation remains limited, based on small retrospective case series without data regarding overall survival (OS) and associated prognostic factors nor molecular features.[1-3] Besides, no data about differential antigen expression of tumoral cells in skin vs bone marrow are available.

Our objective was to describe outcome, prognostic factors, and clinicophenotyping specificities of ALL/LBL with skin involvement. We collected retrospective data from a multicenter cohort of patients with ALL/LBL with cutaneous involvement from 13 hospitals from 1997 to 2018.

Patients' characteristics are listed in Table I. Among 38 patients with ALL/LBL (12 females, 26 males),