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Key words: monozygotic twins, porphyria, protoporphyrinogen oxidase, recurrent mutation, variegate porphyria

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Dermatology and junior doctors: an evaluation of education, perceptions and self-assessed competencies

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SIR, Dermatology is now established as part of the core curriculum of most U.K. medical schools and is a recognized component of the curriculum for trainees in general internal medicine.¹ However, exposure to dermatology, at both undergraduate and postgraduate levels, remains highly variable.¹ In order to ascertain the extent of dermatology experience among junior doctors, we undertook a survey of doctors attending three consecutive preparatory courses in 2006 for the Membership of the Royal College of Physicians (MRCP) Part II Clinical Examination (PACES, Practical Assessment of Clinical Examination Skills) at a large teaching hospital in Leicester, U.K. Places on the course were allocated on a first-come, first-served basis.

Doctors attending the course were asked to complete a questionnaire about dermatology experience at medical school and following qualification; this included statements regarding their perceptions of the specialty using a 10-point Likert scale (1, strongly disagree; 10, strongly agree). In addition, doctors' perceived competencies in performing routine bedside dermatological investigations were also assessed. The questionnaire comprised 40 questions in total: four relating to previous dermatology experience; 11 to perceptions of dermatology; 10 enquired about self-perceived competencies; 10 asked about attitudes towards dermatologists possessing the MRCP qualification; and five questions were asked to collect demographic data.

All 118 individuals who attended the course in 2006 completed the survey. There were 83 males and 35 females. The mean age of those surveyed was 29.4 years (range 25–39). Thirty-three per cent had graduated from one of the 17 U.K. medical schools represented in our survey. Of these, 58% had qualified outside Leicester. The majority of those surveyed were in either their third or fourth year of training post-qualification. Ninety-three per cent were working within the U.K. at the time of attending the course with 97% expressing a desire to practise in the U.K. post-MRCP.

Overall, 25% had undergone a previous clinical attachment in dermatology as a medical student ranging from 2 days to up to 8 weeks in duration. This proportion increased to 33% among U.K. graduates, with the remainder of these graduates receiving lecture-based teaching. No U.K. graduates were among the eleven individuals (9%) who had not received any dermatology teaching at medical school. Twenty-four doctors (five of whom were U.K. graduates) had some prior dermatology experience at either pre-registration house officer or senior house officer level. Interestingly, however, the presence of dermatology experience at undergraduate or postgraduate level had little effect on those who wished for greater exposure to the specialty—84% wished for more dermatology exposure at undergraduate level and this increased to 90% at postgraduate level. Despite the possibility of encountering a dermatological condition in their PACES examination, only 20% of doctors felt confident in their ability to describe a rash and only nine doctors (8%) felt confident in initiating basic therapy for a skin complaint. Thirty-three per cent of doctors had never taken a skin swab and 90% had never performed a skin scraping and were unsure how to do so. However, a significant proportion of those surveyed (40%) felt that all junior doctors should be competent in these procedures.

Only five doctors expressed a desire to pursue dermatology as a possible career option post-MRCP. Interestingly, however, over half (64), expressed that if dermatological training was coupled with internal medicine allowing dual accreditation, they would 'seriously consider it as a career option'. Over 70% agreed that dermatology allowed a person to 'achieve a favourable work-life balance' although a significant proportion (37%) considered it a 'soft' option for those wishing to stay in hospital medicine. Most doctors felt that MRCP qualification remained a necessary requirement for dermatologists. The

many cutaneous manifestations of systemic disease and the use of potentially toxic systemic therapies were felt to be the most important reasons for possessing this qualification.

In 1993, following the General Medical Council's recommendations,² new undergraduate curricula were introduced in all U.K. medical schools. However, undergraduate exposure to dermatology at the time remained highly variable¹ and our findings suggest that this still appears to be the case. Over the past decade significant work has been undertaken by the British Association of University Teachers of Dermatology (BAUTOD) to address and improve the teaching of dermatology within medical curricula.³ However, the fact that such a high proportion of those surveyed wished for more exposure at both undergraduate and postgraduate levels continues to place a degree of responsibility on all dermatologists to respond to such requirements.

Despite the drastic changes to postgraduate medical education that have taken place in recent times, dermatology has maintained its position as a core component of the curriculum of general internal medicine. Whether the graduate practises in hospital medicine or primary care, we would argue that the teaching of dermatology remains important as previous studies have noted that at postgraduate level little attention is given to the skin even when relevant to the general medical condition of hospital inpatients⁴ and up to 15% of GP consultations are specifically related to the skin.⁵

The lack of confidence displayed by junior doctors in their ability to describe a rash is somewhat alarming given the possibility of our cohort encountering a dermatological case in their PACES examination and beyond this, in real life medical practice. The recent transition to competency-based graduate training may address this, as well as issues relating to the performance of routine bedside dermatological investigations.

Although U.K. graduates comprised one-third of those surveyed, we feel the findings remain very relevant to U.K. dermatology teaching and practice. Overseas doctors made up 33% of U.K. senior house officer posts and 14% of pre-registration house officer posts in 2003⁶ and continue to give invaluable service commitment to the NHS while working in training grades. Indeed, in many district general hospitals more than two-thirds of junior doctors have trained overseas.⁶

In conclusion, the findings from our survey highlight the importance of retaining dermatology teaching as a core component of the undergraduate medical curriculum. In addition the findings would seem to strengthen the case for ensuring that dermatology posts are part of the 2-year foundation programme as well as part of core medical training. Only through increased exposure to the specialty at both undergraduate and postgraduate level can we hope to see an improvement in junior doctors' basic dermatology skills. Furthermore, we believe that an increased understanding of the specialty (ultimately through increased exposure) remains the most effective way of correcting the common misconceptions and attitudes that many still have about dermatology and dermatologists.

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Key words: dermatology education, dermatology teaching, dermatology training, MRCP, PACES

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Perifolliculitis capitis abscedens et suffodiens successfully controlled with infliximab

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SIR, Perifolliculitis capitis abscedens et suffodiens (dissecting cellulitis or dissecting folliculitis) manifests with perifollicular pustules, nodules, abscesses and sinus tracts on the scalp, eventually resulting in extensive scarring alopecia. When it is associated with acne conglobata and hidradenitis suppurativa the syndrome is referred to as the follicular occlusion triad, and when also with pilonidal cysts as a tetrad.¹ The frequent association of these diseases suggests a common pathogenesis. Its course is chronic and relapsing, and treatment is frequently difficult. Therapies include isotretinoin, antibiotics, prednisone, X-ray therapy, surgical excision and skin grafting.²

Tumour necrosis factor (TNF) is a proinflammatory cytokine that seems to play an important role in the pathogenesis of these diseases. Infliximab is a chimeric monoclonal antibody that binds specifically to TNF- α , decreasing the effect of the cytokine in inflammatory diseases. Infliximab monotherapy has been shown to be an effective therapeutic alternative for severe extensive forms of hidradenitis suppurativa.³

We report a 24-year-old man who presented with pustules, tender nodules and sinus tracts on the scalp causing scarring