

# Correspondence

## Spider Myths and a Case of a Bite by a Yellow Sac Spider

*To the Editor:* We enjoyed reading Frithsen's<sup>1</sup> report on the paradox of the number of reported spider bites exceeding the number of *Loxosceles* spiders in South Carolina. As an amendment, we would like to draw attention to spider myths in Central Europe. A 31-year-old male patient was admitted to our hospital after a bite from a spider that had found shelter in his slipper. His toe showed local edema and erythema, and he reported severe pain comparable to a hornet sting. No generalized symptoms occurred. The patient caught the medium-sized, long-legged, golden and straw-colored spider with pedipalps and multiple dorsal eyes, and brought the living spider with him in a glass. The spider was identified as a yellow sac spider (genus *Cheiracanthium*, Figure 1). According to review articles, medical textbooks, and medical journal correspondences, yellow sac spiders are considered to be the only potentially dangerous spiders in Central Europe causing dermonecrosis.<sup>2,3</sup> This is not supported by a case series of 20 verified bites by *Cheiracanthium* spiders from the United States and Australia (none with necrosis), nor by a review of the international literature on 39 verified *Cheiracanthium* bites (which found only one case of mild necrosis in the European species, *Cheiracanthium punctorium*, nearly 50 years ago).<sup>3,4</sup> No verified case of a *Cheiracanthium* bite in Central Europe has been reported since then in medical literature, but reports of spider sightings have dominated local media in Austria for a year, triggering hundreds of calls to the Vienna poison hotline and prompting the government to issue a plea for calm.<sup>5</sup> Spider mythology and spider phobia are clearly phenomena not only of the past.<sup>5</sup> Our patient recovered completely within a few days after symptomatic therapy.

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**Figure 1. Yellow sac spider (genus *Cheiracanthium*)**

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**Note:** Frithsen declined to respond because the author is in agreement.

## Community-based Participatory Research: Providers, Patient, and Community in Partnership to Improve Health Disparities

*To the Editor:* Rust and Cooper<sup>1</sup> present a case for improving health disparities through practice-based research and 12 strategies to close the gap on health outcomes disparities. Community-based participatory research (CBPR) complements cooperative grants in select regions and forms a fundamental basis for these strategies. CBPR promotes the conduct of research in “real

world, limited resource, high-disparity primary care practice settings” called for in the article.

CBPR and cooperative grants through the National Cancer Institute (NCI) combine principle and practice to yield significant improvements in access to care and standard of care protocols for cancer patients. NCI’s Cancer Disparities Research Partnership (CDRP) ([www3.cancer.gov/rp/CDRP/index.html](http://www3.cancer.gov/rp/CDRP/index.html)) links community cancer centers with comprehensive cancer centers to create the triangulation-based care by providers, patient, and community that Rust and Cooper emphasize. The CDRP program was initiated in response to an Institute of Medicine Report in 1999 outlining significant discrepancies between the level of care received in community hospitals versus large academic medical centers.

Current CDRP sites include Rapid City, SD; Wilmington, NC; Inglewood, CA; McKeepsport, PA; and Pascagoula, MS. The program in Rapid City, SD (*Walking Forward*), addresses cancer disparities for nearly 60,000 American Indians (AIs) who suffer from some of the highest cancer death rates in the nation.<sup>2–4</sup> We are researching methods to improve cancer treatment and outcomes for AIs in western South Dakota. This program consists of patient navigation, clinical trials, surveys to evaluate barriers to access, and a molecular study (ATM [ataxia telangiectasia mutated] gene) to assess a potential molecular reason for increased treatment induced toxicities. To date, more than 1400 AIs have been enrolled in these studies over a period of 3 years. The phase II clinical trials use tomotherapy and brachytherapy to shorten the overall treatment time.<sup>5,6</sup> In addition, more than 70 clinical trials are open through the cooperative group mechanism.

The *Walking Forward* program works with AIs on 3 reservations and in the Rapid City community. All 4 sites employ Community Research Representatives (CRRs) who serve as a bridge between the cancer center and the communities being served. CBPR is more than a principle to be followed for the CRRs; it is where they live and work. Multiple barriers have been identified, leading to interventions promoting cancer education and screening in hopes of diagnosing patients with earlier stages of cancer.

Because of the overwhelming success of the *Walking Forward* program in navigating patients, our cancer center has implemented a similar program for all patients. One navigator assists breast cancer patients through the continuum of cancer care. A second navigator works with the general population of cancer patients. It is a significant step for responsive patient services to an underserved rural population that reflects disparate access and outcomes to cancer care.

Rust and Cooper challenge us to meet the need of disparities in research in the community setting by providing 12 strategies to move forward. The CDRP model paired with community-based participatory research promotes an investment in health care that is responsive to

community needs and provides significant improvement in access and standard of care.

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*The above letter was referred to the authors of the article in question, who offer the following reply.*

## Building a Bridge Between Community-based Participatory Research (CBPR) and Primary Care Practice-based Research (PBR)

*To the Editor:* We are pleased to hear of these specific examples of community-based participatory research (CBPR) focused on cancer care and outcomes for American Indian communities in South Dakota. CBPR and primary care practice-based research (PBR) too often operate in separate silos, one focused on community-based, health-promoting interventions outside of clinical health care settings, and the other inherently conducted within the clinical practice. Reiner and Petereit describe a perfect example of how to build a bridge between these 2 important arenas of disparities research toward a common goal of improved health outcomes. The use of community health workers, navigators, *promotoras*, or in this case “Community Research Representatives,” are essential to bridging the culture gap between clinical practitioners and individuals in the communities they serve. As presented here, they also can play a key role in