Letters to the Editor

Send letters to Kenneth W. Lin, MD, MPH, Associate Deputy Editor for *AFP* Online, e-mail: afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680.

Please include your complete address, e-mail address, and telephone number. Letters should be fewer than 400 words and limited to six references, one table or figure, and three authors.

Letters submitted for publication in *AFP* must not be submitted to any other publication. Possible conflicts of interest must be disclosed at time of submission. Submission of a letter will be construed as granting the American Academy of Family Physicians permission to publish the letter in any of its publications in any form. The editors may edit letters to meet style and space requirements.

Identifying Erythema Migrans Rash in Patients with Lyme Disease

Original Article: Arthropod Bites

Issue Date: December 15, 2013

Available at: http://www.aafp.org/afp/2013/1215/p841.html

TO THE EDITOR: This article is comprehensive and well written, but it contains a potentially misleading image and description of the characteristic bull's-eye rash of Lyme disease.

Immediately following tick removal, patients often develop an erythematous inflammatory papule as a localized reaction to the bite. It is often misidentified by patients as indicative of Lyme infection, which may take five to 10 days or longer to develop and only after the tick has been attached for two to three days. However, other tick-borne agents (e.g., *Babesia*, *Anaplasma*, Powassan virus, deer tick virus) may be transmitted within the first hour of feeding.

Our medical practice diagnoses close to 100 cases of Lyme disease annually. The typical erythema migrans rash of Lyme disease is almost always a solid, blanching, erythematous patch, rather than the bull's-eye appearance. In some instances, *Borrelia* may produce a necrotic lesion similar to the eschar described in rickettsial infections (e.g., African tick fever). Unfortunately, we have treated many patients with Lyme disease who delayed seeking treatment because their rash was not the classic bull's-eye presentation.

KENNETH DARDICK, MD
Storrs, Conn.
E-mail: kdardick@gmail.com

Author disclosure: No relevant financial affiliations.

IN REPLY: I agree that the classic bull's-eye rash of Lyme disease is not always seen and that, when present, erythema migrans (also called erythema chronicum migrans) may initially appear as a red annular patch before the characteristic rings develop. The rash often evolves and expands over several weeks. Although it is common for patients to mistake the transient inflammatory papules from recent tick bites for erythema migrans, the lesions differ in size, appearance, and duration.

Erythema migrans—with or without the bull's-eye pattern—remains the classic presenting rash for Lyme disease, but only the bull's-eye pattern is pathognomonic. The red patches of developing erythema migrans that Dr. Dardick has observed in patients with early Lyme disease are less diagnostic because they may resemble other common skin conditions, such as contact dermatitis. However, Lyme disease should still be considered in these cases, even when initial test results are negative. Retesting the patient later will often yield a positive result. When followed over time, many of these lesions eventually develop the classic bull's-eye pattern before fading. In the South, the rash of southern tick-associated rash illness closely mimics the erythema migrans rash of Lyme disease, but both conditions respond to doxycycline.

I concur that clinicians need to suspect Lyme disease in high-incidence areas, even when the classic erythema migrans rash is absent or only developing.

GREGORY JUCKETT, MD, MPH
Morgantown, W. Va.
E-mail: gjuckett@hsc.wvu.edu

Author disclosure: No relevant financial affiliations.

Correction

Error in drug class. The article "Identifying and Managing Posttraumatic Stress Disorder" (December 15, 2013, p. 827) contained an error in Table 3 (p. 832). Of the four drugs listed under the header "alpha-adrenergic blockers," only prazosin (Minipress) is an alpha-adrenergic blocker. The header should have been "antiadrenergic agents" instead. The online version of this article has been corrected. ■