deleterious effects in culture. bFGF is a natural growth factor for melanocytes, produced in vivo by fibroblasts and keratinocytes and probably an important factor of melanocyte behaviour and growth (1, 2). It is normally present in nearly every tissue, bound to basement membrane and subendothelial cell extracellular matrix (3–5), and is probably liberated by any cellular or tissue injury. Local infusion and topical application of bFGF have been shown to enhance bone graft and wound healing, respectively (6). We found that melanocytes from adult and newborn skin, cultured in the presence of bFGF for a period of 3–8 weeks, always died after removal of bFGF, and they do not proliferate, unlike transformed cells. Not a single colony grew out from at least 400 million cells in the absence of growth factors. Similar long-time culture experiments have been reported by Lerner et al. (7). Nor could we see any negative morphologic changes in light microscopy such as multiple nuclei. As far as we know no one has been able to convert a normal pigment cell into a malignant one with the use of bFGF.

Dr. Falabella suggests that keratinocytes would be a more normal regulator of melanocytes. We have now in 40 recently transplanted patients used cultures with various percentages of keratinocytes and fibroblasts but have not seen any difference in the melanocyte growth or in the clinical healing effect.

As far as we know there is no theoretical or practical evidence that cultured cells initially stimulated by bFGF should be more prone to produce an unwanted clone than in the presence of keratinocytes.

REFERENCES

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In reply to the letter by Dr. Falabella concerning our article on the treatment of vitiligo with epidermal grafts and cultured melanocytes, we would like to mention that we are prepared to study if the cultures can be performed without the use of phorbol esters, but we have to go through a substantial amount of more basic work before these conditions can be established. There are, however, at present no data, which indicate that phorbol esters in the concentrations we have used should be harmful (1). Concerning the influence of keratinocytes we do not want to discuss whether these cells are necessary for obtaining “normal melanocytes” in culture, but we can add that 75% of our cultures contain a variable amount of keratinocytes. The cells we have used for autotransplantation are also in general “young cells”. The great majority are neither enlarged nor multi-nucleated. This does not guarantee that a single altered cell could originate an unwanted clone. This could, however, also happen with PUVA, the present standard therapy for vitiligo.


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**Anthropophilic Transmission of Blistering Distal Dactyliitis**

Sir,

A 39-year-old white male presented at our clinic with a 2-day history of a painful blister on the tip of his right middle finger. The patient did not have any associated constitutional symptoms and denied a history of burn or trauma to the digit. He was otherwise healthy, had no history of diabetes and was not receiving any immunosuppressive drugs. His daughter had been diagnosed by throat culture as having group A beta hemolytic streptococcal pharyngitis 2 weeks prior to this incident.

Physical examination revealed a single 2-cm tense blister on an erythematous base on the volar surface of the right middle finger (Fig. 1). Gram stain of the fluid showed rare white blood cells with many gram positive cocci in pairs and chains. Bacterial cultures grew two organisms: group A beta hemolytic streptococci and 1 betalactamase positive *Staphylococcus aureus*. The lesion resolved following incision, debridement, and a 14-day course of oral dicloxacillin (500 mg twice a day).

Blistering distal dactyliitis (BDD) is a superficial skin infection of the anterior surface of the distal or middle phalyns of the finger (1–6). BDD most commonly affects children aged 2–16, but 4 cases have been reported in adults, of which 2 were immunosuppressed (2–5). Clinically, BDD presents as tense superficial blisters on a tender, erythematous base. The blister may extend to the dorsal nail fold and involve more than one
furthermore, in a number of cases reported by hays & mullard, as in this case, in addition to group a streptococci cultures also grew staphylococci organisms (1). in their series, almost all BDD cases were assumed to be the result of streptococcal nasopharyngeal or conjunctival autointoxication. Since BDD cultures frequently grow staphylococci in addition to streptococci organisms, the use of beta-lactamase resistance antibiotics, such as dicloxacillin, is the oral therapy of choice.

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REFERENCES


The Case of the Mercury Heart

Magic must keep an important place in everyday life, even among youngsters, if cases like the one we describe here can still be observed.

CASE REPORT

A 25-year-old woman, without any history of atopy, was seen for an acute, intensely pruritic dermatitis which had begun on her preternental area and had rapidly spread. On examination, she exhibited an erythematous-pustular dermatitis which was particularly severe on the cardiac, preternental and submammary areas, abdomen, groins (fig. 1) and midback. No systemic symptoms were present.

She referred that the rash had developed a few hours after wearing a small heart-shaped cloth amulet (fig. 2) inside the left cup of her bra. The “heart” contained a few grains of rice, pieces of laurel leaves and droplets of metallic mercury taken from a dental amalgam. No history of previous medications with mercurochrome or other mercurials was obtained.

Blood and urinary laboratory tests were normal, but the urinary mercury concentration, analyzed by atomic absorption spectrosopy, was 1 μg/l (50 μg/l is the limit for professional exposure).

Histopathology of a lesion showed slight spongiosis, edema of the papillary dermis and a superficial perivascular, lymphoeytic and neutrophilic infiltrate.

Topical corticosteroids and oral antihistamines cleared the eruption in a few days.

Two weeks later, patch tests with the Italian standard series (GIRDCA) (including thymeral) yielded negative results. Patch tests with a mercurial series revealed, at 48 h, a positive reaction to ammoniated mercury (1% in petrolatum) (+ + +) and metallic mercury (0.5% in petrolatum) (+ + +). Mercurochrome chlorido (0.05% in water) and phenylmercuric acetate (0.01% in water) reacted weakly (+ +). In addition, an erythematous and pruritic reaction developed the day after in the patch test site and spread to her groins and abdomen. As the patient treated herself with topical and oral corticosteroids, no reliable further readings of the patch tests were possible.

COMMENT

Metallic mercury is promptly absorbed through the skin, both as a metal and vapor. Especially when applied under occlusion at body temperature, it may cause a generalized rash, particularly in patients sensitized to topical drugs containing mercurials (1).

According to Nakayama et al. (2), the mercuric exanthem appears a day or two after contact with metallic mercury. Usually, contact occurs during a dental treatment or because of a broken clinical thermometer. A previous sensitization to organic mercury (often mercurochrome) is common. The clinical picture is typical, including a symmetrical erythema on the major flexures with a V-shaped erythema on the upper antero-medial