

normal development of the skin” and should not be treated within the state system. We do not believe that they should not be treated by the dermatologist so that they can be passed on to the primary care physician. What we do believe is that, in the state system, no-one should treat them, but that outside the state system, clearly the best person to treat them is a dermatologist.

A decision of this type means that there may always be a sector of the population whose poorer financial situation will discriminate against them in the sense that they cannot afford treatment for minor, yet unsightly, skin lesions. This altruistic argument could lead some dermatologists to try to please everyone so as not to create social injustice. It could also lead them to feel that the solution is not to cut health care provision but to provide it with more resources. It is true that we need much more staff and technical support, but for other ends. If a health care professional wishes to practice dermatologic charity with minor aesthetic lesions, then this must be done outside the state system, and not at its expense.

Following this line of action requires a change in culture, both among the general public and among primary care physicians, dermatologists, and the

managers of health care institutions. The investment is long-term, a long-distance race involving continuous information for patients and primary care physicians, a great deal of patience from dermatologists, and, of course, teamwork.

Some months after our deliberate change of approach, we are starting to observe that, since primary care physicians are regulating the patients they refer to us, patients are beginning to understand our position, and we have been able to reduce outpatient waiting lists and the number of patients per session to the extent that we are a little closer to the desired number—still a long way off—that will enable us to provide better quality health care.

Joint decision making by all health care professionals and the support of our institutions, such as the Spanish Society for Dermatology and Venereology and media such as this journal provide an exchange of viewpoints that will enable us to define the profile we want for our specialty.

We believe that this approach does not interfere with patients’ rights, nor with the ethical principles set out in the Law on Health Care,⁵ and we fully support the proposal of J. M. Carrascosa that dermatologists in the public health system should not treat minor and

benign skin lesions. Instead, we should direct our efforts towards developing other, more necessary, important, and complex areas of our specialty.

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Reply to: “Treatment of Minor and Benign Skin Lesions in the Spanish Public Health System: Experience in Health Area 19 of the Autonomous Community of Valencia”

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To the Editor

I thank Dr Betloch for her comments on my article.¹ These lead

me to believe that the conditions, circumstances, and conviction that led me to write it are echoed throughout

the Spanish public health system. From an absolutely legitimate and law-abiding standpoint, the approach adopted by

dermatologists from health area 19 in Alicante initially generated a crisis that even involved the media. This reflects how dermatologists often underestimate the repercussions of their actions in society. Although the angry response of some patients can be considered legitimate—and perhaps encouraged by the populist and unclear messages from some political corners—I am surprised by such an out-of-date attitude from primary health care physicians, as one might expect a more understanding response from a group of professionals who are usually the first to feel the effect of the vicissitudes of the health system. Although the full extent and the definitive consequences of these actions are not yet supported by figures, which in themselves could provide us with an excellent argument for future lobbying, it seems that the perseverance of Dr Betlloch's team has, at no extra cost, vindicated the dermatologists. Thus, in a reasonably short period, we have seen an improvement in the main warhorse of the public health system—a reduction in the dreaded waiting lists. This in turn has made it possible to restructure appointment systems, not so that dermatologists can work less, rather so

that they can work more comfortably and provide better care and guarantees of quality for the patient. This second important target is always deferred due to the difficulty in achieving the first one.

Dr Betlloch says that “patients are beginning to understand our position.” This is not a trivial point, given that the “change in culture” promoted by the author cannot and must not be made for the patient, but rather with the patient. This approach is completely consistent with the current concept of alliance between physician and patient in clinical decision making, once we have overcome the commercial or consumer model that was prevalent during the 1990s, the results of whose maxim “the customer is always right” we know only too well.²

Given that the resources of the public health system are and will always be limited—despite the fact that this does not always appear to be the case—it is of the utmost importance to optimize them so as to fulfill the principal objective of this system, that is, to offer individuals with skin complaints quality health care within a reasonable timeframe.

Something to think about: If Dr Betlloch's impression is confirmed, the last link in the chain, that of health care provision, might successfully implement—the latest buzzword—the objectives to which the public health system allocates many costly mechanisms, players, and resources and which it fails to achieve time and time again, namely, to reduce the waiting list and create a more appropriate distribution of the time dedicated to patient care. This is yet another demonstration of the enormous potential—often underestimated—of dermatologists to make an impact. Common sense tells us that, if we can improve our work situation, then this can only be to the advantage of our patients.

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Intermediate-Grade Myxofibrosarcoma Mimicking a Blistering Disease

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To the Editor

Malignant fibrous histiocytoma is one of the most common sarcomas of soft tissue in old age^{1,2} and groups together a series of histologic variants—pleomorphic (60%), myxoid (25%), angiomatoid, giant-cell, and inflammatory.¹⁻³ Some authors consider myxofibrosarcoma to be a myxoid variant of malignant fibrous histiocytoma,⁴ whereas others maintain that it is an independent entity.⁵

Malignant fibrous histiocytoma typically manifests as a soft and painless nodular mass in the subcutaneous tissue of the lower limbs (80%)² in elderly patients. Other clinical variants have been reported, such as diffuse infiltration, multiple nodules, or papules,² and even 1 case that mimicked papulous mucinosis.⁶ The tumor originates in the subcutaneous tissue, and often extends to deeper layers (90%)³; extension to

upper layers (dermis) is uncommon, with fewer than 10 cases reported in the literature.^{2,3,6} A series of histologic grades has been reported,⁷ and variants with a sparse myxoid matrix and greater cellularity, pleomorphism, and number of mitoses have been considered high-grade. Lower-grade variants generally have an abundant myxoid matrix in the superficial layers,³ and this necessitates deep incisional biopsies to reach layers