

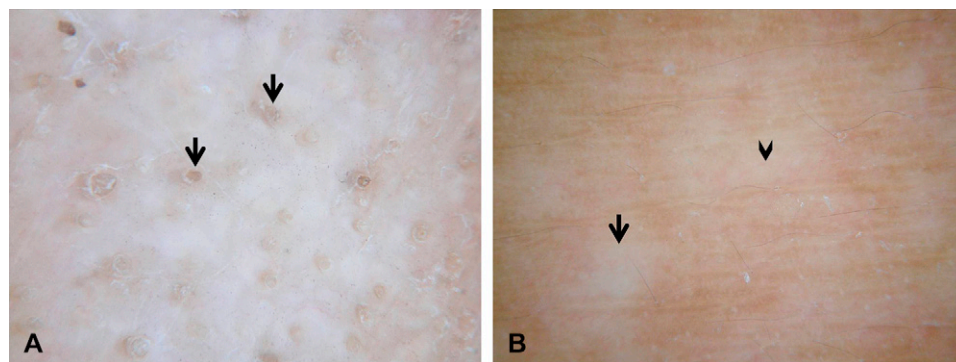


Fig 1. Dermoscopic features. **A**, Lichen sclerosus et atrophicus showing widespread whitish patches and comedo-like openings (arrows). **B**, Morphea consisted of fibrotic beams (arrow) and linear branching vessels (arrowhead).

morphea are summarized in Table I. The incidence of comedo-like openings ($P = .006$) and whitish patches ($P = .038$) was significant in LSA whereas the incidence of fibrotic beams ($P = .038$) was distinct in morphea. The incidence of pigment network-like structures ($P = .170$) and linear branching ($P = .455$) was not significantly different between the groups. Comma-like vessels ($n = 2$, 11.1%), hairpin vessels ($n = 2$, 11.1%), and dotted vessels ($n = 1$, 5.6%) were observed only in the LSA group, not in the morphea group.

Very few have reported the use of dermatoscopy to differentiate LSA and morphea. Garrido-Rios et al³ reported characteristic dermatoscopic findings of extragenital LSA, such as the comedo-like openings and the whitish patches, and Campione et al⁴ described the dermatoscopic feature of morphea as accentuated fibrotic beams crossed by spreading telangiectasia. However, no other studies emphasized the dermatoscopic differences between the two diseases.

In this study, we found that the significant dermatoscopic features of LSA were comedo-like openings and whitish patches (Fig 1, A) whereas that of morphea was fibrotic beams (Fig 1, B). Our results show a close correlation between dermatoscopic patterns and their underlying histologic features. The comedo-like openings represent follicular plugging and the whitish patches indicate atrophy of the epidermis—typical histopathologic features of LSA.³ The fibrotic beams observed in morphea indicate sclerotic dermis.⁴ Our study was uncontrolled and nondouble-blinded and the results do not reflect variability in age, sex, location, or activity of the lesion.

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Two-year assessment of effect of topical corticosteroids on bone mineral density in adults with moderate to severe atopic dermatitis

To the Editor: Application of topical corticosteroids may be a risk factor for low bone mineral density

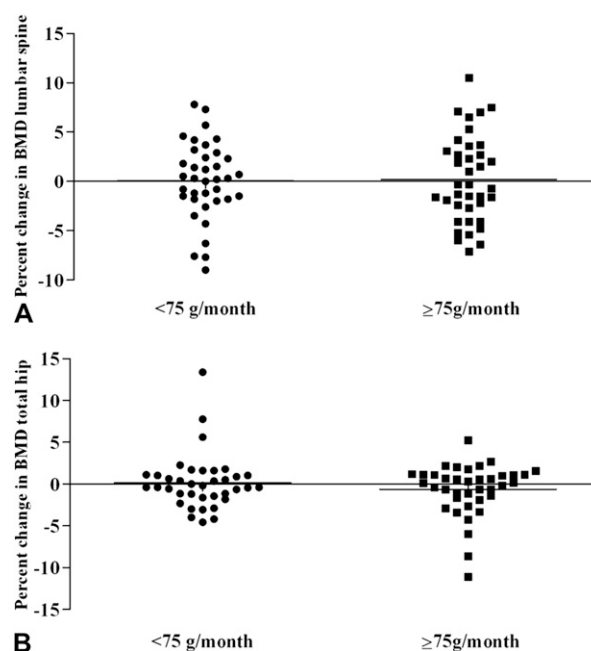
Table I. Cumulative topical corticosteroid use between baseline and follow-up

European classification	Mean grams $\pm$ SD
Class I; least potent	
1% Hydrocortisone acetate cream/ointment	8 $\pm$ 23
Class II; mid potent	
0.05% Clobetasone butyrate ointment	162 $\pm$ 339
0.1% Triamcinolone acetonide ointment	70 $\pm$ 219
0.02% Flumetasone ointment	10 $\pm$ 84
Class III; potent	
0.1% Betamethasone valerate ointment	1171 $\pm$ 1482
0.005% Fluticasone propionate ointment	429 $\pm$ 796
0.1% Mometasone furoate ointment	39 $\pm$ 239
0.25% Desoximetasone lotion	283 $\pm$ 592
Class IV; superpotent	
0.05% Clobetasol propionate ointment	302 $\pm$ 630

SD, Standard deviation.

