

AMI symptoms (for instance, we compared urinary values on day 2 after admission in the streptokinase group with values obtained the first day of admission in the no-streptokinase group). The time-course for U-ALB and U-RBP did not differ significantly between the two groups (table).

Our data indicate that AMI may cause a transitory dysfunction not only of the glomeruli, but also of the proximal tubuli. These abnormalities did not seem to be influenced by the administration of streptokinase. Above-normal concentrations of noradrenalin, renin, angiotensin-converting enzyme, and aldosterone are also characteristically seen in the initial phase of AMI.³ This activation begins to subside within the first 72 h after onset of symptoms, so our findings for U-ALB and U-RBP correspond to these hormonal changes. Similarly, patients with heart failure often have increased U-ALB and U-RBP before therapy with an angiotensin-converting enzyme inhibitor and these values may fall after initiation of therapy.^{4,5}

We invite prospective collaborators to contact us with a view to investigating whether dysfunction of glomeruli and proximal tubuli mainly indicates transitory haemodynamic and neurohormonal changes in the acute phase of an AMI.

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Response of Dupuytren's contracture to high-potency topical steroid

SIR—Baird and colleagues' study (June 26, p 1622) suggests that Dupuytren's contracture may be T-cell mediated, and that medical treatment may be an alternative to surgery. We have successfully treated five men and one woman (aged 40-72) with Dupuytren's contracture of the palm with 0.05% clobetasol propionate cream (Temovate). Two typical cases are described here.

A 62-year-old man had a painful fibrous cord in his right palm extending up the fourth finger for 9 months. Finger extension was not compromised. Topical treatment included twice daily clobetasol cream and 0.1% tretinoin cream at bedtime. After 3 months of treatment, pain resolved and the contracture was shrinking. By 9 months, the skin was normal. Treatment continued for 6 months. There has been no recurrence in the 2 years post-treatment.

The second patient was a 57-year-old man seen in April, 1990, for painful palmar Dupuytren's contracture for 1 year. Extension of the left 4th finger was limited to 90°. After 4 months of twice-daily clobetasol cream, pain and tenderness were gone, digital cord and palmar nodules had regressed, and finger 4 could be fully extended. Treatment was discontinued

after a heart attack. Resumption of treatment in June, 1991, was not as successful.

Our experience suggests that the local immunological inflammatory change triggering Dupuytren's contracture can be suppressed. Treatment needs to be prolonged and may call for adjuvants to enhance penetration of topical steroid (eg, tretinoin cream). The programme requires strict long-term compliance, and may help some patients who would resist the surgeon's hand.

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Salmonella contamination of eggs

SIR—A case-control study in 1989 showed an association between the consumption of poultry and eggs, and *Salmonella enteritidis* phage type (PT) 4 infection. Foods associated with illness included raw-egg dishes, shop-bought sandwiches containing egg or mayonnaise, and hot "take-away" chicken. The consumption of lightly cooked egg dishes was the greatest risk.¹ Similar associations between *S enteritidis* and eggs have been reported from other countries.²⁻⁴ A study was done to determine the current prevalence of contamination in UK-produced hens' eggs and in eggs imported from other European Community countries.

During 1991, 18 Public Health Laboratory Service laboratories in England and Wales tested 94 050 hens' eggs in batches of 6; 42 270 bought from highstreet retail outlets were of UK origin and 51 780, sampled at the port of entry, were from other European Community countries. This study did not allow a distinction to be made between contamination of the egg contents and the shell. Bacteria belonging to the genus *Salmonella* were isolated from 65/7045 samples of 6 UK eggs (0.9%) and from 138/8630 (1.6%) similar samples of imported eggs. *S enteritidis* was isolated from 47 UK samples (0.7%), 33 of which were *S enteritidis* PT4. Among imported eggs, 19 samples (0.2%) were contaminated with *S enteritidis*, and PT4 was isolated from 16. *Salmonella* serotypes other than *S enteritidis* were isolated from 0.3% of the samples of UK eggs and from 1.4% of the samples of imported eggs. All isolates of *S enteritidis* from Belgium, France, and Germany belonged to PT4, as did 9 of 12 from the Netherlands. Estimates of prevalence of salmonella contamination for single eggs are shown in the table. Although the frequency of contamination with salmonella was higher in imported eggs, contamination with *S enteritidis* and *S enteritidis* PT4 was higher in UK eggs. There was a striking seasonal variation in the degree of contamination of imported eggs but not among UK eggs. Information on the packing station was available on 36 of the samples of UK eggs contaminated with *S enteritidis*. 26 (72%) came from 3 packing stations which packed only 32% of all eggs for which the packing station was known. There is a statistically significant difference ($p < 0.001$) in the incidence of *S enteritidis*-contaminated eggs between these packing stations and the rest. Among UK eggs the presence of visible faecal matter was more frequently reported on eggs contaminated with salmonella 47/390 (12%) than from uncontaminated eggs 1692/41 880 (4%) ($p < 0.001$). Faecal matter was also present on the shell surface of 12% of imported eggs contaminated with Sal-

Source	Salmonella	<i>S enteritidis</i>	<i>S enteritidis</i> PT4
UK	1/650 (1/830-1/510)*	1/880 (1/1170-1/660)	1/1320 (1/1860-1/930)
Imported	1/370 (1/440-1/320)	1/2720 (1/4270-1/1740)	1/3040 (1/4900-1/1890)

*95% CI.

Table: *Salmonella* contamination in UK and imported eggs