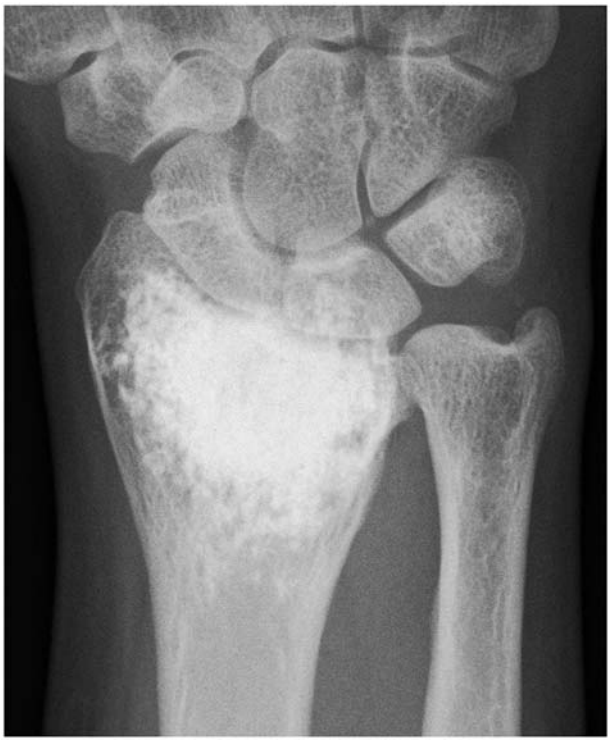

Fig 2 Consolidation of the bone graft and hydroxyapatite without recurrence of brown tumour.

improved from 50% to 100% of the opposite hand. Follow-up radiographs of the distal radius revealed consolidation of the grafted bone and hydroxyapatite, and no recurrence of the lesion (Fig 2).

A brown tumour presents with areas of radiolucency particularly in the facial bones, pelvis, ribs and femur (Doğan et al., 2004). Our patient had an unusual location of this disorder although this has been documented before (Resnick, 1974). As usual, the diagnosis of brown tumour, giant cell tumour, giant cell reparative granuloma and aneurysmal bone cyst must be considered and radiographic features do not help to distinguish between these diagnoses. A raised serum calcium and PTH and a decrease in BMD suggest a brown tumour with PTHT with successful parathyroidectomy improving the lesions (Agarwal et al., 2002; Doğan et al., 2004; Raeburn et al., 2002). However, curettage and bone graft could be considered for persistent symptoms after parathyroidectomy.

Conflict of interests

None declared.

References

Agarwal G, Mishra SK, Kar DK et al. Recovery pattern of patients with osteitis fibrosa cystica in primary hyperparathyroidism after successful parathyroidectomy. Surgery. 2002, 132: 1075–85.

Doğan A, Algű n E, Kisli E et al. Calcaneal brown tumor with primary hyperparathyroidism caused by parathyroid carcinoma: an atypical localization. J Foot Ankle Surg. 2004, 43: 248–51.

Raeburn CD, Cothren C, McIntyre Jr RC. End-stage skeletal manifestations of severe hyperparathyroidism. Surgery. 2002, 131: 896–8.

Resnick DL. Erosive arthritis of the hand and wrist in hyperparathyroidism. Radiology. 1974, 110: 263–9.

Norimasa Iwasaki, MD, PhD and
Akio Minami, MD, PhD
Department of Orthopaedic Surgery, Hokkaido University School of Medicine, Sapporo, Japan
E-mail: niwasaki@med.hokudai.ac.jp

doi: 10.1177/1753193409344530 available online at http://jhs.sagepub.com

A case of severe cutaneous nocardiosis

Dear Sir,

Cutaneous nocardiosis is rare in the immunocompetent patient. It manifests as a single tender abscess or an ulcerated papule at the site of minor skin lesions contaminated with soil. *Nocardia* appear as gram-positive branching or filamentous rods (Hearne et al., 2009). Patients infected with *Nocardia brasiliensis* may progress to nodular lymphangitis, sometimes with mild systemic symptoms (Dinubile, 2008).

A 65-year-old woman developed severe phlegmonous swelling of the right thumb with nodular lymphangitis caused by *Nocardia brasiliensis*. She had sustained a prick from a cactus spine at home. The cactus had been bought 18 months before from a market garden in Germany. Seven days after the injury, a small papule developed at the site. When seen 14 days after injury, there was a hypertrophic nodular papule with surrounding purulent skin infiltration (Fig 1). Swelling and redness subsequently spread to the dorsum of the hand. There was a slightly tender, cord-like and nodular lymphangitis extending to the axilla (Fig 2). Her temperature was 37.6°C. There was a leucocytosis of 12.12 G/l, CRP was 22.7 mg/dl, Na 120 mmol/l.

