

Derek M. Sorensen, MD
Wesley Eilbert, MD

From the University of Illinois at Chicago Emergency Medicine Residency Program, University of Illinois College of Medicine, Chicago, IL.

0196-0644/\$-see front matter
Copyright © 2009 by the American College of Emergency Physicians.
doi:10.1016/j.annemergmed.2009.06.016



Figure. Ecchymotic leg lesion. Used with permission of Derek M. Sorensen, MD, University of Illinois at Chicago Emergency Medicine Residency Program, University of Illinois College of Medicine, Chicago, IL.

[Ann Emerg Med. 2010;55:302.]

A 53-year-old man presented with a painful skin lesion on his left lower leg, without trauma. The lesion was initially pruritic and had appeared spontaneously 2 weeks earlier. The patient had been evaluated 1 week earlier and was prescribed clindamycin for presumed cellulitis. Despite this, the lesion continued to grow. The patient had a history of peripheral vascular disease and had resumed receiving warfarin sodium for this 1 week before appearance of the lesion. On physical examination, the patient was afebrile, with a 5-cm- \times -7-cm nonraised area of ecchymosis with an erythematous border on the anterior left lower leg (**Figure**).

*For the diagnosis and teaching points, see page 305.
To view the entire collection of Images in Emergency Medicine, visit www.annemergmed.com*

ment in this issue for examples of specific conflicts covered by this statement.

1. Millard WB. For whom the Bell Commission tolls: unintended effects of limiting residents' hours. *Ann Emerg Med.* 2009;54:25A-29A.
2. Landrigan CP, Rothschild JM, Cronin JW, et al. Effect of reducing interns' work hours on serious medical errors in intensive care units. *New Engl J Med.* 2004;351:1838-1848.
3. Shetty KD, Bhattacharya J. Changes in hospital mortality associated with residency work-hour regulations. *Ann Int Med.* 2007;147:73-80.
4. Volpp KG, Rosen AK, Rosenbaum PR, et al. Mortality among patients in VA hospitals in the first 2 years following ACGME resident duty hour reform. *JAMA.* 2007;298:984-992.
5. Saxena A, George CF. Sleep and motor performance in on-call internal medicine residents. *Sleep.* 2005;28:1386-1391.

In reply:

While welcoming the commentator's thoughts on the subject and appreciating his close, clear attention to both this article and the surrounding research on work hours limits, I would call attention to a genre distinction. The News & Perspective department, as the editors' introduction has pointed out, treats its topics journalistically rather than academically; it occasionally makes room for views that are frankly somewhat

contrarian; presenting "more perspective than news" is not a lapse but its acknowledged mission. It often places these discussions in the context of peer-reviewed literature (including in this case the IOM report, with its thorough references), but it does not aspire to the comprehensiveness of a full, rigorous literature review. The department serves a different and more informal purpose, presenting the quoted physicians' individual perspectives, not so much "put[ting] aside" the published evidence assembled by the IOM as reflecting on its relation to their clinical experience. I hope that the separate, complementary functions of research and commentary will strike most readers as useful.

William B. Millard, PhD
New York, NY

doi:10.1016/j.annemergmed.2009.11.015

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 might 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.

IMAGES IN EMERGENCY MEDICINE

(continued from p. 302)

DIAGNOSIS:

Warfarin sodium skin necrosis. Necrotic skin lesions develop in 0.01% to 0.1% of patients receiving warfarin sodium, with the majority of cases in women.^{1,2} The lesions most commonly occur on the breast, buttock, or thigh.^{3,4} The majority of cases of warfarin sodium skin necrosis occur within 3 to 6 days of starting therapy, though it may occur after months or even years.⁵

The lesions are typically painful, localized, abrupt in onset, and the result of thrombosis of the underlying microvasculature. The first sign is an evanescent flush, followed by petechial hemorrhages that coalesce into a well-demarcated ecchymosis. Within hours, hemorrhagic bullae may form. Warfarin sodium skin necrosis may be confused with necrotizing fasciitis or purpura fulminans.

Treatment of warfarin sodium skin necrosis is supportive, with wound care, debridement, and occasionally skin grafting.⁵ Warfarin sodium is typically withheld, with the use of heparin as bridging therapy for those patients who require long-term anticoagulation.

REFERENCES

1. Chan YC, Valenti D, Mansfield AO, et al. Warfarin induced skin necrosis. *Br J Surg.* 2000;87:266-272.
2. Gelwix TJ, Beeson MS. Warfarin-induced skin necrosis. *Am J Emerg Med.* 1998;16:541-543.
3. Nalbandian RM, Mader IJ, Barrett JL, et al. Petechiae, ecchymosis, and necrosis of skin induced by coumarin congeners: rare, occasionally lethal complication of anticoagulant therapy. *JAMA.* 1965;192:107-112.
4. Cole MS, Minifee PK, Wolma FJ. Coumarin necrosis: a review of the literature. *Surgery.* 1988;103:271-277.
5. Ward CT, Chavalitanonda N. Atypical warfarin-induced skin necrosis. *Pharmacotherapy.* 2006;26:1175-1179.