

Coding of Dermatologic Diagnoses: An Unresolved Issue[☆]



La codificación de diagnósticos dermatológicos. Una cuestión aún por resolver

Information is essential in all fields, including medicine. In research, epidemiology, prevention, and health care management, the information we work with must be correctly classified.

In particular, information on diagnoses must be recorded and classified uniformly and accurately to ensure common practice among all health professionals over time. Because the number of known diseases is so enormous—and constantly increasing, thanks to medical advances in technology and research—this is not as simple as it may seem at first glance.

The International Classification of Diseases (ICD), in its various versions, is the most widely used system for diagnostic coding. The 10th and current revision of the ICD (ICD-10) has recently been criticized for not including certain diagnoses. In dermatology, an ICD adaptation developed in Spanish years ago attempted to solve this problem.¹ Given this background, it is necessary to analyze the inaccuracies and coding-related difficulties associated with the dermatologic diagnoses included in the ICD-10, with a view to achieving a better classification in the ICD-11.

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In this study, carried out in the context of outpatient dermatology care in Spain, the authors conducted an agile and well-designed analysis of the causes of these difficulties and identified those which arise from deficiencies in the ICD-10 that may or may not have been rectified in the draft version of the ICD-11.² The authors concluded that the ICD-10 and the ICD-11 draft are both valid but not free of deficiencies, especially with regard to the inclusion of diagnoses discovered or developed in recent years. Nevertheless, the ICD-11 draft does include some improvements that were identified in this study.

In conclusion, this study underscores the need for constant vigilance and ongoing improvement in disease classification, particularly in dermatology.

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Local Experience with Vismodegib[☆]



Vismodegib, una experiencia local

Vismodegib is the first medication to be approved by the United States Food and Drug Administration and the European Medicines Agency for the treatment of locally advanced basal cell carcinoma in patients who are not candidates for surgery or radiotherapy and for the treatment of metastatic basal cell carcinoma. Therefore, this Hedgehog pathway inhibitor has generated high hopes among oncologists and dermatologists, since no alternative treatment is available for these patients, whose condition is difficult to manage and for whom no standard therapeutic approach has been established.

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Initial enthusiasm has been tempered by the emergence of resistance, adverse effects that are sometimes poorly tolerated, possible liver toxicity, and a questionable increased risk of developing squamous cell carcinoma. However, experience with vismodegib as a neoadjuvant approach before surgery is growing. Similarly, we now know more about pulse dosing to diminish adverse effects and combination with other Hedgehog pathway inhibitors to increase effectiveness. Knowledge of the response to this drug in the patients we treat, therefore, is now particularly valuable; hence, the importance of the publication by Bernia et al.¹ in this issue of *ACTAS DERMOSIFILIOGRÁFICAS*.

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An Algorithm to Guide the Rational, Evidence-Based Use of Omalizumab in the Treatment of Chronic Urticaria[☆]



Aproximación a un uso racional y reglado de omalizumab en la urticaria crónica

Omalizumab is a monoclonal anti-IgE antibody currently used in the treatment of chronic spontaneous urticaria (CSU) as a third-line option in cases refractory to treatment with the licensed dose of the first-line treatment or up to 4 times that dose. The introduction of omalizumab into the therapeutic arsenal for CSU brought about a real revolution in the management of this condition. However, the dose recommended in the Summary of Product Characteristics—based on the results of pivotal studies carried out as part of the approval process—is 300 mg/mo for a period of up to 6 months. In the present issue, the Catalan-Balearic working group presents a treatment algorithm to guide the use of omalizumab in the management of CSU. They discuss the various aspects of management related to the rational and evidence-based use of this drug, including candidate population, monitoring tools (Urticaria Activity Score 7 [UAS7] and Urticarial Control Test [UCT]), starting dose and dose adjustment as well as the definition of response and response time.¹

In a novel approach, the authors of the algorithm propose the use of an increased dose of 450 or 600 mg every 4 weeks if the licensed doses do not achieve adequate control of

disease activity—defined as a UAS7 of 6 or less. A study by the Catalan workgroup showed that 21% of patients require the increased dose to achieve a UAS7 of 6 or less and that 7% did not achieve disease control even with the higher dose. The predictors of partial response to 300 mg and the need for higher doses included prior treatment with ciclosporin, obesity, and age under 57 years.²

This algorithm is of particular interest to dermatologists working in clinical practice.

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