Opponents such as the National Community Pharmacists Association of Chain Drug Stores, the National Community Pharmacists Association, and the American Pharmacists Association pointed to having pharmacists practice “off-label” as well.

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. Eczema did the trick. He had a yeast infection.

"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 rash 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

Richardo has a patch of psoriasis peaking out from his right frontal scalp. Nice pink, monomorphic 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—grieseofulvin. 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/rrdness 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 treatment had 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.

Dr. ROCKOFF practices dermatology in Brookline, Mass. To respond to this column, write Dr. Rockoff at our editorial offices or e-mail him at sknews@elsevier.com.