

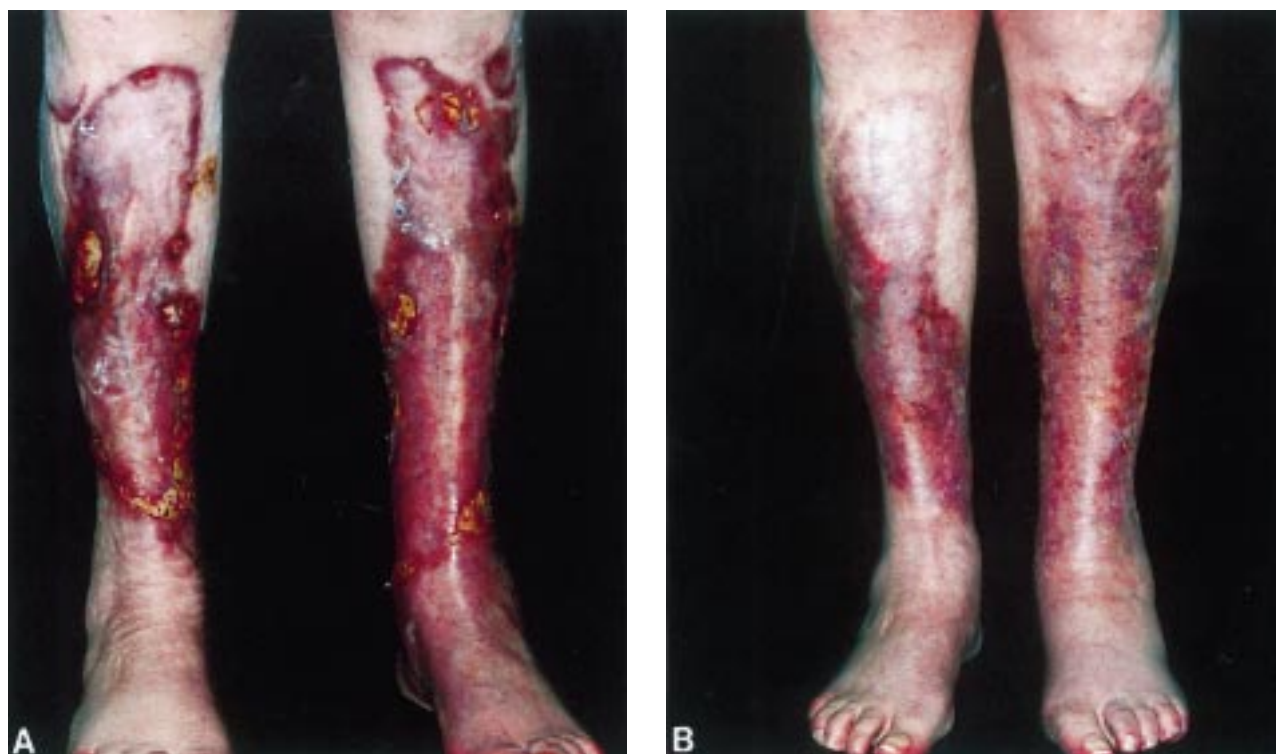


Fig. 1. Lower legs of the patient before (A) and 4 weeks after (B) the beginning of therapy.

DISCUSSION

MMF is used as a potent immunosuppressant for prevention and treatment of renal-transplant rejections (2). However, treatment of bullous pemphigoid (3), psoriasis vulgaris (4) and other diseases with MMF is promising. Here, we provide evidence that MMF may be useful in the management of otherwise therapeutically resistant ulcerated necrobiosis lipoidica.

REFERENCES

1. Silverman Kitchin JE, Keltz Pomeranz M, Pak G, Washenik K, Shupack JL. Rediscovering mycophenolic acid: A review of its mechanism, side effects, and potential uses. *J Am Acad Dermatol* 1997; 37: 445–449.
2. Lipsky J. Mycophenolate mofetil. *Lancet* 1996; 348: 1357–1359.
3. Böhm M, Beissert S, Schwarz T, Metze D, Luger T. Bullous pemphigoid treated with mycophenolate mofetil. *Lancet* 1997; 349: 541.
4. Haufs MG, Beissert S, Grabbe S, Schütte B, Luger T. Psoriasis vulgaris treated successfully with mycophenolate mofetil. *Br J Dermatol* 1998; 138: 179–181.

Accepted 20 March 2000.

Günter Reinhard, Frauke Lohmann, Manfred Uerlich, Ralf Bauer and Thomas Bieber
Department of Dermatology, Rheinische Friedrich-Wilhelms-Universität, D-53105, Bonn, Germany. E-mail: reinhard.g@debitel.net

A Suppurating Fistula from a Cement Foreign Body Presenting as a Tumour of the Nail

Sir,

Nail malignant tumours are not very common and, when diagnosed, tend to cause great alarm amongst patients as well as physicians. The condition is often initially misdiagnosed (1).

