Under My Skin

If It's Wet, Dry It

Nondermatologists like to mock, "Hey, we know what you guys do: If it's wet, dry it, and if it's dry, wet it."

Most of the students who follow me around are headed for primary care. When I meet a new one, I'm tempted to say, "The goal of this elective is to make sure that, by the time you leave, you won't say, 'If it's eczema, I'll treat it as a fungus, and if it's a fungus, I'll treat it with a steroid.' "

BY ALAN ROCKOFF, M.D.

That would be snide and condescending, though, so I stifle the impulse. But then comes a new student, Darlene, and a day like last Thursday. …

Case 1

"Doc, I have this rash between my butt cheeks, and the cream I'm using doesn't help at all."

"Which cream is that?"

"Clotrimazole."

"See the pinkness spanning the cleft?" I show Darlene. "That's inverse psoriasis, so clotrimazole won't work. He needs a steroid."

Case 2

"It's been a week, Fred. How are you?"

"My butt feels much better, Doc. The itch was maddening."

His gluteal cleft looks all clear. A couple of weeks of nystatin-triamcinolone had left him with a nice rim of satellite pustules and a lot of itch. Econazole did the trick.

"He had a yeast infection," I say. "The triamcinolone trumped the nystatin. A straight antiyeast cream is what he needed."

"Isn't that the opposite of the other patient?" Darlene asks.

The kids are so smart these days.

Case 3

"How long has Vince had this scaling on his soles?"

"He's 10, so I guess it's about 6 years."

"And what has his pediatrician recommended?"

"An antifungal cream. It sort of works. After 2 weeks of using it, the scaling is a little better."

"Let's try a different approach. Foot rashes on prepubertal kids are usually eczematous rather than fungal," I explain.

"Why didn't the pediatrician change the prescription?" Darlene asks.

"Probably because the patient didn't complain. The fungus cream is a cream, after all, so it smoothed things down a bit."

"But for 6 years?"

Case 4

Ricardo has a patch of psoriasis peeking out from his right frontal scalp. Nice pink, micaceous scale. Clearly defined outline. Treatment hasn't been working.

"What did you use?"

"My doctor gave me a cream and some pills. I wrote it down—griseofulvin. I took it for a month, but it didn't help."

"Tinea affects the scalp mostly in kids," I tell Darlene, "and Ricardo is 23. Also, tinea causes hair loss, which he doesn't have."

"If it's inflammatory, treat it as a fungus," she says with a sly smile, "and if it's a fungus … "

"You said it," I tell her, "but I thought it."

The Internet Post

Thursday was unusual, but such stories are not. Here's a typical Internet post:

I saw a doctor a couple times because a small lesion appeared near my urethra last September. It's small and doesn't bother me much, but it weeps a clear fluid. It also came along with dry skin/redness on my scrotum, which bothers me occasionally. The doctor told me it was nothing to worry about and it was just a fungus.

What fungus would that be, exactly?

Differentiating an inflammatory dermatosis from a fungus or yeast can be tricky: Scrapings are sometimes unreliable, cultures delayed and overgrown with contaminants.

I confess to my share of "whoops" moments when the sight of spreading, polycyclic lesions on the ankles or neck showed that a topical steroid might not have been such a good idea after all. When it comes to papulosquamous rashes, there are just two basic choices—fungus or not fungus—and two outcomes—better and not better. This isn't rocket science.

Yet, year in and year out, people troop in to show me nummular eczema that their doctors, some even older than I am, have been treating with endless applications of Lamisil (terbinafine) or clotrimazole. The monotony of such cases is relieved only by the occasional unfortunate with *Candida* or tinea who's never been taken off the triamcinolone or steroid-antifungal combination that's clearly making things worse.

There's a big push these days to rate (and pay) physicians based on their efficient use of evidence-based therapies with reliable outcomes. Here, I suggest, is a good place to start: Train doctors while they're still in school that, wet or dry, if it's a fungus, treat it as one, and if it isn't, don't. ■

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Guest Editorial

'Behind-the-Counter' Prescribing Is Problematic

Americans are desperate for ways to reduce the costs of health care and improve access to care. At the same time, physicians are frustrated with the status quo. After a 30-year campaign by the media to disparage physicians with negative stories about them; reductions in reimbursement by public and private payers alike; and the intrusion of managed care and increases in costs, paperwork, and overhead, many physicians literally are going out of business and shutting their offices.

BY HELENA W. RODBARD, M.D.

In addition to these pressures, American medicine once again faces the recurring challenge of "behind-the-counter" (BTC) "prescribing" by pharmacists. In recent hearings, the Food and Drug Administration sampled viewpoints on the advantages and limitations of the creation of a new class of BTC medications.

I first became involved in this issue 3 years ago, when I was privileged to represent the American Association of Clinical Endocrinologists at the National Lipid Association's "Town Hall Discussion" regarding the proposition that statins should be available as a BTC class of medications. At that time, the FDA decided that statins should not be made available BTC.

Should pharmacists be empowered to dispense a variety of drugs, ranging from birth control pills, statins, medications for migraine, and perhaps medications for erectile dysfunction? The idea has the support of several pharmacy groups, including the National Association of Chain Drug Stores, the National Community Pharmacists Association, and the American Pharmacists Association.

But before the American public, Congress, and the FDA embrace this as-yet-untested notion, there are several questions that need to be considered:

► What training would pharmacists receive in order to dispense these medications? What percentage of pharmacists has the time, inclination, clinical skills, and clinical judgment to take on a new role such as this?

► Would dispensing medication be tantamount to having pharmacists practice medicine without a license? Would pharmacists charge for this service?

► Would pharmacists have the necessary information readily available to permit intelligent, rational, and safe choices of medications? For instance, would they have access to a medical record? Would they have the ability to perform a physical exam?

► Would pharmacists have full and accurate knowledge of the various medications that the patient is taking? Would they have access to laboratory data that so frequently govern the selection and dosage of medications?

► Would they be able to put everything into perspective in terms of the overall risks and benefits to the patient? Would these medications be provided with a set plan or protocol, for example, for follow-up laboratory studies to monitor possible side effects?

► Would the pharmacist create a medical record to indicate what medications were "prescribed," sold, and dispensed, together with a rationale, impression, and plan for follow-up? Would there be a record of the patient education that was provided at the time the medication was prescribed—or rather—provided?

In addition to these practical questions about the BTC process itself, larger questions arise. For instance, would this be a safe and effective method for delivery of health care? Would it be cost effective? What about unintended consequences—for example, would this new route to obtaining medical care result in patients bypassing their physicians and thereby losing continuity of care? What about legal liability or malpractice implications for the pharmacist and the pharmacy? And finally, would this represent a conflict of interest for pharmacists?

In my view, there are too many potential problems with this type of health care. The BTC approach represents a cheapening of American medicine. Progressively, we find that all "health care providers" are being treated as coequals. Physicians have allowed themselves to be called "providers" for too long.

At the hearing, this topic found some consensus among two unlikely bedfellows—Joseph W. Cranston, Ph.D., the American Medical Association's director of science, research, and technology; and Public Citizen's Sidney Wolfe, both of whom opposed the proposal to create a BTC class of drugs.

Dr. Wolfe cited a GAO study of pharmacists counseling patients in Florida and in foreign countries. That study showed that counseling by pharmacists was infrequent, incomplete, did not increase access to appropriate medications, and did not reduce costs. The BTC approach represents yet another challenge to the quality of health care in America. ■

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