Case Report

Capnocytophaga sputigena primary iliopsoas abscess


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Iliopsoas abscess is usually secondary to the spread of infection from a contiguous focus. Primary disease is uncommon, except in children where Staphylococcus aureus is the main pathogen. We report a 60-year-old woman who developed a primary iliopsoas abscess as a result of haematogenous spread of Capnocytophaga sputigena from a palatal fistula and chronic sinusitis due to previous treatment for nasopharyngeal carcinoma. Pyomyositis due to unusual and fastidious Gram-negative bacilli should be considered in patients with head and neck tumours who have previously received radiotherapy.

Introduction

Pyomyositis of the iliopsoas muscle used to be an uncommon condition until recently. The increasing number of cases reported in the past few years has been attributed to the greater availability of imaging techniques, an ageing population and the increasing number of immunocompromised hosts (Navarro López et al., 2009). The classical clinical manifestations include fever, lower abdominal or back pain, and referred pain to the hip or knee. However, the symptoms and signs may be non-specific in the early phase of the disease. Iliopsoas abscess is usually secondary to contiguous spread from adjacent foci of infection, such as the spine, gastrointestinal and urinary tracts, intra-abdominal vessels, and decubitus ulcers. In these cases, Mycobacterium tuberculosis from spondylitis and gastro-intestinal or urinary tract flora, such as Enterobacteriaceae, enterococci and anaerobes, are the usual pathogens. Primary iliopsoas abscess can occasionally result from haematogenous spread from a distant site and is usually found in children where Staphylococcus aureus is the predominant causative organism. With the exception of viridans streptococci (Navarro López et al., 2009) and Haemophilus aphrophilus (Chien et al., 2009), component organisms of the human oral flora have not been found in cases of primary iliopsoas abscess. We report what is believed to be the first case of primary iliopsoas abscess caused by Capnocytophaga sputigena in a patient with a history of nasopharyngeal carcinoma complicated by post-treatment palatal fistula.

Case report

A 60-year-old Chinese woman presented with fever and right groin pain for 5 days. She had a past history of left hip tuberculosis 40 years ago, and nasopharyngeal carcinoma treated with surgery and radiotherapy 9 years ago, which was complicated by bilateral temporal radionecrosis, chronic sinusitis and palatal fistula. Physical examination showed she had a temperature of 38.0 °C and tenderness over the right groin. Computed tomography (CT) scans of the abdomen and pelvis revealed two rim-enhancing collections suggestive of intramuscular abscesses at the right iliopsoas and right rectus femoris muscles measuring 1.2 cm × 1.1 cm × 3.5 cm and 1.2 cm × 0.5 cm × 4.5 cm, respectively (Fig. 1). Magnetic resonance imaging of the lumbosacral spine did not reveal any evidence of primary bone or joint infection. Ultrasound-guided aspiration of the right iliopsoas abscess yielded a small amount of turbid fluid. Gram, Grocott and Ziehl–Neelsen stains of the aspirate were negative for micro-organisms, and routine culture under aerobic and anaerobic conditions on blood, chocolate and MacConkey agars revealed no growth after 7 days of incubation. The aspirate injected into the anaerobic blood culture bottle (BACTEC Aerobic/F and Anaerobic/F; Becton Dickinson) for enrichment became positive on day 3 of incubation. Tiny non-haemolytic colonies of Gram-negative bacilli appeared on 5 % sheep blood agar after 2 days of incubation in 5 % CO2 at 37 °C. The bacterium was oxidase and catalase negative. Two Vitek identification systems (GNI and ANI; bioMérieux) gave conflicting results and identified the organism as Acinetobacter Iwoffii/Acinetobacter junii and Capnocytophaga species with 64 and 99 % confidence levels, respectively. 16S rRNA gene sequencing using the MicroSeq 500 identification system was performed on the isolate, which was shown to be 100 % homologous with the C. sputigena sequence. The organism showed susceptibility to penicillin, ampicillin, cefuroxime, erythromycin, clindamycin, levofloxacin and tetracycline.

The patient’s symptoms responded to percutaneous drainage and 1 g oral amoxicillin–clavulanate twice per
first to describe *C. sputigena* as a sole cause of primary iliopsoas abscess, which has traditionally been associated with *S. aureus* in children.

The reason why *C. sputigena* caused a distant pyomyositis in this patient is uncertain. The prior radiotherapy to the head and neck region for the treatment of nasopharyngeal carcinoma was likely an important predisposing factor as local irradiation is associated with changes in the oral microbiota, which is sometimes related to xerostomia. In a study on nasopharyngeal carcinoma patients who had previously received radiotherapy for treatment, the prevalence of *Capnocytophaga* species in subgingival plaques ranged from 17 to 44%, in contrast to 0% in healthy subjects (Leung *et al.*, 1998). These patients may therefore be prone to metastatic Gram-negative infections when there is a breakdown of the mucosal barrier. An analogy is seen in the high prevalence of Gram-negative bacillary meningitis in patients with nasopharyngeal carcinoma (Huang *et al.*, 2003). Another important predisposing factor for metastatic capnocytophagal infection is concomitant oral pathology as described in a case of vertebral osteomyelitis (Duong *et al.*, 1996). Although bacteraemia is almost certainly a preceding event in these patients, the fact that it might have occurred transiently prior to the development of distant infections means that it may not be detectable on presentation. Also, the only set of blood cultures from our patient was taken after two doses of oral amoxicillin–clavulanate, which may also explain the negative culture results.

Most *Capnocytophaga* strains are susceptible to β-lactam/β-lactamase inhibitor combinations, clindamycin, tetracycline, chloramphenicol, linezolid and imipenem, and resistant to polymyxin, fusidic acid, fosfomycin, colistin and trimethoprim. Susceptibility to other classes of antibiotics varies (Jolivet-Gougeon *et al.*, 2007). While β-lactams and quinolones are often used as the first-line treatment for such infections, resistant strains capable of causing serious infections have been reported elsewhere (Gomez-Garces *et al.*, 1994; Matsumoto *et al.*, 2008). We believe that in patients who have a history of head and neck tumours treated with radiotherapy, empirical therapy for musculoskeletal infections should include additional Gram-negative coverage whilst culture results are pending.

As host factors significantly affect the aetiology of primary iliopsoas abscess, accurate identification of the causative organism is crucial. CT-guided aspiration of the abscesses must be considered in all patients to assist in the choice of antimicrobial therapy. The importance of obtaining cultures prior to the commencement of antibiotics – except in patients with fulminant sepsis – cannot be overemphasized. Routine laboratory cultures may miss infections caused by fastidious and slow-growing pathogens such as *Capnocytophaga* spp., especially in patients who have been put on antibiotics. The increasing availability of molecular methods such as 16S rRNA sequencing facilitates the rapid identification of these unusual pathogens, which may
otherwise be misidentified by traditional laboratory techniques and commercially available identification systems.

References


