Elgart, Milikowski, Civantos, and Goldberg have no conflicts of interest to declare.

Correspondence to: James M. Grichnik, MD, PhD, Department of Dermatology and Cutaneous Surgery, University of Miami Miller School of Medicine, 1501 NW 10th Ave, Room 912, BRB, Miami, FL 33136
E-mail: grichnik@med.miami.edu

REFERENCES

Potential exsanguination from a punch biopsy
To the Editor: The importance of patient safety for dermatologists was previously outlined in this journal.1 Potentially lethal mishaps in the dermatologist’s office are exceedingly rare but should be disclosed and publicized to promote safety.

A 66-year-old man presented for possible nephrogenic systemic fibrosis. His past medical history included diabetes mellitus, stage IV chronic kidney disease, and surgery for chronic ulcers on his right leg. Five months earlier, he underwent magnetic resonance angiography. He now complained of pruritus involving his forearms and trunk. Xerosis with mild lichenification was observed on his arms and trunk along with a sclerotic, hyperpigmented plaque on his right distal lateral thigh. A 5-mm punch biopsy was attempted at the right lateral thigh, but even before the plastic handle of the punch tool reached the skin a massive arterial bleed occurred. Blood forcefully ejected approximately 3 feet from the patient. Applied pressure and tourniquet were ineffectively attempted while emergency response services were activated. The patient was transported to the emergency center and received 5 units of packed red blood cells. The vascular surgery team repaired an arteriotomy to the right femoral to anterior tibial artery polytetrafluoroethylene (Teflon) bypass graft in the operating room (Fig 1).

We present this case to alert dermatologists to the danger of performing a punch biopsy on a patient with a bypass graft. A detailed history of bypass grafting is essential if a punch biopsy is needed on the leg. Physical examination may identify signs of previous surgeries (ie, medial versus lateral scars on the lower extremities).

In arterial bypass procedures, many potential variations exist, including the route in which grafts are tunneled and the material used.2 Infrainguinal vessels are generally exposed through a medial approach, except for the anterior tibial and peroneal arteries, which are accessed laterally. The bypass graft can be tunneled deep in an anatomic position or subcutaneously. Current data suggest that graft location does not influence its patency.3 The more superficially tunneled grafts facilitate Duplex ultrasound surveillance of graft patency and are more accessible for future revisions.5 The most preferred graft material is an autogenous, ipsilateral saphenous vein.4 If not available, a prosthetic graft is used. Polytetrafluoroethylene (PTFE) grafts are used...
for smaller diameter grafts. Polyethylene terephthalate or polyester (Dacron) grafts are woven or knitted textile grafts, suitable for large vessel replacement, and have shown similar success to PTFE grafts for infrainguinal arterial bypass. One key difference is that autogenous veins and polyester grafts are compliant and feel pulsatile; however, the PTFE graft is noncompressible and does not feel pulsatile.

Finally, cautiously consider punch biopsy locations at the medial and lateral thigh just above the knee. This is where grafts are frequently tunneled to reach the distal anastomosis of the arterial bypass in the lower leg. The grafts may travel medially or laterally (Fig 2) from the femoral artery and then, depending on the target artery for the distal anastomosis, they may cross over above or below the knee to the contralateral side.

Laura Paul Fite, MD, David F. Butler, MD, and Katherine Fiala, MD

Department of Dermatology, Scott and White Memorial Hospital and Clinic, Temple, TX

Funding sources: None.

Conflicts of interest: None declared.

Correspondence to: Katherine Fiala, MD, Assistant Professor Department of Dermatology, Scott and White Memorial Hospital and Clinic, 409 West Adams Street, Temple, TX 76501

E-mail: kfiala@sw.org

REFERENCES

http://dx.doi.org/10.1016/j.jaad.2013.05.010

Green foot syndrome: A case series of 14 patients from an armed forces hospital

To the Editor: Pseudomonas aeruginosa is a gram-negative bacillus that characteristically produces greenish-blue pigments. Some distinct cutaneous infections with *P. aeruginosa* have been well established; toe web infection, green nail syndrome, hot foot syndrome, and hot tub folliculitis. Meanwhile, green foot syndrome has been poorly recognized until now. Only 2 case reports exist in the English-language literature.

From May 2009 to September 2011, 14 patients presented with greenish discoloration of the soles of the feet in our armed forces hospital. All patients were immunocompetent, healthy young male soldiers (median age: 20 years). They had worn either casts or splints applied by the department of orthopedics, and noted itching of the affected areas a few days (2-6 days) after the accidental seepage of bathing water into the cast or splint. After removal of the cast or splint, various degrees of greenish discoloration on the soles were seen, particularly where the sole had been in close contact with the cast (Fig 1). All cutaneous lesions were cultured and grew *P. aeruginosa*. Patients were diagnosed with

Fig 1. Green foot syndrome. Well-demarcated greenish discoloration on the sole of foot and spontaneous resolution of condition 3 weeks after splint removal (case 5).

Fig 2. Green foot syndrome. Greenish stain on the cotton inside splint (case 13).