all 3 of our patients with pulmonary sarcoidosis. The present study, together with previous reports of tofacitinib efficacy,[1,2] raise interest to further investigate tofacitinib use in sarcoidosis. Limitations of this study include small patient numbers, retrospective nature, and lack of control group. Larger prospective studies will help validate findings.

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Hydroxychloroquine prescribing habits and impact of the COVID-19 pandemic

To the Editor: COVID-19 clinical trials and media attention have led to public familiarity with hydroxychloroquine (HCQ). Attention has been drawn to rare HCQ adverse effects, such as severe arrhythmia and cardiomyopathy.[1] Anecdotally, patients have contacted us regarding such adverse effects, despite being on long-term HCQ without issue. The purposes of this study were to characterize dermatologists' HCQ practice habits and to determine if the COVID-19 pandemic has affected these habits.

An institutional review board–exempt survey was distributed via the Association of Professors of Dermatology e-mail distribution list. Sixty dermatologists completed the survey. Eighteen respondents (30%) reported being contacted by patients regarding HCQ shortages, and 14 (23%) were contacted by patients regarding adverse effects they had seen in the media but had not personally experienced. Twenty respondents (33%) were contacted by nondermatology physician colleagues regarding adverse effects or laboratory monitoring. The COVID-19 pandemic has not changed how most dermatologists (57; 95%) will use HCQ in practice. Most respondents (53; 88%) were "very comfortable" with prescribing HCQ for indications approved by the US Food and Drug Administration, and fewer respondents (44; 73%) were "very comfortable" with off-label use. Screening and monitoring habits are presented in Supplemental Table I (available via Mendeley at http://doi.org/10.17632/f526xz9p7v.1), and counseling habits and adverse effects experiences are presented in Supplemental Table II (available via Mendeley at http://doi.org/10.17632/f526xz9p7v.1).

HCQ laboratory habits vary greatly, with 18% of respondents not obtaining baseline studies, and 25% obtaining a glucose 6-phosphate dehydrogenase (G6PD) assay before initiation. There are no reports of HCQ-induced hemolysis, and antimalarial monotherapy is thought to be safe in glucose 6-phosphate dehydrogenase–deficient patients.[2] This practice gap is likely based on theoretical concerns. Most HCQ adverse effects are symptomatic in nature, but regular screening laboratories can detect hepatotoxicity and/or blood dyscrasia, although the interval at which these tests should be performed is not well defined.[3] Reflecting this, respondents performed screening tests at varying intervals, with 22% not performing any such tests. Although formal guidelines do not exist for dermatologists, The American College of Rheumatology recommends only baseline blood counts and liver transaminase and creatinine levels before HCQ initiation and does not recommend surveillance blood testing.[4] Ophthalmologic screening habits also vary among dermatologists despite formal retinopathy screening guidelines existing, which include a baseline examination and then annual examinations after 5 years, if there are no other retinopathy risk factors.[5]

Cardiac adverse effect concerns were second only to retinopathy concerns, although most respondents do not take a cardiac history before starting HCQ. Regarding coadministration of qTC-prolonging medication, respondents were most concerned about azithromycin, likely influenced by ongoing attention to this combination. During COVID-19 trials, HCQ discontinuation was rarely required because of qTC prolongation, even with azithromycin coadministration.[6] Long-term HCQ use may actually protect against conduction abnormalities, and HCQ-induced cardiomyopathy is not seen acutely, with a diagnosis after a median of 22 years of HCQ therapy.[1]

Limitations include the number of respondents reached via the e-mail distribution list and selection bias. This study shows the impact that the ongoing COVID-19 pandemic has had on dermatology practice, in addition to highlighting the variability of practice habits and real-time concerns of dermatologists. The lack of standardized practice habits highlights a need for formal task force guidelines regarding HCQ use and also provides an opportunity for quality improvement.

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