Because of an allergy to penicillin, 600 mg clindamycin was given intravenously three times daily. However, because of clinical deterioration and evidence of *Nocardia brasiliensis*, clindamycin was discontinued. A combination of 960 mg trimethoprim-sulfamethoxazole (three times daily), 400 mg moxifloxacin and 500 mg amikacin (once daily) was started on the fourth day after admission. Amikacin was discontinued after resistance testing showed sensitivity to trimethoprim-sulfamethoxazole, gentamicin, tobramycin, ciprofloxacin, moxifloxacin and tetracycline. Local debridements were done 1, 3, 4 and 8 days after presentation. Due to further deterioration, a perforated drain was placed between the serial incisions from the wrist to the upper arm at the

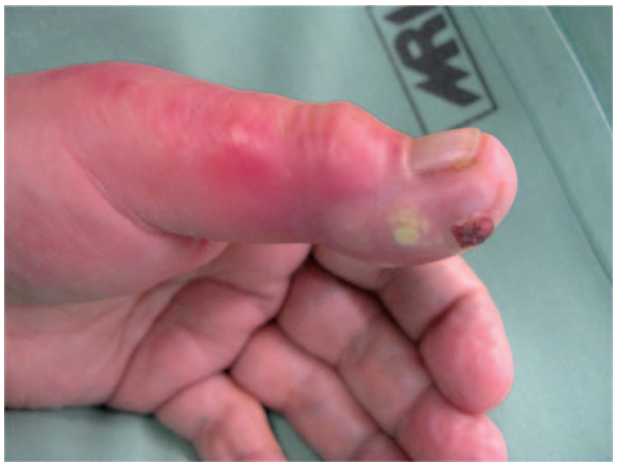

Fig 1 Hypertrophic nodular papule at the site of the cactus spine prick with surrounding purulent skin infiltration.

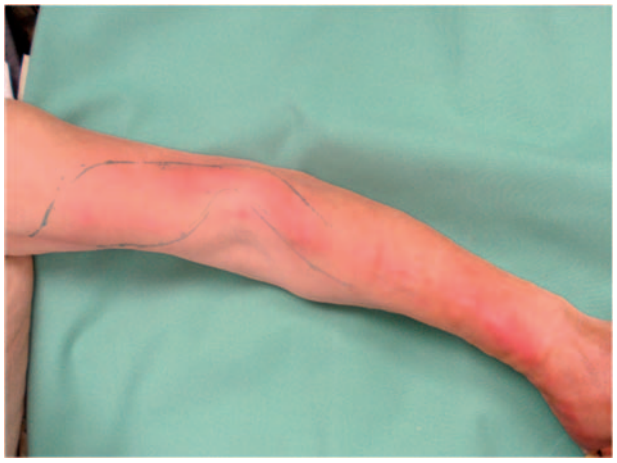

Fig 2 Nodular lymphangitis (the extent is marked with blue dye).

fourth day and rinsed twice daily with balanced electrolyte solution. The wound was closed after 14 days with additional skin grafts for the distal forearm. After resolution of symptoms, 960 mg trimethoprim-sulfamethoxazole was taken orally twice daily over the next 6 months. Six months after the first operation, the patient had a good functional result with thumb opposition to the fingertip of the fifth digit.

Acute lymphangitis is commonly associated with Group A streptococcal infection. Lymphangitis with nodular subcutaneous changes is rare, with specific aetiologies (Dinubile, 2008). Most cases result from infections with five microbial pathogens. It is seen with superficial inoculation with *Sporothrix schenckii*, *Mycobacterium marinum*, *Nocardia brasiliensis*, *Francisella tularensis*, *Leishmania guyanensis* and *Leishmania panamensis*. Although *M. marinum* is associated with marine environments, sporotrichiosis and nocardiosis typically affect gardeners. *F. tularensis* infections usually cause a painful chancre with purulent discharge at the site of the initial lesion, which may be associated with fever, chills and malaise. The formation of pus is also common in nocardiosis. Ulcers caused by *Sporothrix* and *Leishmania* are usually painless, whereas tenderness is common in infections with the others organisms. Tissue biopsies should be taken, especially if the wound swab shows negative results.

In this case, thorough repeated debridements and the use of a rinsing drain between the serial incisions, combined with broad spectrum antibiotics, helped to control severe progressive nodular lymphangitis. Trimethoprim-sulfamethoxazole is the antibiotic of choice for primary cutaneous nocardiosis (Wallace et al., 1982).

Conflict of interests

None declared.

References

Dinubile MJ. Nodular lymphangitis: a distinctive clinical entity with finite etiologies. Curr Infect Dis Rep. 2008, 10: 404–10.

Hearne CB, Eckford J, Forjuoh SN. The gardener's cellulitis. Am J Med. 2009, 122: 27–8.

Wallace RJ, Septimus EJ, Williams TW et al. Use of trimethoprim-sulfamethoxazole for treatment of infections due to Nocardia. Rev Infect Dis. 1982, 4: 315–25.

Jörn Andreas Lohmeyer, MD,
Hans-Günther Machens, MD, PhD and
Klaus-Dieter Werber, MD
Technische Universität München, Klinikum rechts der Isar, Dept. of Plastic Surgery and Hand Surgery, Munich Germany
E-mail: lohmeyer@lrz.tum.de

doi: 10.1177/1753193409344814 available online at http://jhs.sagepub.com

A haemangioma of the flexor tendon sheath causing carpal tunnel syndrome

Dear Sir,

A 35-year-old man presented with a tingling sensation over the index, middle and ring fingers and a popping mass proximal to the wrist crease when he clenched his fist; the mass disappeared on releasing his grip. He had suffered minor trauma involving wrist extension 2 weeks earlier. There was diffuse swelling and tenderness over the flexor tendon to the index finger in the palm. Tinel's sign was positive over the median nerve and Phalen's test was negative. There was no atrophy of the thenar muscles. The range of motion in the wrist, hand and fingers was full but he complained of pain on