CASE REPORT

We report here on a 19-year-old male who complained of a lesion on his right toe. One and a half years earlier there had been some surgical intervention on a bone in that toe. The patient was informed that the

surgeon had "cured a cyst" in his bone and put in an osseous graft. During the 3 months prior to his visit he had a recurrence of pain and swelling, with purulent discharge. A colleague described this as a hemorrhagic tumour close to the nail. In addition to a homolateral inguinal adenopathy, the clinical findings led to the differential diagnosis of a pyogenic granuloma or an ulcerated melanoma.

On clinical examination we discovered, adjacent to the proximal nail fold, an emerging round tumour with a clear peripheral and dark central area. There was some purulent and hemorrhagic exudate. This was firm and moderately painful on palpation and was responsible for a slight limp. The nail plate appeared dystrophic (Fig. 1). X-ray showed a homogeneous radiopaque body at the center of the distal



Fig. 1. Round emerging tumour, with dark central area and purulent exudate.

phalanx of the right toe, surrounded by a lytic margin (Fig. 2). When the nail matrix was viewed laterally, a spicule was visible adjacent to the matrix. Suspecting a possible exostosis originating from the bone graft, surgery was undertaken and a small, round piece of resin was removed from the suppurating lesion which grew *Staphylococcus aureus* in cultures. Following an antibiogram, cloxacillin was prescribed at 500 mg q.i.d. for 4 weeks. The patient's post-operation course was satisfactory and, 7 months later, the 3 proximal quarters of the nail plate were completely normal and the X-ray also showed marked improvement of the bone hollow. One year later the patient remained asymptomatic.

Our final diagnosis was a suppurating fistula resulting from previous treatment of a Brodie's abscess with bone cement and gentamycin.

DISCUSSION

Hematogenous osteomyelitis in its acute and subacute forms affects the tubular bones in the metaphyseal region, particularly in young patients. Involvement of the flat and small bones is less common, but is quite often seen in the subacute form (2, 3). A lack of symptoms of acute osteomyelitis, together with the absence of specific laboratory tests, make diagnosis difficult. Typically, the small bones are affected close to the articular cartilage and apophyseal growth plates (4). *S. aureus* is the most common organism isolated from bony aspirates or intraoperative swabs. Seventy-five per cent of affected patients are <25 years of age (5).

There are some aspects of the present case that merit discussion. Firstly, the initial diagnosis of osteomyelitis should have been that of a Brodie's abscess, taking into account the dull pain and the radiologic, culture and surgical findings. It would appear that the initial surgical treatment without adequate antibiotic cover led to chronic osteomyelitis. Proper systemic, antibiotic treatment should have been



Fig. 2. X-ray image of distal phalanx of the right toe showing homogeneous calcium-density body.

administered in order to avoid subsequent osteomyelitis relapse. Secondly, the remaining cavity was small enough to have been filled with a piece of cement <1 cm in diameter. Thirdly, the cement should subsequently have been removed. This would have precluded the rejection and infection of the foreign body. The total recovery of the dystrophic nail suggests a reversible disorder similar to the recovery of the nail matrix from the pressure and irritation of a benign tumour and without any destruction of the nail despite subjacent osteomyelitis (6).

REFERENCES

1. Salasche SJ, Garland LD. Tumors of the nail. *Dermatol Clin* 1985; 3: 501–519.
2. Trueta J, Morgan JD. Late results in the treatment of 100 cases of acute hematogenous osteomyelitis. *Br J Surg* 1954; 41: 449–457.
3. Ezra E, Wientroub S. Primary subacute haematogenous osteomyelitis of the tarsal bones in children. *J Bone Joint Surg Br* 1997; 79B: 983–986.
4. Nixon GW. Haematogenous osteomyelitis of metaphyseal-equivalent locations. *AJR Am J Roentgenol* 1978; 130: 123–129.
5. Mader JT, Calhoun J. Osteomyelitis. In: Mandell GL, Bennett JE, Dolin R, eds. *Mandell, Douglas and Bennett's principles and practice of infectious diseases*. New York: Churchill Livingstone; 1995: 1039–1051.
6. Zook EG. The perionychium: Anatomy, physiology and care of injuries. *Clin Plast Surg* 1981; 8: 21–31.

Accepted March 17, 2000.

Santiago Vidal¹, Luis Barcala¹, Jose Barberán², J. A. Heras¹, Jose Antonio Tovar³ and Robert Baran⁴
Departments of ¹Dermatology, ²Infectious Diseases, ³Bone and Joint Surgery, H.M.C. "Gómez-Ulla", Glorieta del Ejército, 28047, Madrid, Spain and ⁴Nail Disease Center, Cannes, France