Table I. Characteristics of vismodegib-treated patients with locally advanced basal cell carcinoma (laBCC), including presence of basal cell carcinoma nevus syndrome (BCCNS) diagnosis, age at evaluation, tumor type, year of initiation of vismodegib therapy, duration, and complicating issues

Patient number	BCCNS	Age	Tumor characteristics	Year started	Months on vismodegib	Comments
1	Yes	34	Sclerotic BCC overlying carotid sheath following two radical neck dissections and radiation.	2011	42	Excellent response. Reversible amenorrhea, alopecia, weakness, muscle spasms, dysgeusia, cramps. Two-month "drug holiday."
2	Yes	63	A multiply recurrent incompletely excised BCC at skull base with a free flap coverage.	2011	41	Excellent response. Severe weight loss, hair loss, dull taste, cramps. One-month "drug holiday."
3	No	74	7.0 cm recurrent BCC following surgery and radiation. Surgical option was rhinectomy.	2012	2	Terminated therapy. Palpitations and fatigue terminated therapy early.
4	No	61	>40 BCC including several recurrent tumors after surgery. Patient refused further surgery and elected vismodegib off-label.	2012	3	Terminated therapy. Severe leg cramps.
5	No	93	>30 BCC and SCC on both legs, failed surgery and radiation. Could no longer walk due to chronic wounds from tumors.	2012	4	Terminated therapy. Hyponatremia and fatigue. No clinical BCC after 2 years.
6	No	44	8 cm BCC overlying prior calavarial defect from childhood brain tumor. Patient was unwilling to pursue neurosurgery.	2013	17, deceased	Terminated therapy. Psychosocial issues and died from disease progression.
7	Yes	45	6 cm BCC of eyelid and orbit following 2 episodes of radiation.	2013	4, deceased	Terminated therapy. Worsening seizures prompted hospice referral.
8	No	76	10 cm recurrent tumor after excision with orbital involvement and facial muscle paralysis.	2014	13	Terminated therapy. Weight loss and cramps worsening dentition.
9	No	93	12 cm plaque on cheek, nose eyelid of multiple foci of recurrent BCC following radiation and surgery.	2013	16	Terminated therapy. Clinical improvement and fatigue prompted discontinuation.
10	No	94	4 cm recurrent tumor on lip after radiation for BCC.	2014	1	Terminated therapy. Rapid tumor growth on vismodegib; rebiopsy revealed SCC.
11	No	51	3.5 cm BCC of lower eyelid.	2014	1	Terminated therapy. Incarceration interrupted treatment.
12	No	48	12 cm eroded BCC on face with maxilla involvement.	2015	3	Ongoing therapy.

SCC, Squamous cell carcinoma.

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Patient satisfaction in dermatologic care delivered by a medical–student-run free clinic

To the Editor: Dermatologic care for low-income, uninsured patients can be poorly accessible.[1] As such, it is essential to evaluate current efforts to extend care to these populations and engage current

and future dermatologists in treating underserved populations. The present study is a single-institution cross-sectional chart review and telephone survey that was performed to address three aims: (1) To characterize the most common dermatological conditions in a free clinic patient population; (2) to understand patient characteristics; and (3) to assess the patient satisfaction of dermatology care delivered in this setting.

The Cardinal Free Clinics (CFC), a partnership between Stanford Healthcare, community-based physicians, and students of Stanford University, serve mostly low-income and immigrant populations via a weekend clinic that provides general and specialty care. Dermatology clinics are held monthly. Clinics are funded by philanthropy and University contributions. Medical students manage clinic infrastructure, patient scheduling, and physician staffing. Medical students and residents see each patient and then present the patient to the attending physician. Afterwards, diagnosis and management is performed together at the bedside via the on-site Stanford-affiliated dermatologist. Biopsies were interpreted by Stanford dermatopathologists pro-bono. Most patients were self-referred; however, some patients were referred internally either from the general CFC or after an offer of a "free skin cancer check."

A retrospective chart review was completed for all patients seen at the dermatology clinic at CFCs from October 1, 2013 through April 1, 2015. An institutional review board-approved 6-question telephone survey was administered between March 2015 to May 2015 to all patients in the study period. Seventy-one patients representing all major demographics (Table I) were seen during the study period, with a survey response rate of 63%. Socio-economic status was not assessed within our survey; however, 62% of patients from the general clinic have an annual household income of less than $25,000; the majority of patients were uninsured. The most common conditions treated included acne vulgaris (14%), tinea (14%), psoriasis (11%), and atopic dermatitis (10%). Two-thirds of patients had not received prior care of their chief complaint by any health care provider, and of those that did receive prior evaluation, the majority classified prior therapy as ineffective (Table II). After receiving care at the CFCs, 82.2% of patients considered the treatment effective. Eighty-four percent reported that they were either likely or highly likely to visit a dermatologist again in the future.

