Anthropophilic Transmission of Blistering Distal Dactylitis

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: 4+ group A beta hemolytic streptococci and 1+ betal lactamase positive *Staphylococcus aureus*. The lesion resolved following incision, debridement, and a 14-day course of oral dicloxacillin (500 mg twice a day).

Blistering distal dactylitis (BDD) is a superficial skin infection of the anterior surface of the distal or middle phalynx 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

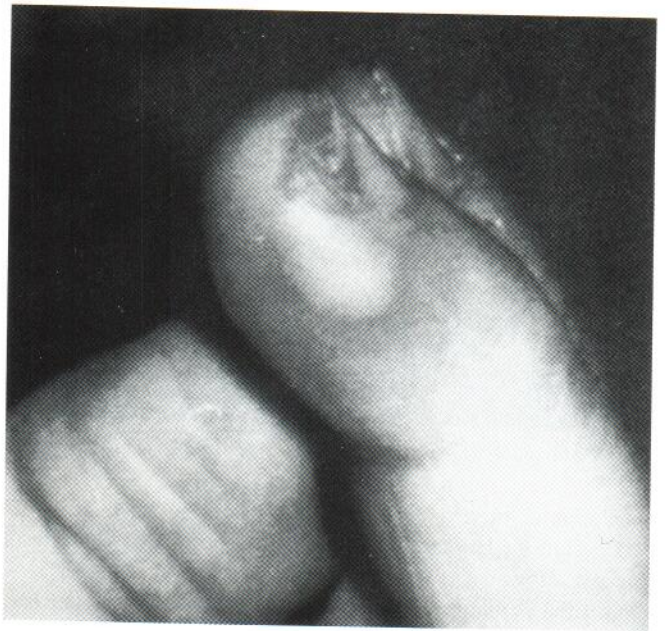

Fig. 1. Clinical picture of blistering distal dactylitis.

finger. Group A beta hemolytic streptococci are the most common organisms isolated from these lesions (1). However, in one case, group B streptococcus were isolated (3). The authors and others recently reported cases of BDD where only the *Staphylococcus aureus* organism was isolated (5, 6). One group of authors suggested that *Staphylococcus aureus* is more likely to be the causative organism of BDD when several fingers are involved (6).

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 nasopharyngial or conjunctival autoinfection. 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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