those expectations, level of satisfaction on various facets of our offering, and whether they would have had the opportunity to visit our program if in-person away rotations were not canceled. With an overall response rate of 75% (n = 18), majority of the rotators reported "very satisfied" with the clinical curriculum, learning objectives, formal didactics, ability to assess program culture, opportunity to demonstrate interest, access to the residents, faculty advising, and diversity and inclusion initiatives (61%, 67%, 100%, 100%, 72%, 100%, 72%, and 83%, respectively; Fig 1). They viewed research opportunities and obtaining letters of recommendation as "not applicable" (Fig 1), but these aspects were also not the highest priorities reported (Fig 2). The students acknowledged that they received ample opportunity to meet their priorities for an away rotation (78%; Supplemental Fig 1, A, available via Mendeley at https://data.mendeley.com/datasets/6d9zg7m4h9/2), and 39% noted that they might not have had the traditional advantage to rotate with this program (Supplemental Fig 1, B).

The nationwide discussion of adapting medical education and our sampling of applicant perspectives reflect the need for further data-driven exploration of virtual away rotations. The intrinsic selection and acquiescence biases in polling students interested in this specific program were addressed with informed consent emphasizing anonymity and no effect on evaluations, and recall bias was minimized by survey completion on a rolling basis immediately after a student's rotation ended. Academic faculty's views were not examined. Despite these limitations, our findings illustrated that the priorities of away rotations can be met through a virtual model and that remote alternatives can capture candidates unable to leverage a physical clinical rotation. Investing resources to establish or improve virtual visiting electives will not only mitigate challenges in this application cycle but also catalyze changes that address financial and scheduling inequities inherent to the traditional away rotation system.

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Funding Sources: None.

IRB approval status: Designated as exempt (NCR203119).

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Conflicts of interest

None disclosed.

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https://doi.org/10.1016/j.jaad.2021.02.085

Isomorphic and symmetric adult-onset generalized morphea are associated with distinctive clinical features: A retrospective multicenter study

To the Editor: Generalized morphea (GM) is a rare subtype of localized scleroderma characterized by widespread involvement. GM is defined by the presence of at least 4 lesions larger than 3 cm that involve at least 2 anatomic sites.[1] Isomorphic and symmetric subsets of GM were recently delineated based on a computerized lesion mapping approach.[2] In the isomorphic pattern, the lesions favor areas of skin friction (ie, brassiere band, waistband, inguinal creases), whereas in the symmetric one, they occur with a symmetric distribution on the trunk and extremities. A higher frequency of deep involvement was reported in patients with symmetric GM, whereas lichen sclerosus-like changes were a frequent finding in morphea plaques from patients with isomorphic GM.[2]

Table I. Demographic characteristics and associated comorbidities of GM

Characteristics	Value
Patients, N	27
Sex	
Female, n (%)	21 (78)
Male, n (%)	6 (22)
F:M	3.5:1
Age of onset, y, mean (SD)	60 (11)
Time to diagnosis, mo, mean (SD)	18 (26)
Genital lichen sclerosus, n (%)	15 (56)
Autoimmune comorbidities, n (%)	9 (33)
Autoimmune thyroiditis	2
Inflammatory bowel disease	1
Alopecia areata	1
Systemic lupus erythematosus	1
Spondyloarthropathy	1
Psoriasis	1
Rheumatoid arthritis	1
Polymyalgia rheumatica	1

F, Female; *M*, male; *SD*, standard deviation.

This retrospective study aimed to describe the clinical characteristics of another cohort of patients with adult-onset GM and to investigate if further differences exist between isomorphic and symmetric subsets.

We conducted a retrospective chart review of 27 patients followed up for GM in 3 hospitals from the east of France between 2009 and 2019. Cases were identified using the international coding for morphea (L94.0 in the International Classification of Diseases, 10th revision). Data including demographics, comorbidities, and laboratory findings were retrieved. Two investigators (AB and CL) independently reviewed the photographs to categorize patients into isomorphic or symmetric subsets, when possible, using the skin mapping recently published.[2] A third blinded investigator (DL) was involved in case of disagreement. Comparison between subsets was made using the Student *t* test and Fisher's exact test. Interrater agreement was assessed with the Cohen kappa test.

The relevant demographic characteristics and patient comorbidities are summarized in Table I. All patients had undergone systematic genital examination. Fifteen patients (56%) had genital lichen sclerosus, and 9 (33%) had autoimmune comorbidities. Twenty-three patients (85%) could be classified into either the isomorphic (n = 12) or symmetric (n = 11) subsets. The 4 remaining unclassed patients had either features of both subsets or none. Cohen's kappa was 0.88, suggesting a very good agreement between raters in favor of the applicability of this classification.

Table II. Comparison between isomorphic and symmetric GM

Characteristics	Isomorphic GM	Symmetric GM	*P**
Patients, n (%)†	12 (52)	11 (48)	
Sex, n (%)			
Female	10 (83)	8 (73)	.64
Male	2 (17)	3 (27)	
Age at onset, y, mean (SD)	63 (12)	57 (10)	.20
Pruritus, n (%)	4 (33)	7 (64)	.22
Functional impairment, n (%)	0 (0)	3 (27)	.09
Genital lichen sclerosus, n (%)	10 (83)	4 (36)	**.04**
Autoimmune comorbidities, n (%)	1 (8)	6 (54.5)	**.03**
Antinuclear antibodies positivity, n/total (%)‡	1/7 (14)	4/10 (40)	.34

GM, Generalized morphea; *SD*, standard deviation. Bold text signifies statistical significance (<.05).
**P* < .05 was considered significant.
†Four patients did not fit into either subset.
‡≥1/160; only 17 patients were tested (7 isomorphic, 11 symmetric).

