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A career jump-start courtesy of the College

I am pleased and honoured to receive a Janus Scholarship and certainly thank the College of Family Physicians of Canada for this support.

I must admit that, after I had submitted my application for the scholarship, I put the decision about starting my Master's degree on hold. As family and golf competed with work and running over the summer, my enthusiasm for this new challenge was wavering. My wife has 1 year left on her second degree, and I thought that one adult university student per family was enough!

When I received your letter notifying me of the award, I was surprised to be successful. More gratifying, however, was the fact that I immediately became enthusiastic about the Master's degree. My application to the Master's program is accepted, and I am registered for my first course. This is not the first time that the College has jump-started a new direction in my career!

—*Preston Smith,* MD, CCFP, FCFP
Moncton, NB
by e-mail

Must have been a spider

I am the physician camping in Algonquin Park who had the necrotizing skin lesion that you refer to in the introduction of your article on spider bites.[1] True, I did not see a spider bite me. Your list of differential diagnoses is complete, but none applied to my situation. The lesion appeared as I slept but took only 2 hours to reach maximal diameter and 6 hours to reach maximal necrosis depth, at which time the bulla burst, and I could see the depth of tissue loss. It did not worsen after that hyperacute onset; abrupt

cessation of progression rules out bacterial, fungal, or viral infections. There was only one huge bullous lesion on my arm—not typical of poison ivy or other contact reactions. It was clearly not a burn; I would have known if it were.

There was no surrounding redness. The margins were not undermined. I have no chronic medical conditions. The lesion was on my arm; that rules out pyoderma gangrenosum. The lesion healed with no treatment; that rules out cancer. There was no lymphadenopathy or systemic symptoms or contact with rabbits; that rules out tularemia. Pressure ulcer at the flexor crease of my elbow is not a credible diagnosis, either.

That leaves spider bite as a genuinely credible alternative. You hold too high a standard to prove spider bites as cause of such a lesion. For example, I often do not see mosquitoes bite me. That does not mean that the pruritic boggy papules that frequently appear on my skin in the summer are not mosquito bites. I concede that *Loxosceles reclusus* might not have been the species that bit me. But I still have no doubt that it was a spider of some sort. There may be "myths" about spider bites. But that does not mean that lesions like mine are not due to spiders. It is the only credible diagnosis in this instance.

—John Nelson, MD
Fort Frances, Ont
by e-mail

Reference

1. Bennett RG, Vetter RS. An approach to spider bites. Erroneous attribution of dermonecrotic lesions to brown recluse or hobo spider bites in Canada. *Can Fam Physician* 2004;50:1098-101.

Response

Although we applaud your efforts to diagnose your necrotic skin ulcer, we remain convinced it was not the result of a spider bite. At this point, long after the event, likely the only realistic diagnosis is "idiopathic necrotic lesion."

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The long list (referenced in our article) of necrotic conditions misdiagnosed as spider bites is far from exhaustive. You have ruled out only about a half dozen of the many listed conditions, and you still show no evidence to implicate a spider. Also, you would not be the first person to mistakenly rule out one of the many diagnoses more probable than spider bite. For example, we know of at least one person who unknowingly suffers repeated thermal burns and blames the subsequent lesions on spiders.

Your mosquito bite analogy is faulty. Mosquitoes (and other obligatorily hematophagous arthropods) actively seek out mammals and other vertebrates for the blood meals necessary for their survival. No spider does this. We are sure you have witnessed the actual bites of many individual mosquitoes representing a variety of genera and species. Therefore we are confident in your ability to diagnose certain types of lesions as *likely* resulting from the bite of a mosquito. No one has ever shown a causal relationship, however, between the bite of any Canadian spider and a necrotic lesion. You have no factual basis to blame a spider for your lesion.

In fact, apart from the rare cases of true loxoscelism, "necrotic arachnidism" is a myth. As Geoffrey Isbister states in his article[1]:

> This association [of necrotic ulcers and spiders] remains despite no significant evidence to support the involvement of spiders in necrotic ulcers. The medical community is by no means immune to the myth of necrotic arachnidism and is responsible for its persistence by not questioning the evidence or investigating necrotic ulcers in the same way as any other disorder.

Considering the current desire for evidence-based medicine as well as the medical community's conservative nature and consequent reticence to accept new concepts, techniques, or remedies without proof, it astonishes us that spiders are so commonly and erroneously implicated as causative agents of idiopathic lesions. Apparently we have succeeded in convincing you that "*Loxosceles reclusus might* [our emphasis on "might"] not have been the species that bit" you. We strongly urge you to accept that a *Loxosceles* spider *did not* bite you and that, furthermore, there is no evidence to suspect any spider in your case, or any of the other cases we report. To do otherwise contributes to the perpetuation of a lamentable decades-old medical myth.

—Robert G. Bennett, MSC, PHD
Saanichton, BC
—Richard S. Vetter
Riverside, Calif
by e-mail

Reference

1. Isbister GK. Necrotic arachnidism: the mythology of a modern plague. *Lancet* 2004;364:549-53.

Good intentions, poor study design

Your article[1] "Caveat emptor. 'Probiotics' might not be what they seem" by Dr Brenda Huff caught our attention. As scientists working with the probiotic industry to improve standards and promote evidence-based efficacy substantiation, we can appreciate Dr Huff's motivation for doing this project, especially because third-party verification of probiotic compliance with label claims is not available to consumers or health care professionals. We fully support recommendations for probiotic products to live up to label claims as per the recent FAO/WHO guidelines (see **http://www.who.int/foodsafety/fs_management/en/probiotic_guidelines.pdf**). Indeed, there are likely commercial probiotic products that do not comply with their label claims.

A proper intention does not, however, justify poor study design and use of improper media and poorly described methods. The choice of media for detection and enumeration are inconsistent with those optimal for detecting probiotic lactobacilli. The lack of clarity in defining abbreviations left us to make some assumptions (did BAP stand for bacterial alkaline phosphatase as stated or more common