Torrey A. Laack, MD
Latha G. Stead, MD
Martin E. Wolfe, MD

From the Department of Emergency Medicine, Mayo Clinic, Rochester, MN.

0196-0644/$-see front matter

doi:10.1016/j.annemergmed.2007.02.021

Figure 1. Spider

Figure 2. Site of bite. Used with permission of Martin E. Wolfe, MD, Department of Emergency Medicine, Mayo Clinic, Rochester, MN.

[Ann Emerg Med. 2007;50:368.]

A 46-year-old man was working in a warehouse in southern Minnesota which receives shipments from the south-central United States. He felt something crawling under his shirt, followed by a sharp pain in his left upper back. He captured the spider pictured (Figure 1). Several hours later, he presented to the emergency department with a painful erythematous lesion with central raised ecchymosis (Figure 2) at the site of the bite. He was treated conservatively. On follow-up with his family physician at 1 week, the wound was unchanged, and a 10-day course of cephalexin was initiated. The wound resolved in approximately 3 weeks.

For the diagnosis and teaching points, see page 370.
To view the entire collection of Images in Emergency Medicine, visit www.annemergmed.com

the federal government (Department of Health and Human Services and National Highway Traffic Safety Administration) fund the development of medication dosage guidelines, formulations, labeling, and administration techniques for the emergency care setting to maximize effectiveness and safety for children.

Perhaps it is time to convene a national consensus meeting of experts in the pediatric emergency care medication process to establish some standard guidelines necessary for further research in this critically important area. The establishment of recommended dosing ranges for medications used in the pediatric emergency setting and a standard approach to measuring pediatric medication errors would allow us to more accurately identify and quantify errors and, more important, to define better strategies to prevent harm to children from medications used in emergency care.

Supervising editor: Kathy N. Shaw, MD, MSCE

Earn CME credit: Continuing Medical Education for this article is available at www.acep.org/AnnalsCME.

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article, that may create any potential conflict of interest. The author has stated that no such relationships exist. See the Manuscript Submission Agreement in this issue for examples of specific conflicts covered by this statement.

Publication date: Available online April 27, 2007.

Address for reprints: Karen S. Frush, MD, Duke University Health System, Duke University School of Medicine, Durham, NC, 27710; 919-681-2246, fax 919-681-7402; E-mail frush002@mc.duke.edu.

REFERENCES

1. Institute of Medicine Committee on Identifying and Preventing Medication Errors. *Preventing Medication Errors: Quality Chasm Series*. Washington, DC: National Academies Press; 2006.
2. Marcin JP, Dharmar M, Cho M, et al. Medication errors among acutely ill and injured children treated in rural emergency departments. *Ann Emerg Med*. 2007;50:361-367.
3. Institute of Medicine Committee on the Future of Emergency Care in the United States Health System. *Emergency Care for Children: Growing Pains*. Washington, DC: National Academies Press; 2006.

IMAGES IN EMERGENCY MEDICINE

(continued from p. 368)

DIAGNOSIS:

Loxosceles reclusa bite. Loxosceles reclusa, commonly known as the brown recluse spider, is not native to Minnesota.[1] In this case, it appears to have been inadvertently transported with a shipment from the south-central United States, where it is native. Skin wounds of other causes are commonly misdiagnosed as brown recluse spider bites.[2] This case represents a rare confirmed *Loxosceles reclusa* envenomation outside of the spider's normal geographic range. These bites may result in necrotic cellulitis, with the treatment primarily supportive. Specific treatments are commonly used, but strong clinical evidence is lacking and significant adverse sequelae may result from these unproven therapies.[1]

REFERENCES

1. Swanson DL, Vetter RS. Bites of brown recluse spiders and suspected necrotic arachnidism. *N Engl J Med.* 2005;352: 700-707.
2. Vetter RS, Bush SP. The diagnosis of brown recluse spider bite is overused for dermonecrotic wounds of uncertain etiology. *Ann Emerg Med.* 2002;39:544-546.