The comparative clinical and biological characteristics are summarized in Table II. Sex and age at onset were equivalent between the 2 groups. Genital lichen sclerosus was strikingly more frequent in patients with the isomorphic subset (10/12 vs 4/11; $P = .04$), whereas patients with symmetric GM more often had autoimmune comorbidities (1/12 vs 6/11; $P = .03$).

We found an even higher prevalence of genital lichen sclerosus than already reported in patients with classical morphea.[3] This prevalence peaked in the subgroup of patients with isomorphic GM, whereas patients with symmetric GM had a higher frequency of autoimmune comorbidities. Despite its retrospective design and small sample, our study strongly supports the clinical relevance of this dichotomous classification. Taken together, the findings published by Teske et al[2] and our results suggest that lichen sclerosus, whether in a genital location or not, may represent the most superficial manifestation in the spectrum of morphea, where subtle repetitive trauma would play a determinant pathophysiologic role.

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Funding sources: None.

Conflicts of interest: None disclosed.

IRB approval status: Reviewed and approved by the Hôpitaux Universitaires de Strasbourg IRB (NCT04264728).

Reprints not available from the authors.

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https://doi.org/10.1016/j.jaad.2020.07.109

Dermoscopic predictors of melanoma arising in small- and medium-sized congenital nevi

To the Editor: The risk of melanoma in congenital nevi (CN) is known to increase with the nevus size.[1] The estimated lifetime risk of melanoma in small- and medium-sized CN is low, especially if the nevi are solitary or few. However, the incidence of small- and medium-sized CN is much higher compared with large and giant CN. Therefore, the absolute number of melanomas developing in small- or medium-sized CN might be considerable.[1]

Melanoma developing in large and giant CN usually originates within the dermis, rendering its early recognition particularly difficult. In contrast, melanoma in small- or medium-sized CN usually develops at the dermoepidermal junction. Therefore, it should result in dermoscopically visible alterations of the color or the architecture, or both, of the pre-existing CN.[2]

To investigate dermoscopic melanoma predictors, we screened the databases of 3 skin cancer referral centers to identify small- or medium-sized CN that were excised or biopsied to rule out melanoma developing in the nevus. The inclusion criteria are explained in the Supplemental Material (available via Mendeley at https://doi.org/10.17632/p3y7fc7gc3.1anl). Crude and adjusted odds ratios were calculated by univariate and multivariate logistic regression, respectively.

Table I. Results of the dermoscopic analysis

Criterion*	Melanomas in congenital nevi (n = 32)	Congenital nevi (n = 87)	*P* value†
Global pattern			.24
Globular	10 (31.3)	22 (25.3)	
Reticular	17 (53.1)	54 (62.1)	
Homogeneous	1 (3.1)	2 (2.3)	
Mixed	4 (12.5)	9 (10.3)	
Location of the suspicious area			
Peripheral	23 (71.9)	26 (29.9)	**<.001**
Central	7 (21.9)	25 (28.7)	
Diffuse	2 (6.2)	36 (41.8)	
Atypical network	17 (53.1)	26 (29.9)	**.02**
Pseudopods	6 (18.8)	3 (3.4)	**.01**
Radial streaks	2 (6.3)	3 (3.4)	.41
Negative network	12 (37.5)	3 (3.4)	**<.001**
Shiny white streaks	7 (21.9)	3 (3.4)	**.01**
Irregular dots/globules	16 (50.0)	36 (41.8)	.26
Irregular blotch	8 (25.0)	13 (14.9)	.16
Blue-white veil	5 (15.6)	3 (3.4)	**.03**
Regression structures			.13
Scar-like area	1 (3.1)	12 (13.8)	
Peppering	1 (3.1)	5 (5.7)	
Blue regression structures	3 (9.4)	2 (2.3)	
Polymorphous vessels	12 (37.5)	25 (28.7)	.24
Gray angulated lines	21 (65.6)	25 (28.7)	**<.001**

*Data are presented as number (%).
†Bold *P* values are statistically significant ($P < .05$).

Overall, 119 tumors from 63 men and 55 women, with a mean age of 35.6 ± 16.3 years, were included in the study (Supplemental Material). Of them, 87 (73.1%) were histopathologically diagnosed as CN and 32 (26.9%) as melanoma in CN.

The results of the dermoscopic analysis are summarized in Table I. The multivariate analysis revealed the following potent melanoma predictors: peripheral location of the suspicious area (333.3-fold), negative network (106.5-fold), gray angulated lines (12.5-fold), and atypical network (6.6-fold) (Fig 1 and Supplemental Material).

The importance of the peripheral location of the suspicious area is consistent with previous studies that described the macroscopic morphology of melanomas in CN and suggested that, also macroscopically, the suspicious area is usually eccentric.[3] Of the local dermoscopic features evaluated in our study, negative network was the most potent melanoma predictor. A previous study suggested that negative network is more frequent in nevus-associated than in de novo melanoma,