



At baseline, 31 of the 114 SN (27.2%) exhibited a starburst pattern. Of these 31 lesions, 10 (32.3%) maintained this dermoscopic appearance after a median FUP of 10 months, while 21 (67.7%) after a median FUP of 29.2 months evolved in a quite repetitive pattern characterized by a tiny brown network at the periphery and a central black to grey hyperpigmented area with or without a superimposed superficial black network (Fig. 1).

Our finding suggests that pigmented SN exhibiting a starburst pattern at onset tend to change into a specific pattern not yet described. Our group previously demonstrated that the majority of pigmented and non-pigmented Spitz naevi tend to disappear over time. However, it is still not clear what changes in the baseline dermoscopic pattern become visible in SN before final involution. The pattern we identified in 67.7% of SN with baseline starburst pattern is characterized by a central, black to grey, structureless or reticular, hyperpigmented area and remnants of a delicate brown network at the periphery. The analytic description of this pattern might be summarized by the metaphoric term 'stardust pattern', which can be useful to recall the most common evolution of the 'starburst' pattern.

The recognition of this pattern as one of the physiological evolutions of pigmented Spitz naevi can help reduce the need of biopsy of this type of lesions, especially when dealing with prepubertal children.

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Facial dermatitis: epidemiological retrospective study and patch test

Editor

The face is a body area exposed to many foreign substances, and it is a frequent location for allergic contact dermatitis (ACD).¹

The diagnosis of facial dermatitis (FD) is complex because other dermatological and systemic diseases must be considered.²

The aim of this study was to identify clinical and epidemiological features of patients with FD using the Spanish Contact Baseline Series.³ In addition, depending on the clinical history, patients' own suspected products were also tested.

We recruited patients with long-lasting (6 months) FD between January 2000 and 2011. Every patient underwent a clinical history, dermatological exploration and patch test with the Spanish Baseline Series.³ Patches were applied to the upper back and left on for 48 h, then read on day D2 and D4. Data were analysed with the Statistical Package for Social Sciences (SPSS) program 17.0 for Mac; several statistical analyses were performed when needed (chi-square test), and $P < 0.05$ was considered statistically significant.

A total of 1457 patients were visited; 281 (19.28%) of the patients asked about FD and 1176 had non-FD (80.72%). An initial comparative analysis was conducted, and no difference was detected between these two groups. Distribution by age and sex of patients suffering from FD/non-FD is described in Fig. 1.

Of the 281 patients diagnosed with FD, 175 (62.3%) patients showed at least one positive reaction to any of the allergens tested. The positive reaction rates were 60.7% ($n = 714$) in the non-FD group. The population was stratified by sex and age, and significant statistical differences were found between FD and positive result to any allergen in the patch test ($P < 0.014$). These differences were due to men under 20 and over 60.

Positive reaction rates to the most common allergens are detailed in Table 1. The most common positive allergen with clinical current relevance was nickel sulphate in the FD group, affecting to the 41.3% ($n = 116$) of patients tested. In addition, 104 of 218 patients (37%) with FD had previous history of metal intolerance. Patients with previous metal intolerance had a six

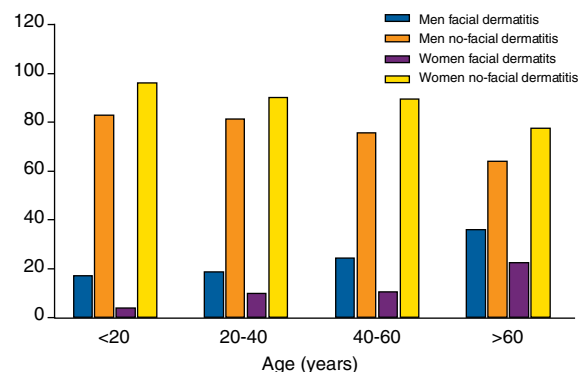


Figure 1 Distribution by age and sex of patients suffering from facial eczema and eczema in other anatomical location attending to Contact Dermatitis and Cutaneous Allergy Department.

