Infections in Athletes Demand Close Attention

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Contributing Writer

VANCOUVER, B.C. — Managing skin infections in young athletes can be more challenging than in the general pediatric population, because close physical contact and use of shared equipment can lead to rapid spread of infections and outbreaks.

In addition, some athletes with skin infections must be cleared by a physician to return to play and will try to hide symptoms, warned Dr. Andrew Gregory at a meeting on pediatric and adolescent sports medicine sponsored by the American Academy of Pediatrics. They may try to abrade lesions with sandpaper, cover them with makeup, or bleach them, he said.

Good hygiene is key to preventing methicillin-resistant *Staphylococcus aureus* (MRSA). Coaches and certified athletic trainers should encourage athletes to shower and clean their equipment regularly with soap and water and to avoid sharing equipment, clothing, towels, and razors, said Dr. Gregory of the departments of orthopaedics and pediatrics at Vanderbilt University, Nashville, Tenn.

When MRSA is detected in an athlete, coaches and trainers should talk with others on the team to see if any of them have lesions, he advised. Treatment of MRSA in this population is the same as that in other children and adolescents—incision and drainage and antibiotic therapy appropriate for that specific community.

According to recommendations from the Centers for Disease Control and Prevention, athletes with any staphylococcal infection—including MRSA—should receive oral antibiotic therapy for a minimum of 3 days of before returning to play sports involving skin-to-skin contact

Dr. Gregory said physicians and administrators should beware of sales pitches for products such as turf coatings that promise to protect athletes from MRSA. "There is no evidence they do what they claim."

Tinea infection, called tinea gladiatorum in wrestlers, is believed to be passed primarily by skin-to-skin contact. Treatment

Some athletes will try to hide symptoms by covering lesions with makeup or bleaching them.

DR. GREGORY

consists of topical antifungal agents as first-line therapy and oral ones as second-line therapy. Wrestlers with this infection must be withheld from practice and competition until they have had treatment for 48-72 hours. Simply covering lesions is inadequate, said Dr. Gregory, who reported no conflicts of interest. ■

Triamcinolone 10 mg Is Best for Psoriatic Nails

CHICAGO — Triamcinolone acetonide 10 mg/mL is the best dose for psoriatic fingernails dystrophy, according to a randomized, dose-comparison study.

The 90 psoriatic fingernails included in the study were divided into three groups of 30 and treated with an intramatrix injection of triamcinolone acetonide 2.5 mg/mL (group A), 5 mg/mL (group B), or 10 mg/mL (group C), reported Dr. Savreet Kaur and Dr. Karan Jit Pal Singh Puri. Treatment was repeated at 6 and 12 weeks. Assessment was done using the Nail Psoriasis Severity Index, with a grade IV change defined as more than a 75% improvement.

The study included 32 patients (aged 17-62 years). At 6 months, a grade IV improvement was observed in group A, B, and C in pitting in 27%, 78.5%, and 83% of nails, respectively; onycholysis (12.5%, 46%, and 53%); subungual hyperkeratosis (36%, 33%, and 59%); discoloration (33%, 44%, and 71%); and crumbling (0%, 50%, and 92%), the researchers noted in a poster at the annual meeting of the American Academy of Dermatology's Academy.

Dr. Kaur is at the Civil Hospital Khanna, in Punjab, India, and Dr. Puri is head of the department of dermatology, venereology, and leprosy at the Government Medical College, in Amritsar, India. They reported no conflicts of interest.

—Patrice Wendling