

Pedicure Whirlpools May Swirl With Mycobacteria

BY SHERRY BOSCHERT
San Francisco Bureau

KOHALA COAST, HAWAII — Nail salons that offer pedicures may be peddling infections along with pretty toes.

If a female patient complains of recurrent folliculitis of the lower legs, ask if she's had a pedicure lately and if she shaves her legs before going to the nail salon. The shaved skin can be a portal of entry for mycobacteria that exist in tap water and that grow in the filter systems of whirlpool footbaths used in nail salons, said Timothy G. Berger, M.D.

"You can scrub the inside of the salon tub all you want, but it's in the filter and irrigation system, and you can't clean that," he said at a conference on clinical dermatology sponsored by the Center for Bio-Medical Communication Inc.

Pedicures are popular in the San Francisco Bay area. "We've had outbreaks affecting hundreds of patients with this," said Dr. Berger, professor of clinical dermatology at the University of California, San Francisco.

He described a typical patient: a 37-year-old woman referred to him by her primary care physician for chronic folliculitis of the lower legs who failed sequential treatment with ciprofloxacin, cephalexin, and amoxicillin/clavulanate potassium (Augmentin). She had multiple, firm, focally ulcerated and eroded lesions 0.5-1.5 cm in size below the knees. The dermal and subcutaneous nodules had left multiple scars.

A biopsy suggested she might have mycobacterial infection, and a culture of the

tissue biopsy grew one of the rapidly growing types of mycobacteria, such as *Mycobacterium fortuitum* and *M. chelonae*, which can be seen in cultures in 7-10 days.

Some patients may be followed with observation, but they usually require a prolonged course of antibiotic treatment for 6 months. "If you're lucky enough to grow the bug, then you can get sensitivities" to help pick the antibiotic, he said.

If you don't know the bug's antibiotic sensitivity, treat with monotherapy using

doxycycline, clarithromycin, azithromycin, or ciprofloxacin, he suggested. Sulfonamides and trimethoprim are also options. Depending on how the patient responds, combination therapy may be needed. These rapidly growing mycobacteria do not respond to antimicrobials used to treat tuberculosis, such as isoniazid or ethambutol.

Dr. Berger distinguished between the rapid growers such as *M. chelonae* and *M. fortuitum* and two other types of my-

cobacteria that are seen commonly. One, *M. marinum*, causes papules or plaque on the hands after exposure to water in fish tanks. The other, *M. tuberculosis*, can cause tender calf nodules and erythema induratum.

Sometimes biopsies from patients with erythema induratum will show polyarteritis nodosa (PAN). If cutaneous TB is the cause, putting those patients on steroids will make them worse, Dr. Berger cautioned. ■

Onychomycosis May Lurk in Psoriasis, Pseudomonas Cases

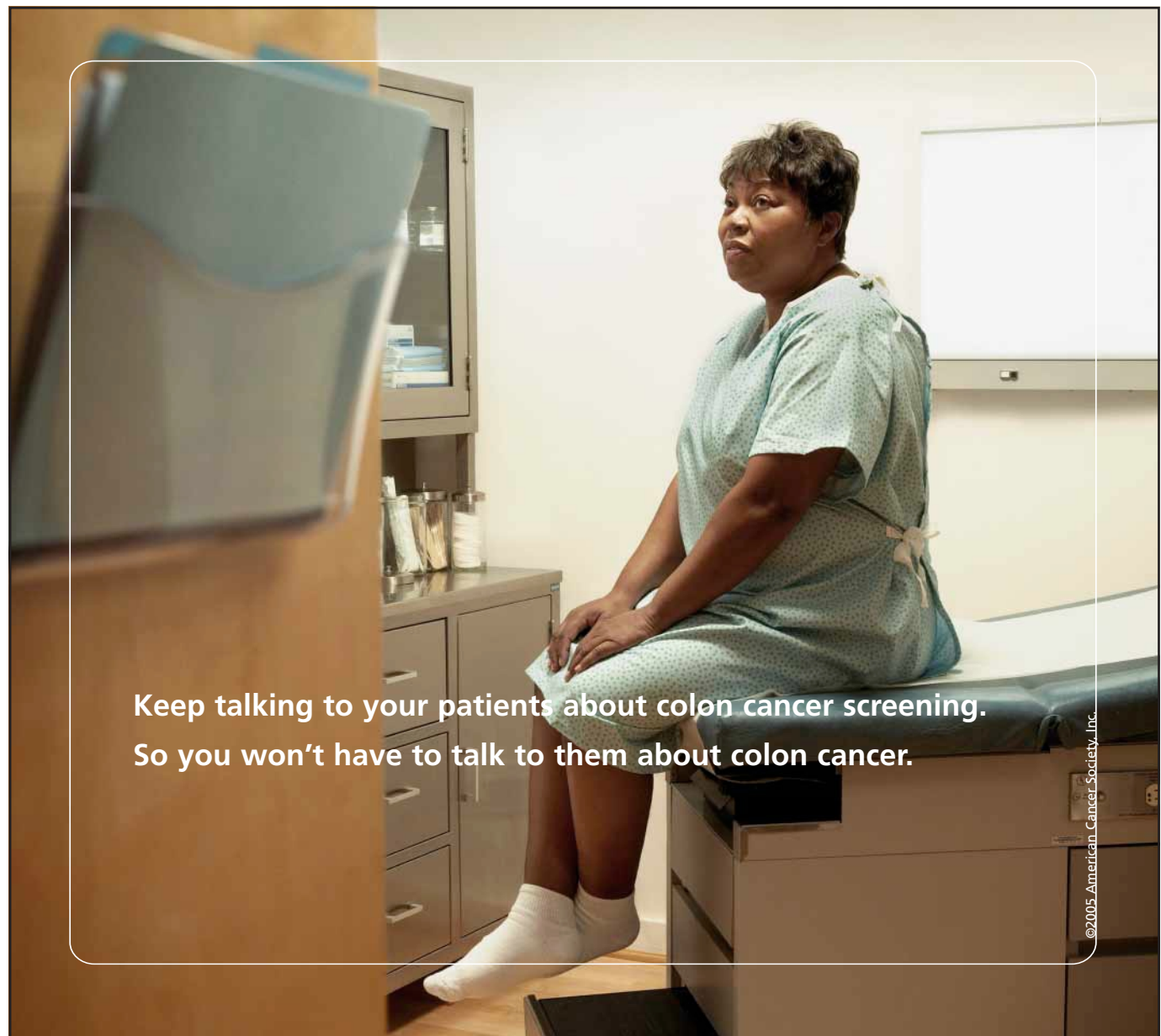
KOHALA COAST, HAWAII — Dermatophytes are common copathogens in nails with pseudomonas infection or in abnormal-looking nails with psoriasis, Boni E. Elewski, M.D., said at a conference on clinical dermatology sponsored by the Center for Bio-Medical Communication Inc.

Look twice to catch onychomycosis in patients with green nails typical of bacterial infection with pseudomonas, she suggested. It's reasonable to assume that a green-nailed patient has pseudomonas and to treat it with a quinolone antibiotic. A culture for onychomycosis at this stage will be negative because pseudomonas inhibits the growth of dermatophytes, although a potassium hydroxide (KOH) test probably will be positive for dermatophytes.

To be sure, see the patient again after you've eradicated the pseudomonas to check for onychomycosis, said Dr. Elewski, professor of dermatology at the University of Alabama, Birmingham.

When Dr. Elewski sees a patient whose psoriasis doesn't warrant systemic treatment but whose nails look abnormal, she cultures the nails for fungus.

—Sherry Boschert



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