Table 1 Frequency of patients tested and positive result for the different allergens in patients with facial dermatitis (FD) and no facial dermatitis (NO-FD)

Allergens	No patient test FD	FD positive result, n (%)	No Patient tested NO-FD	Non-FD positive result, n (%)
Balsam of Peru	281	11 (3.9)	1176	27 (2.3)
Black rubber mix	281	4 (1.5)	1176	12 (1)
Budesonide	281	3 (1.1)	1176	15 (1.3)
Caine mix	281	8 (2.8)	1176	14 (1.2)
Carba mix	281	2 (0.8)	1176	30 (2.6)
Cobalt dichloride	281	13 (4.60)	1176	99 (8.5)
Colophony	281	5 (1.8)	1176	18 (1.5)
Diazolidinyl urea. Germal II	281	1 (0.4)	1176	8 (0.7)
Epoxy resin	281	3 (1.1)	1176	16 (1.4)
Ethylenediamine dihydrochloride	281	3 (1.1)	1176	11 (0.9)
Formaldehyde	281	4 (1.5)	1176	23 (2)
Fragrance mix	281	17 (6.10)	1176	55 (4.7)
Hydrocortisone-17-butyrate	281	4 (1.5)	1176	13 (1.1)
Imidazolidinyl urea. Germal 115	281	2 (0.8)	1176	4 (0.4)
Mercapto mix	281	1 (0.4)	1176	4 (0.4)
Mercaptobenzothiazole	281	1 (0.4)	1176	1 (0.1)
Methylchloroisothiazolinone/ Methylisothiazolinone (MCI/MI)	281	13 (4.60)	1176	103 (8.7)
Neomycin sulfate	281	6 (2.2)	1176	9 (0.8%)
Nickel Sulfate	281	116 (41.3)	1147	417 (36.4)
p-Phenylenediamine	281	16 (5.60)	1176	38 (3.2)
P-Tert butylphenol formaldehyde resins	281	7 (2.5)	1176	29 (2.5)
Paraben mix	281	4 (1.5)	1176	6 (0.6)
Potassium Dichromate	281	8 (2.8)	1176	111 (9.5)
Quaternium-15	281	3 (1.1)	1176	25 (2.1)
Quinoline mix	281	0 (0)	1176	4 (0.4)
Thiomerosal	281	12 (4.3)	1176	55 (4.7)
Thiuram mix	281	1 (0.4)	1176	21 (1.8)
Tixocortol-21-Pivalate	281	3 (1.1)	1176	10 (0.8)
Wool alcohols	281	1 (0.4)	1181	8 (0.7)

higher risk of a positive result to nickel sulphate ($P < 0.0001$) and a confidence interval of 95% (3.4/10). This is in contrast with other series, in which cosmetic and topical medication were the commonest contact allergens in patients with facial eczema,⁴ nickel sulphate and fragrance mix were the commonest contact allergens in FD in our group.

No statistically significant differences were found between age, sex or localisation of the eczema lesions (FD/non-FD) and a positive contact sensitisation to nickel sulphate, fragrance mix, cobalt chloride or p-phenylenediamine. However, 'patients with a positive patch test to methylchloroisothiazolinone/methylisothiazolinone (MCI/MI), had in most cases non-FD, with statistically significant differences ($P < 0.026$) OR 0.5 (CI 95% 0.28/0.9)'. Since the first years of this decade, several authors have started pointing to MCI/MI as an emerging allergen primarily related with wet wipes but also present in many daily cosmetic products as a preservative.⁵⁻⁷ In our series, MCI/MI is less frequent than in

other papers, but we found it had clinical and statistical relevance in non-FD.

Finally, the MOAHLFA INDEX (male, occupational dermatitis, atopic dermatitis, hand, leg, face and age >40 years) index of the FD group was as follows: 76.2% of the patients were men, 7.8% were atopic, 16.4% had hand eczema, 0% had leg eczema, 100% had facial eczema and 66.90% had age >40. No patient in our study had a dermatosis related to his/her job.