These results indicate that providing dermatology care in a medical–student-run free clinic is associated with positive patient satisfaction and perception of effective care. Our findings suggest that medical–student-led free clinics provides a valuable opportunity for undergraduates and

Table I. Patient demographics and dermatologic conditions

Demographic/Condition	Total patients (N = 71)	Proportion
Age, years		
Median (25%-75%)	41.5	(28-50)
Sex, n (%)		
Male	35	(49.3)
Female	36	(50.7)
Ethnicity, n (%)		
Black	5	(7.0)
Asian American	22	(30.9)
White	18	(25.4)
Hispanic	26	(36.6)
Insurance status (%)	n = 45	n = 45
Uninsured	24	(53.3)
Medicare	6	(13.3)
Medicaid	12	(26.7)
Private insurance	3	(6.7)
Pigmentary changes (%)		
Postinflammatory hyperpigmentation	4	(5.6)
Dysplastic nevi	2	(2.8)
Vascular abnormalities	1	(1.4)
Varicosities	2	(2.8)
Growths (%)		
Premalignant/malignant		
Actinic keratosis	2	(2.8)
Squamous cell carcinoma	1	(1.4)
Benign		
Seborrheic keratosis	1	(1.4)
Epidermal cyst	1	(1.4)
Lentigo	1	(1.4)
Melanocytic nevus	4	(5.6)
Rashes (%)		
Acne vulgaris	10	(14)
Psoriasis	8	(11)
Rosacea	2	(2.8)
Atopic dermatitis	7	(9.8)
Foreign-body reaction	1	(1.4)
Generalized drug reaction	1	(1.4)
Bedbugs	3	(4.2)
Tinea pedis	6	(8.4)
Tinea cruris	1	(1.4)
Tinea versicolor	3	(4.2)
Zoster	1	(1.4)
Scabies	3	(4.2)
Condyloma acuminatum	2	(2.8)
Nail abnormalities (%)		
Onychomycosis	1	(1.4)
Onychodystrophy	1	(1.4)
Melanonychia	1	(1.4)

Table II. Summary of survey responses

Survey question	Response rate (%) Total N = 45
How long was your complaint present before being seen?	
0-7 days	0 (0)
1-4 weeks	14 (31.1)
1-3 months	10 (22.2)
3-6 months	6 (13.3)
6 months-1 year	8 (17.7)
1+ year	7 (15.5)
Have you seen a prior provider regarding this complaint?	
Yes	15 (33.3)
No	30 (66.7)
Was that prior treatment effective?	
Yes	3 (20)
Partially	4 (26.7)
No	8 (53.3)
Was the treatment you received in the free clinic effective at resolving your chief complaint?	
Yes	37 (82.2)
Partially	6 (13.3)
No	2 (4.4)
Have you ever visited a dermatologist before coming to clinic?	
Yes	8 (17.7)
No	37 (82.3)
How likely are you to visit a dermatologist in future?	
Highly unlikely	0 (0)
Unlikely	3 (6.7)
Neutral	4 (9.5)
Likely	6 (13.3)
Highly likely	32 (71.1)

medical students to gain hands-on exposure to a breadth of dermatology conditions at the bedside, while having an direct role in delivering impactful care to underserved populations. Experience of undergraduate students, medical students, and residents to working with underserved populations has been shown to promote future practice in underserved communities[2] and may serve as a valuable long-term approach to fostering interest of trainees in clinical dermatology, and engagement in caring for the underserved.

These survey data should be interpreted with limitations. First, as a single-institution study, results may vary from other clinics and locations. Additionally, we acknowledge potential response and social desirability bias for patients. Finally, although the survey instrument included questions commonly utilized in quality assurance/improvement studies, it had not been previously validated. Nonetheless, we feel that the information gained from the CFC experience supports the value of partnerships between dermatologists and free clinics to provide hands-on experience and mentorship to future generations of dermatologists, while providing a useful service to a population that struggles to access dermatology care.

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Clusters of CD123+ plasmacytoid dendritic cells help distinguish lupus alopecia from lichen planopilaris

To the Editor: The distinction of cicatricial (primary scarring) alopecia secondary to lichen planopilaris (LPP) from lupus erythematosus (LE) can be challenging because of significant clinical and histopathologic overlap, and there is a need for additional tools to help make a diagnostic distinction between LPP and LE in everyday practice. We report the differences between the CD123+ plasmacytoid dendritic cells (PDCs) expression in LPP and LE alopecia.

PDCs produce type I interferons in response to pathogenic agents and play a crucial role in the initiation of inflammation in autoimmune and immuno-allergic dermatoses, cutaneous neoplasms, and skin infections. PDCs are found in skin biopsies from patients with systemic LE, discoid LE, Jessner's lymphocytic infiltrate (lupus tumidus), and subcutaneous LE.[1] Type I interferon system activation has also been reported in dermatomyositis, Sjogren syndrome, morphea, systemic sclerosis, and alopecia areata. The presence of PDCs has already been used