(BMD) in patients with atopic dermatitis (AD).¹ We assessed the effect of topical corticosteroids on BMD during a 2-year follow-up study in 75 adult patients with moderate to severe AD (mean age, 40.2 years; 52% men). Using dual-energy x-ray absorptiometry, BMD was measured at the lumbar spine and hips. T-scores of each patient were calculated. Cumulative dose of topical and oral corticosteroids during follow-up was calculated from pharmacy records. Life style parameters were collected by a questionnaire. Biochemical parameters of bone metabolism were measured. Statistical analysis was adjusted for other corticosteroid use and possible confounders, such as dairy intake. The medical ethical committee of the University Medical Centre Utrecht approved this study; patients gave their written informed consent.

Absolute BMD at baseline and follow-up did not differ significantly (*P* value lumbar spine 0.47; total hip 0.06). Furthermore, the number of patients with a T-score <1 at baseline (41.3%) did not differ from the number of patients with a T-score <1 at follow-up (44.3%). Topical corticosteroid use between baseline and follow-up is specified in Table I. Cumulative use of topical corticosteroids during follow-up varied between 1 and 480 grams (mean, 86.8 $\pm$ 80.5 grams). BMD change between baseline and follow-up did not differ significantly between patients using <75 or $\geq$ 75 grams of topical corticosteroids per month (Fig 1 and Table II). Baseline

**Fig 1.** Percentage change in BMD in the two topical corticosteroid use groups (<75 g/mo and $\geq$ 75 g/mo) of the lumbar spine (A) and total hip (B).

levels of biochemical parameters of bone metabolism (parathyroid hormone, bone-specific alkaline phosphatase, C-terminal telopeptide of type I collagen and 25-hydroxyvitamin D) did not differ between patients using <75 or $\geq$ 75 grams of topical corticosteroids per month during follow-up.

In conclusion, use of topical corticosteroids during this 2-year follow-up study had no effect on BMD in adult patients with AD. This may be explained by the use of low amounts of topical corticosteroids by our patients. Furthermore, the potential negative effect of topical corticosteroids on bone may be reversed by intermittent use of topical corticosteroids.² Finally, in patients using oral corticosteroids, the greatest decrease in BMD is seen during the first 12 months of treatment.³ After this period bone loss continues at a lower rate, despite continuing oral corticosteroid therapy.⁴ In our study population patients have been using topical corticosteroids for years and the rate of bone loss may be low because of this mechanism.

Interpreting changes in BMD over time can be challenging. A change between two BMD measurements only reflects a 'real' change if the random error of the DXA system is exceeded.⁵ The random error or least significant change has been described to be between 3.3% and 4.7% for the total hip.⁵ In the current study the decrease in BMD after 2 years in patients using high ($\geq$ 75 g per month) amounts of topical corticosteroids was only 0.484% for the total

Table II. Mean bone mineral density changes in patients using less than 75 grams or 75 grams or more of topical corticosteroid per month

BMD changes (mean % $\pm$ SD)	Unadjusted BMD lumbar spine	Adjusted BMD lumbar spine*	Unadjusted BMD total hip	Adjusted BMD total hip*
<75 g topical corticosteroid use per month (Group 0; n = 37)	0.073 $\pm$ 3.913	0.657 $\pm$ 4.307	0.170 $\pm$ 3.296	0.164 $\pm$ 3.223
$\geq$ 75 g topical corticosteroid use per month (Group 1; n = 34)	0.138 $\pm$ 4.399	0.204 $\pm$ 4.431	-0.716 $\pm$ 3.197	-0.484 $\pm$ 3.18
P value	.806	.571	.273	.100

BMD, Bone mineral density; SD, standard deviation.

*Adjusted for age, sex, dairy intake, physical activity, body mass index, and other steroid use.

hip, a very small, and clinically not relevant, decrease. Additional follow-up studies are necessary to evaluate if this small decrease in BMD continues over time and after which time period this decrease becomes clinically relevant.

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The relative popularity of nonprocedural dermatology fellowships

To the Editor: Multiple sources have documented an insufficient supply of medical dermatologists as well as some dermatology subspecialists.¹ Although the popularity and competitiveness of procedural dermatology fellowships have been well described,² there is limited literature examining training trends in other subspecialties, such as pediatric dermatology or dermatopathology.³

We therefore examined survey data to determine whether interest in nonprocedural dermatology fellowships has similarly been affected and whether debt appears to be a factor in the decision to pursue additional training.

As previously described,⁴ survey data were obtained from recent residency graduates participating in the Galderma Board Review course from 1999 to 2010, with the exception of 2001. Fellowship data from different age cohorts, based on graduation year from residency, derived from the American Academy of Dermatology's 2009 Practice Profile Survey⁴ was also analyzed.

Practice profile data showed that the percentage of respondents pursuing dermatopathology fellowships, as classified by graduation year, steadily decreased from 13.6% (pre-1970) to 2.3% (2000-2004), with a modest subsequent increase to 3.5% (2005-2008) (Fig 1). Consistent with this pattern, the percentage of recent graduates pursuing dermatopathology fellowships increased from 2% (1999, n = 4/223) to 7% (2004, n = 12/171) and remained similar through 2006 (n = 14/137) (Fig 2). Subsequently, the proportion varied more widely, ranging from 1% (2007, n = 2/163) to 8% (2008, n = 8/103).

National practice profile data indicate a small but steady increase in pediatric dermatology from 1.2% (1970-1974) to 2.1% (2005-2008). Pursuit of pediatric dermatology remained fairly consistent from 1999 to 2010, ranging from 0% (2005, n = 0/192) to 6% (2010, n = 5/84).