In summary, facial eczema is cosmetically alarming, and usually affects patients' self-perception, their quality of life, and their personal and working lives. Unfortunately, it is frequently poorly managed because certain diagnosis is not easily made. Clinicians need to be aware of the possibility of ACD from different allergens in patients consulting for facial eczema, and the use of patch tests is invaluable.

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Patient expectations and determinants of patient satisfaction in a dermatology outpatient clinic

Editor

Patient expectations shape the patient's attitude towards the consultation and the treatment, and are determinants of patient satisfaction.^{1–4} The aim of this study was to investigate the expectations of dermatological patients concerning the doctor, the consultation and the treatment, and to identify factors associated with patient satisfaction in an outpatient setting.

A total of 133 consecutive, newly referred patients to the outpatient clinic of a dermatological university department (Department of Dermatology, Bispebjerg Hospital, Copenhagen, Denmark), 85 (63.9%) women and 48 (36.1%) men, with a mean age of 43.9 years (range 18–75 years) answered pre- and

postconsultation questionnaires developed by Bowling *et al.*,⁵ which assess patient expectations and experiences on a 5-point Likert scale. Patients were approached by the first author or clinic secretaries when checking in for their first consultation. Ordinal regression was used to investigate factors associated with patient satisfaction, and the Wilcoxon signed-rank test was used to compare patient expectations with experiences. A total of 77 patients (57.9%) already had an established diagnosis of their condition upon referral. A total of 103 patients (82.4%) answered that they were satisfied or very satisfied with the consultation, and 86 patients (68.3%) had their expectations met a lot or completely. The majority of patients (61.1%) preferred to share the responsibility with the doctor in deciding which treatment was best, whereas 18.3% patients preferred to make the final decision on which treatment to receive, and 20.6% patients preferred to leave that decision to their doctor.

Patients had very high preconsultation expectations about their doctor being respectful and helpful, indicated by mean values of 1.25 (SD = 0.45) and 1.33 (0.61), respectively, on a Likert scale of 1–5 with 1 indicating the highest expectations. However, expectations were not met regarding the doctor involving the patients in decisions about treatment (preconsultation value = 1.35 (0.67) vs. postconsultation value = 1.77 (1.03)), $P < 0.001$. In contrast, sex, age and type of condition were not statistically significantly associated with patient expectations regarding the doctor. Further, expectations were not met regarding being given a full explanation of what caused the symptoms/condition (preconsultation value = 1.99 (0.97) vs. postconsultation value = 2.33 (1.09)), $P = 0.004$, and the benefits/side-effects or complications/risks of the treatment (preconsultation value = 1.54 (0.78) vs. postconsultation value = 2.31 (1.21)), $P < 0.001$. Also, expectations about being given advice on the condition/health (preconsultation value = 1.64 (0.82) vs. postconsultation value = 1.98 (1.01)), $P = 0.001$, and having tests/investigations performed (preconsultation value = 2.48 (1.18) vs. postconsultation value = 3.1% (fraction who answered affirmatively, not possible to compute mean value)), $P = 0.007$ (calculated for percentage change), were not met. Increasing age was statistically significantly associated with expectations of getting a full explanation on what caused the disease/symptoms ($r = -0.26$, $P = 0.003$), having a physical examination ($r = -0.27$, $P = 0.002$), having tests/investigations performed ($r = -0.36$, $P < 0.001$), being given a diagnosis or having a previous diagnosis confirmed ($r = -0.21$, $P = 0.012$), and with expectations of getting reassurance during the consultation ($r = -0.25$, $P = 0.004$).

No statistically significant difference in patient satisfaction was seen between the sexes ($P = 0.878$); however, patient satisfaction increased with increasing age ($P = 0.015$) (Table 1). Similar results have been found in another study of dermatological outpatients.⁶ Also, having one's expectations met was strongly associated with patient satisfaction ($P < 0.001$).