Cutaneous absorption of trivalent chromium: tissue levels and treatment by exchange transfusion

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ABSTRACT A man was accidentally immersed in hot acidic trivalent chromium sulphate solution but none was swallowed. The clinical course was dominated by burns, intravascular haemolysis, and acute renal failure. Blood concentrations of chromium were measured during treatment and tissue concentrations were measured at death. Exchange transfusion reduced blood chromium concentrations by two-thirds. The total quantities of chromium absorbed and removed by various routes were calculated. In-vitro studies showed that the chromium solution did not directly cause haemolysis.

Soluble compounds of chromium are widely used in industrial processes, including dyeing, electroplating, and leather tanning.1 Toxicity due to chromium salts includes hand ulcers, dermatitis, perforation of the nasal septum, and lung cancer.1 Ingestion of hexavalent chromium (chromate or dichromate salts) causes ulceration of the bowel, diarrhoea, and renal and hepatic damage.2-4 There are also a few reports of toxicity from hexavalent chromium when absorbed cutaneously.5 Toxic effects are found only with hexavalent chromium compounds, and trivalent compounds are relatively harmless.6,7 To remove chromium, together with the products of intravascular haemolysis, we used an exchange transfusion, which has not previously been reported.

Case report

The patient, a 56-year-old white man, had not previously suffered from serious illness or evidence of chromate toxicity. He was employed on an industrial process to make aqueous, acidic chromium (III) sulphate solution (Cr2(SO4)3, 40% w/w) and Na2SO4, 8% w/w, and H2SO4 at pH 2–3 and 80°C. He became accidentally immersed up to his neck in a vat of this fluid and sustained 70% burns of variable thickness to the skin of the limbs, thorax, and abdomen. The face and neck did not come into contact with the fluid, and none was swallowed. He was transferred for intensive care; on arrival (two and a half hours after the accident) he was still conscious but shocked, with a pulse of 140/minute. There was no buccal erythema or ulceration and no evidence initially of cardiac, hepatic, or renal failure. The first results two and a half hours after the accident were haemoglobin 15.9 g/dl, PCV 0.44, MCV 79 fl, MCH 28.4 pg, WCC 40 × 109/l (90% neutrophils), reticulocytes 2%, platelets 170 × 1012/l. The blood film (fig 1) showed gross anisocytosis and red cell fragmentation with numerous microspherocytes. Plasma haemoglobin was 1.2 g/dl, prothrombin time 28 sec (normal 12 sec), partial thromboplastin time 70 sec (normal 37–45 sec), thrombin-fibrinogen time 16 sec (normal 11 sec), fibrinogen 1 g/l (normal 2.5–4.0 g/l), fibrin degradation products 11 mg/l (normal < 6 mg/l). Plasma sodium was 136 mmol/l, potassium 6.2 mmol/l, chloride 90 mmol/l, bicarbonate 13 mmol/l, urea 4.3 mmol/l, creatinine 0.13 mmol/l, calcium 2.4 mmol/l, glucose 16.0 mmol/l, bilirubin 29 µmol/l (normal 3–19 µmol/l), aspartate transaminase 298 IU/l (normal 6–50 IU/l). Arterial blood gases, breathing air, were PO2 113 mm Hg, PCO2 21 mm Hg. Urine microscopy showed 28 white cells and >100 red cells/mm³. Sputum culture grew Streptococcus pneumoniae and blood cultures grew Escherichia coli and Strep pneumoniae. The first chest radiograph was normal. Intravenous therapy was given and in the next 44 hours before death, in addition to the exchange transfusion, he...
samples of blood were obtained from a healthy volunteer. Triplicate portions of tissue (0.2 to 0.5 g) and blood (0.5 ml) were ashed with nitric acid. Residues were analysed by atomic absorption spectrometry using graphite furnace atomisation. All results quoted are the means of triplicate determinations. Analytical accuracy is estimated at ± 0.02 μg/g for both blood and tissue.

We obtained from the manufacturers a sample of the solution into which our patient was immersed. After adjusting to physiological pH, the solution was added to human blood in vitro to give chromium concentrations from 0.1 to 1 mg/ml and left at 37°C for 24 hours, and then the presence or absence of haemolysis and formation of Heinz bodies and burr cells were noted.

