one study [6], 18% of cases with primary psoas abscess had a recent history of trauma, as well as four of the 10 pneumococcal primary psoas abscesses previously reported [2]. The clinical picture of pneumococcal primary psoas abscess is similar to that caused by any other microorganism, although meningitis may be an important complication [7–9]. No recent history of trauma was recorded in our two cases and no other previously described risk factors were found, other than a recent upper respiratory infection of unknown origin in one patient. Both patients were in their sixties, and adding this information to the four of nine cases previously published with an age over 60 years, advanced age may be considered a risk factor for pneumococcal primary psoas abscess, in contrast with other agents that occur mainly in younger patients [4].

Surgical drainage and antibiotic administration is the treatment of choice for psoas abscess. The first case did not require surgical drainage, although the initial purulent fluid obtained from the CT-guided aspiration might have played a role in abscess resolution. Infection in this patient resolved with meropenem, a broad-spectrum β-lactam, which was later changed to oral cefuroxime, as empirical treatment (both antibiotics being active for pneumococcal infection). Case 2 slowly improved after surgical drainage, but it was not until the ineffective empirical therapy was changed to cefotaxime, a highly effective cephalosporin for pneumococcal infection, that the patient fully recovered.

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REFERENCES


Transesophageal echocardiography and antibiotic prophylaxis for infective endocarditis

Transesophageal echocardiography (TEE) has increased sensitivity and specificity in comparison with the conventional transarterial procedure and it has replaced it for many indications [1]. Passage of the transducer through the oropharynx and proximal oesophagus may cause mucosal disruption with subsequent access of colonizing bacteria to the bloodstream [2]. The reported incidence of bacteremia following this procedure has ranged from 0 to 17% [3–5]. Nonetheless, the American Heart Association (AHA) considers TEE a low risk procedure for which antibiotic prophylaxis of endocarditis is not routinely necessary. We report a case of endocarditis arising after TEE in a patient with a prosthetic aortic valve. To our knowledge there has been only one previous report of this complication following TEE although some doubts as to the cause–effect relationship have been expressed [5].

In 1996 a 65-year-old male was admitted to our hospital with atrial fibrillation. The patient had had a biological aortic prosthetic valve placed in 1980. TEE showed a normally functioning prosthetic valve with normal atrial chamber and with no evidence of thrombi in the left auricle. Drug therapy failed to revert the fibrillation and electrical cardioversion was successfully performed. Twelve hours later the patient developed high fever with chills, and two blood cultures were positive for a group C streptococcus, subsequently identified as Streptococcus equisimilis. Over the following day seven of eight blood cultures grew the same micro-organism, which was sensitive to penicillin (minimum inhibitory concentration <0.03 (mg/L)). Penicillin (20 × 10^6 U/day) and gentamicin (3 mg/kg per day) were started. Shortly thereafter the patient developed headache and became obtunded; a CT scan showed two lesions consistent with arterial embolism. A second TEE revealed a moderate aortic valve insufficiency and a 12-mm valvular vegetation. The patient’s neurologic status rapidly worsened and a second CT scan showed further embolic lesions. An urgent aortic valve substitution was scheduled, but the patient’s condition rapidly deteriorated, and he died 8 days after the start of antibiotic therapy.

The reported incidence of post-TTE bacteremia varies between studies. Mente et al. [3] reported an incidence of 1.2% in intensive care unit patients who received antibiotic prophylaxis prior to TTE and 1.8% in those who received no
REFERENCES


Invasive *Streptococcus pyogenes* infection in a surgeon after an occupational exposure

Surgeons and other healthcare workers are at risk of developing an occupational infection caused by viral blood-borne pathogens such as hepatitis B (HBV) and C (HCV) viruses, and human immunodeficiency virus (HIV), and universal precautions for preventing these troublesome professional diseases have been properly provided [1]. Much less attention is paid to bacterial pathogens such as *Streptococcus pyogenes*, which can cause severe infections as well. We report the first—to our knowledge—documented invasive streptococcal infection occurring in a surgeon following accidental injury by a medical instrument.

A febrile 50-year-old woman with a voluminous uterine leiomyoma was admitted to our hospital for a suspected acute abdominopelvic pathology; she underwent hysterectomy and bilateral adnexectomy. The peritoneal cavity appeared to be filled with purulent material. During surgery, a 47-year-old obstetric–gynecologic surgeon accidentally pricked the inner side of his right middle finger with a pointed lancet. Unfortunately, a plan of action for the control of bacterial infection following occupational exposure did not exist in our hospital at that time, so the surgeon was included in a protocol for prevention of HBV, HCV and HIV transmission alone. Starting the following day, he noted the sequence of: (1) a small bullous lesion on his injured finger; (2) a few hours later, an erythematous edge all around the lesion, followed by serosanguinous discharge and evidence of a necrotic base; (3) within 36 h, fever of up to 39°C with shivers, and a red line of an ascending lymphangitis on his right arm, for which reason he began self-treatment with oral amoxycillin; (4) within 48 h, a right axillary lymphadenopathy. At this time, our colleague was admitted to the infectious disease unit with the diagnosis of bullous cellulitis. Physical and laboratory evaluation revealed: temperature, 38.8°C; blood pressure, 150/85 mmHg; erythrocyte sedimentation rate, 56 mm/h; leukocyte count, 5040/mm3. As the culture of peritoneal liquid intraoperatively obtained from the index patient grew a *S. pyogenes* strain susceptible to all the antibiotics tested (ampicillin, erythromycin, imipenem, penicillin G, piperacillin, teicoplanin, and vancomycin), we initiated intravenous therapy with penicillin G 4 mU every 4 h plus clindamycin 900 mg every 8 h. Such an aggressive therapeutic approach, recommended for severe streptococcal skin infections [2], was chosen because of the rapid progression of the disease. Defervesence was achieved within the second day, and the other physical signs progressively improved by the sixth day, when the surgeon was discharged with oral clindamycin 900 mg.