Lesion in a New Tattoo? Think Mycobacteria

BY BRUCE JANCIN
FROM THE ANNUAL CONGRESS OF THE EUROPEAN ACADEMY OF DERMATOLOGY AND VENEREOLOGY

GOTHENBURG, SWEDEN – Considerable delay in diagnosis of nontuberculous mycobacteria infection as a distinct possibility in patients who present with a rash or other skin lesions within a new tattoo.

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ratively short order, all with tattoos done

by the same artist at a single Rochester, Minn., tattoo parlor.

The likely source of this outbreak of Mycobacterium chelonae infection was the tap water the tattoo artist used to dilute black ink to create shades of gray for the popular gray wash technique, which cre-

ates a subtle photographic effect, she ex-

plained at the annual congress of the Eu-

ropean Academy of Dermatology and Venereology.

The tipoff that the likely contaminant in this was that the skin lesions, although varied in appearance, were concentrated in the gray areas of the tattoos, with the deep black areas and clear-skin uninked portions largely spared, she said.

More broadly, she suggested keeping M. chelonae and the other rapidly grow-

ing mycobacteria (RGM) in mind when diagnosing any patient with a postpro-

cedure skin infection that’s not respond-
ing to appropriate antibiotic therapy.

"RGMs are underrecognized, under-

reported, and we think they’re increasing in prevalence," the dermatologist said.

"I think ‘staph’ first because it’s so much more common. But if an infection isn’t responding within a couple of weeks and tests show it’s not methi-
cillin-resistant staph – and especially if there’s been a procedure – think RGM," Dr. Drage said.

The reason RGM infections are under-
diagnosed is that the culture techniques required to confirm the diagnosis are completely different from those utilized in conventional bacterial cultures. The techniques for nontuberculous myco-
bacteria (NTM) are quite involved, with multiple cultures needing to be started at a variety of temperatures, since some RGM will grow only at 28°-30°C while others require 35°-37°C. Unlike the case in M. tuberculosis infections, where poly-

merase chain reaction or other rapid di-

agnostic systems can be applied directly to the clinical specimen, the NTM or-

ganisms must first be grown out on sol-

id culture media before DNA sequencing can be utilized to identify the species.

"Most physicians who send the speci-

tum to the laboratory fail to order the appropriate test. If you just send it for bacteriologic testing, they won’t do the specific techniques for mycobacteria, and you’ll get a negative result. It’s important to obtain cultures specifically for myco-
bacteria, along with susceptibility stud-

ies. I find it most helpful to speak with the lab so they know what I’m thinking and what to do," she said.

The RGM, which include M. chelonae and M. fortuitum, are the most common NTM involved in community-acquired skin and soft-tissue infections. Indeed, M. fortuitum alone is believed to account for more than 60% of such infections.

These are environmental microorgan-

isms; there is no person-to-person spread. Tap water is the most common source of contamination. The NTM re-

side in the biofilm. They are resistant to sterilizers, disinfectants, and antiseptics. Numerous infections have come from hospital water systems.

Cutaneous infections with RGM have been reported in association with a variety of procedures, including Mohs surgery, acupuncture, punch biopsy, liposuction, laser resurfacing and other cosmetic procedures, and tattooing. In one California study, 29 of 30 pedicure foot baths in 18 salons in five counties contained NTM.

The skin lesions typically appear within a couple of weeks after the procedure, but lengthy delay in diagnosis is common. Patients may initially shrug off the skin lesions as bug bites or something else not warranting medical attention. And once they visit a physician, further diagnostic delay often ensues. In the six Minnesota patients with M. chelonae in-

fections in tattoos, for example, the skin lesions appeared 1-2 weeks after the tattoo was placed, and all patients sought medical care promptly, but they were treated for a diagnosis other than NTM infection. Indeed, the median time be-
tween tattoo placement and the correct diagnosis was 18 weeks.

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Data Source: The 32 organ transplant pa-

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Disclosures: Dr. Stockfleth disclosed serv-
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Diclofenac Gel Cleared Actinic Keratoses After Transplant

BY BRUCE JANCIN
FROM THE ANNUAL CONGRESS OF THE EUROPEAN ACADEMY OF DERMATOLOGY AND VENEREOLOGY

GOTHENBURG, SWEDEN – Topical diclofenac 3% gel proved effective for the treatment of ac-

tic keratoses in organ transplant recipients, according to the re-

sults of a new study.

Sixteen weeks of twice-daily therapy with 3% diclofenac in 2.5% hyaluronic acid (Solaraze) not only proved effective and well tolerated for actinic ker-

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