Results

Figure 2 shows the results of assays for chromium in blood. The chromium concentration in plasma exceeded that in red cells by a factor of 10. Plasma concentrations of chromium declined fairly rapidly for the first few hours, but this process later slowed down. The highest concentration of chromium, 47 μg/ml, obtained five and a half hours after exposure, showed that at least 176 mg of chromium was absorbed through the skin, assuming a plasma vol-

Material and methods

Blood samples for assay of chromium were collected into heparinised containers and the plasma and cells were separated and kept at −20°C together with samples of urine and faeces until just before analysis. Tissue samples obtained at necropsy done 28 hours after death were kept at −20°C. Control samples of tissue were obtained from a patient who had a necropsy on the same day, using the same instruments (after washing) as our patient. Control
Cromium content of tissues at necropsy

<table>
<thead>
<tr>
<th>Material</th>
<th>Chromium (µg/g)</th>
<th>Concentration ratio</th>
<th>Chromium (µg/g)</th>
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|                        | Our patients    | Control             | Patients of Fritz et al
|                        | Chromium toxicity |                     | 1               | 2               |
| Skin severely burnt     | 724             | —                   | 6.7             | —               |
| Skin slightly burnt     | 3.8             | 1.1                 | 12.0            | 0.9             |
| Skin not burnt          | 1.8             | 1.1                 | 15.3            | 5.4             |
| Faeces                  | 12-4            | 0.2                 | 59              | —               |
| Spleen                  | 7-5             | <0.05               | >150            | 10-6            |
| Liver                   | 5-5             | <0.05               | >110            | 8.9             |
| Bone                    | 5-5             | <0.05               | >110            | 8.0             |
| Lung                    | 4-7             | 0.3                 | 15-7            | 8-5             |
| Heart                   | 1-5             | 0.2                 | 7-2             | 2.5             |
| Duodenal contents       | 1-4             | —                   | 0.8             | —               |
| Muscle                  | 0-6             | <0.05               | >12             | 1.3             |
| Brain                   | <0.05           | <0.05               | 0.3             | 0.3             |

The effect of exchange transfusion was to lower the plasma concentration of chromium by 67% (from 5-9–1.9 µg/ml) and to lower the red cell concentration by 65% (from 0.43–0.15 µg/ml), over five hours, and the rate of removal from blood was greatly increased by this procedure (fig 2). During the eight hours after completing the exchange transfusion there were increases both in plasma and red cell concentrations of chromium. The quantity of chromium removed by exchange transfusion was 15-3 mg, most of this (15-0 mg) from plasma and only a trace (0-3 mg) from red cells.

Sequential blood films showed a decrease in the proportion of fragmented red cells even before the exchange transfusion began, with further improvement at the end. In addition, there were improvements in the coagulation abnormalities; at the start and finish of the exchange the prothrombin times were 26 and 17 sec respectively (normal 11–13 sec). In-vitro studies with the chromate solution and normal human blood showed no evidence of haemolysis and no Heinz body formation, but some burr cell formation was seen.

Necropsy showed 70% skin burns of variable thickness; pulmonary oedema; small haemorrhages on the tongue, oesophagus, ileum, and colon. Stomach and duodenum, liver, and heart were macroscopically normal; there was slight oedema of the cerebral hemispheres. Histological findings were: skin—no inflammatory reaction in the burnt areas but the underlying muscle was haemorrhagic; kidneys—mild interstitial oedema, dilatation and degeneration of the convoluted tubules, and granular and red cell casts in the collecting tubules; lungs—acute congestion; liver—swelling of centrilobular hepatocytes; small intestine and colon—mucosal necrosis; trachea and bone marrow—normal. There was evidence of disseminated intravascular coagulation.

Discussion

Since no oral absorption of chromium occurred, we may therefore compare and contrast our patient with two cases reported by Fritz et al in 1960. The clinical course in all three patients included renal failure. Patient 1 of Fritz et al was treated by peritoneal dialysis, and if our patient had survived longer he would have been given haemodialysis.

The extent and severity of burns in our patient were sufficient by themselves to have caused acute renal failure. Hexavalent chromium can cause acute renal failure, but trivalent chromium, to which our patient was exposed, is non-toxic. The tissue distribution of chromium was similar in the three patients with high concentrations in kidney and
spleen and much lower concentrations in muscle and brain (table). The concentration of chromium found in tissues correlated with the damage sustained. In our patient there was no increase in brain chromium, and he remained conscious and oriented. The total body burden of chromium (155 mg) was about 26 times the normal quantity of 6 mg. Blood concentrations of chromium were reduced by two-thirds by exchange transfusion (our patient), and by one-third by haemodialysis (patient of Fristedt et al). The amount of chromium removed by these means, however, is small compared with the total body content of chromium.

In vitro we were unable to show haemolysis with the chromic solution, so haemolysis in life was probably due to a combination of direct thermal injury to red cells and mechanical fragmentation of red cells in damaged capillaries.

High concentrations of chromium were found in severely damaged skin, and this may have been a depot from which chromium could still enter the blood, explaining the secondary increase in blood concentrations of chromium after the exchange transfusion. Possibly a far larger quantity of chromium would have been removed had plasma exchange been implemented at an earlier stage, with consequently less chromium available for uptake by the body tissues.

In conclusion, immediate plasmapheresis together with early excision of all chromium-containing skin may minimise absorption of chromium in a patient with extensive skin burns and chromium contamination.

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References