

Letters to the Editor

The Presence of Bull's Eye Lesion Is Not Required to Diagnose Lyme Disease

Original Article: Clinical Diagnosis of Lyme Disease Frequently Misses the "Bull's Eye" [POEMs]

Issue Date: April 1, 2018

Available online at: <https://www.aafp.org/afp/2018/0401/p474.html>

To the Editor: The title of this POEM¹ may be misleading about the study and the synopsis appearing in *American Family Physician*. Specifically, the title suggests that diagnosing Lyme disease requires the bull's eye form of the erythema migrans rash. This suggestion is repeated in the Bottom Line section, which reads, "For children with suspected Lyme disease but without a classic bull's eye lesion (erythema migrans of at least 5 cm), check serology rather than rely on your clinical impression."

In fact, the research study used the Centers for Disease Control and Prevention's (CDC's) definition of erythema migrans, which does not require a bull's eye lesion. Instead, the key portion of the CDC definition of erythema migrans is "a skin lesion that typically begins as a red macule or papule and expands over a period of days to weeks to form a large round lesion, often with partial central clearing. A single primary lesion must reach greater than or equal to 5 cm in size across its largest diameter."² Further, only 4% of the patients in the study had erythema migrans lesions that met the CDC definition.¹

Central clearing is not needed to make the diagnosis of Lyme disease. It is often faint in appearance or not present, or it may not appear until the lesion grows larger or until more days have elapsed. A 1996 study found that only 37% of patients with Lyme disease had central clearing,³ and another article demonstrating variations on erythema migrans suggests that central clearing at the time of erythema migrans presentation occurs a minority of the time.⁴

Marjorie Bowman, MD, MPA

Kettering, Ohio

E-mail: marjorie.bowman@wright.edu

Author disclosure: No relevant financial affiliations.

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This series is coordinated by Kenny Lin, MD, MPH, Deputy Editor.

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Editor's Note: This letter was sent to the authors of Clinical Diagnosis of Lyme Disease Frequently Misses the "Bull's Eye," who declined to reply.

Genetic Factors Should Be Considered When Caring for Colorectal Cancer Survivors

Original Article: Care of the Colorectal Cancer Survivor

Issue Date: March 1, 2018

See additional reader comments at: <https://www.aafp.org/afp/2018/0301/p331.html>

To the Editor: This article is well written and covers an important topic. Indeed, as cancer care continually improves, the ongoing needs of cancer survivors are poised to become a very important facet of primary care. However, the article omits a critical aspect of the topic: consideration of the role of genetic variation in the care of the cancer survivor.

Genetic variation in somatic (tumor) tissue alters the prognosis and treatment for a wide variety of cancers. This variation has important consequences for tumor recurrence surveillance, as well as the spectrum of short- and long-term adverse effects a survivor is likely to experience. Examples include changes in therapeutic approaches for chronic myelogenous leukemia with tyrosine kinase inhibitors, as well as use of gene expression platforms such as Oncotype DX and MammaPrint, which guide decisions about adjunctive (and often toxic) therapies for breast cancer. In colorectal cancer, testing patients for *KRAS* mutations may affect the choice of chemotherapy approaches and, likely, downstream recurrence risks and adverse effects.¹

The authors' statement that "colorectal cancer survivors should be screened [for secondary cancers] according to the same guidelines used for screening in average-risk persons" seems problematic without added qualifications. The

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Centers for Disease Control and Prevention estimates that as many as one in 20 colorectal cancers results from an underlying hereditary predisposition due to a mutation in key pathways related to oncogenesis. If a cancer survivor has a hereditary cancer syndrome, recommendations for screening for secondary cancers differ from those for the general population.²

W. Gregory Feero, MD, PhD

Augusta, Me.

E-mail: w.gregory.feero@mainegeneral.org

Author disclosure: No relevant financial affiliations.

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In Reply: Thank you, Dr. Feero, for your thoughtful comments. Much of what you point out was simply beyond the scope of our article. For example, genetic tumor variations and chemotherapy choices fall more into the category of colorectal cancer treatment rather than guideline-based follow-up. I did not find current consensus guidelines that recommend altering follow-up schedules based on genetic tumor variation. This highlights the importance of the survivorship care plan, in which subspecialists can detail individualized follow-up schedules that may fall outside the usual guidelines for patients at average risk.

To clarify—and to avoid misunderstandings for clinicians caring for these patients—our article and the guidelines it summarized did not apply to patients with known hereditary cancer syndromes, including Lynch syndrome and familial adenomatous polyposis.

Kristina Burgers, MD, FAAFP

Fort Bragg, N.C.

E-mail: kristina.g.burgers.mil@mail.mil

Author disclosure: No relevant financial affiliations.

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