LETTERS

Letters to the Editor

Vesiculobullous disease

To the Editor:

In the journal's Photo Rounds, Drs Sauret, Yale, and Ahiarah present a case of vesiculobullous disease ("Rupturing bullae not responding to antibiotics," *J Fam Pract* 2004; 53[12]:981–983). We would like to offer additional comment we believe pertinent to family physicians.

In obtaining a biopsy in patients with vesiculobullous eruptions, there are several important factors to be considered compared with most other dermatoses.[1] First, biopsy specimens for immunofluorescence examinations cannot be submitted in the usual specimen preservatives. Instead, they need to be submitted in special transport media for immunofluorescence (typically Michel's medium) or as "fresh" specimens. For the latter, the physician uses a sterile container lined with saline-moistened gauze, into which the biopsy specimen is sealed and then transported to the pathologist "stat" or frozen until picked up. Perilesional skin is best for direct immunofluorescence testing of bullous diseases. Second, an additional specimen should be sent for routine histology. This can be accomplished either by doing two biopsies or by sectioning 1 sufficiently large specimen. Third, lesional skin is required for pathologic evaluation. However, with vesiculobullous eruptions, including perilesional skin allows a point of adherence for the roof of the lesion to the remainder of the lesion. The fourth difference is that a sample of the patient's serum is required for indirect immunofluorescence. Last, because of these logistics, it may be helpful to communicate with the dermatopathologist when biopsying lesions where immunofluorescence studies are considered. Although similar to lesion sampling in other dermopathies, but of critical importance in vesiculobullous disease, choice of lesions for sampling is important. The ideal lesions are fresh (less than 24–48 hours old), intact, and nonexcoriated vesiculobullae, with normal or erythematous perilesional skin for inclusion in the biopsy field.

In teaching residents about vesiculobullous disease, our simplified approach is to state that all primary care physicians should be facile with 3 categories. The first is infections—both viral, such as herpes simplex, varicella-zoster, and Enteroviral (including Coxsackie) infections—and bacterial, including bullous impetigo and staphylococcal scalded skin syndrome. The second category is acute eczematous tissue reactions including allergic contact dermatitis. The third is exogenous trauma, such as thermal burns, bug bites, and friction-induced lesions. The fourth category includes the less common inflammatory bullous diseases and may be within the purview of interested primary care physicians but is always fair game for referral—sometimes urgently. A partial list includes pemphigus, bullous pemphigoid, porphyria cutanea tarda, epidermolysis bullosa, erythema multiforme, drug eruptions, dermatitis herpetiformis and toxic epidermal necrolysis. Division into these categories may be helpful in delineating further workup, including culture and biopsy for pathology and immunofluorescence.

Gary N. Fox, MD
Medical College of Ohio;
Mercy Health Partners Family Practice Residency, Toledo

Gregory L. Swartz, DO
Ohio University;
Mercy Health Partners Family Practice Residency, Toledo

Darius R. Mehregan
Wayne State University, Detroit MI, and
Clinical Associate Professor of Pathology, Medical College of Ohio, Toledo

FAST TRACK

Primary care physicians should be facile with 3 categories when diagnosing vesiculobullous disease

REFERENCE

1. Vesicular and bullous diseases (Chapter 16). In: Habif TP. *Clinical Dermatology: A Color Guide to Diagnosis and Therapy.* 4th ed. New York, NY: Mosby, Inc; 2004:547–554.

Tramadol addiction

To the editor:

The only thing missing from the well-intentioned tramadol piece in *JFP* (McDiarmid T, Mackler L, Schneider DM, "Clinical inquiries. What is the addiction risk associated with tramadol?" *J Fam Pract* 2005; 54[1]:72–73) was a little common sense. The low numbers they quoted on tramadol addiction and detoxification seem paltry in comparison with illicit opiates (such as heroin) and diverted opiates (such as OxyContin), but the numbers can be deceptive—reporting agencies rarely know what's going on in the real world. In the treatment arena we see staggering amounts of Ultracet and tramadol addiction, with patients popping up to 30 or 40 pills daily to fill an ever-expanding mu-receptor void. Many of these fall into the addiction innocently because, and I quote, "My doctor told me that these were safe!" Far from it. The tramadol mu activity is considerable in the opiate-naïve patient, and even more so in the recovering opiate addict. The phenomenon of "reinstatement," where any activity at the receptor level triggers old drug-seeking behavior, is well documented, and should be avoided at all costs, especially given the broad nonopiate choices available to our patients in need, including the highly effective neural modulators (such as Neurontin, Depakote, and Trazodone) and NSAID/COX-2 families. While any primary doc can step into the waters of addiction medicine, some formal training may help avoid potential disasters.

If a patient merits relief from pain that is not handled by current nonsteroidal and adjunctive modality therapy (lets not forget TENS units, massage therapy, and acupuncture), then certainly consider tramadol—but let's also consider the risks and warn the patient accordingly. Monitor their usage periodically, and don't give refills unless the patient is traveling out of the area. And finally, if your patient is one of the millions of opiate addicts seeking relief from bone-fide pain, do him and yourself a favor—don't use an opiate unless absolutely necessary, having exhausted all other measures. The risk of relapse is too great. Lest we forget, "Above all, do no harm."

Stephen Patt, MD,
Family Practice, Santa Monica, Calif

Dr McDiarmid responds:

I regret that Dr Patt did not appreciate the emphasis I hoped to convey of the limitations on validity and generalizability of the manufacturer-sponsored surveillance program's estimated rates of tramadol abuse in a tramadol-exposed population. The limitations mentioned in the Clinical inquiry included nonrandom and nonrepresentative sampling methods, tramadol abuse likely suppressed by presence of more potent euphoriant in the studied addiction communities, and the low return rates of surveys from substance abuse experts. Each of these biases could significantly alter any attempts at estimating tramadol abuse rates in the general tramadol-exposed populations.

I appreciate Dr Patt sharing his experience with patients who abuse large quantities of tramadol. There are case reports in the literature describing similar patient behaviors. I would encourage him to report such case experiences to the FDA's MedWatch program so that what is a personal clinical experience can contribute to the evidence of out collective knowledge.

Todd McDiarmid, MD,
Moses Cone Health System, Department of Family Medicine, University of North Carolina School of Medicine, Greensboro

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