Herein, we describe the first case of a spontaneous breast abscess due to \textit{M. fortuitum} and associated with a reactive arthritis. Tuberculous infections of the breast are rare in the developed world [5]. A survey of 6,000 patients in Dallas, presenting over 10 years, identified only a single case of mammary tuberculosis [6]. However, \textit{M. fortuitum} infection has been associated with breast surgery. One series reported 17 cases of periprosthetic infection due to \textit{M. fortuitum} complex (\textit{M. fortuitum} and \textit{M. chelonae}) after augmentation mammoplasty over 3.5 years [7]. Infection was limited to the periprosthetic space, and microbiological diagnosis was delayed for at least 1 month for 10 patients. No evidence of a contaminated product or a single source of infection was found, although clusters of infection were related both temporally and geographically. There are also reports of \textit{Mycobacterium avium} complex isolated from a silicone injection–augmented breast [8] and of \textit{M. chelonae} isolated from a spontaneous breast abscess in a healthy, nonlactating 46-year-old woman [9].

In conclusion, it is essential that specimens of all breast and other soft-tissue abscesses be sent for mycobacteriological as well as standard microbiological culture to avoid delay in diagnosis, increased tissue destruction, and consequent morbidity.

\textbf{References}


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\textbf{Intestinal Tuberculosis with Associated Coloduodenal Fistula}

Intestinal tuberculosis with coloduodenal fistula is rare and can be easily confused with Crohn’s disease [1]. We describe the second case of a tuberculous coloduodenal fistula [2]. Distinguishing this condition from Crohn’s disease is important because delayed diagnosis may lead to increased morbidity and mortality [1].

A 25-year-old man was admitted to the hospital because of right-lower-quadrant abdominal pain, fever, and diarrhea of 1 month’s duration and a 9-kg weight loss. The patient had emigrated from Mexico 8 months before and had no known exposure to tuberculosis or history of consumption of unpasteurized milk. He denied high-risk sexual behavior, iv drug use, and prior transfusion of blood products. The fever had been intermittent and was associated with chills and night sweats and the passage of watery stools five times per day, without hematochezia. Physical examination revealed a well-developed male. His temperature was elevated to 39.4°C. There was mild enlargement of the supraclavicular, axillary, and inguinal lymph nodes. The abdomen was tender in the right lower quadrant; there was no rebound tenderness.

He was negative for antibodies to HIV-1 on ELISA. A tuberculin skin test (5 TU) was negative. Intradermal mumps antigen was nonreactive. Findings on the chest and abdominal radiographs were normal; however, a barium study of the small bowel demonstrated a fistula between the duodenum and the ascending colon (figure 1). A colonoscopy showed ulceration, “cobblestoning,” and aphthous ulcers in the ascending colon, cecum, and terminal ileum, suggestive of Crohn’s disease.

Histological examination of biopsy specimens obtained from the ileum and cecum showed a mixed acute and chronic inflammatory infiltrate in the lamina propria as well as noncaseating granulomas. Numerous acid-fast bacteria were present throughout the specimens; consequently, isoniazid, rifampin, and pyrazinamide were administered on the seventh hospital day. The patient deferred sex within 24 hours and soon showed other signs of clinical improvement. Cultures of the biopsy specimens yielded \textit{Mycobacterium tuberculosis}.

In the United States, the incidence of intestinal tuberculosis has been increasing since the mid-1980s, with the greatest rise seen among HIV-infected patients and immigrants from developing countries [1]. The most frequent site of involvement is the ileocecum (85%–95% of the cases) [1]. The symptoms of intestinal tuberculosis are nonspecific and include abdominal pain, diarrhea, weight loss, fever, lower gastrointestinal bleeding, and ascites [3]. An abdominal mass, usually in the right lower quadrant, is palpable in 25%–50% of patients. [3]. About 75% of these patients have positive tuberculin skin tests [1]. Findings on chest radiographs are abnormal for only 20% of patients with intestinal tuberculosis [4].

It may be difficult to distinguish Crohn’s disease from tuberculosis, since the clinical and the radiological findings can be identical [5]. Histological confirmation of the presence of acid-fast bacilli...
The complications of intestinal tuberculosis are obstruction, perforation, fistulae, lymphadenitis, malabsorption, and gastrointestinal bleeding [3, 10]. Surgery should be reserved for those cases with complications that do not respond to conservative treatment [1]. In equivocal cases, a therapeutic trial with antituberculous drugs may be undertaken [1, 6]. The response to this therapeutic regimen is usually dramatic, as in our case.

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References


Purulent Pericarditis with Associated Cardiac Tamponade Caused by a Streptococcus pneumoniae Strain Highly Resistant to Penicillin, Cefotaxime, and Ceftriaxone

Purulent pericarditis due to Streptococcus pneumoniae is a serious complication of pneumonia. Although the number of cases has decreased significantly since the introduction of penicillin, pneumococcus remains one of the most frequently isolated bacteria [1, 2].

The prevalence of penicillin-resistant pneumococci has increased progressively in the United States. In a recent study of 1,527 isolates collected from outpatients between 1994 and 1996 [3], 14% of the isolates were found to be intermediary resistant, and 9.5% were highly resistant to penicillin.

Serious infections caused by S. pneumoniae resistant to cefotaxime and ceftriaxone are also a potential problem. There are reports of treatment failure with these antibiotics in cases of meningitis [4] and endocarditis [5] due to S. pneumoniae. The increase in strains resistant to penicillin and cephalosporins should alert physicians to the potential for the reemergence of pneumococcal pericarditis. We describe a case of purulent pericarditis due to S. pneumoniae highly resistant to penicillin, cefotaxime, and ceftriaxone.

A 78-year-old woman with non–insulin-dependent diabetes mellitus was admitted to the hospital with a history of productive cough, fever, chest pain, and progressive dyspnea of 1 week’s duration. Physical examination revealed a temperature of 38°C, pulse of 160 min, blood pressure of 90/50 mm Hg, and respiratory rate of 30. The patient’s neck veins were distended, and bilateral basilar rales were heard on auscultation of the lungs. The heart sounds were irregular and distant, and a friction rub was present.

Laboratory studies revealed the following values: hemoglobin level, 12.9 g/dL; hematocrit, 36.6%; WBC count, 27,000/mm³ (90% granulocytes); serum creatinine level, 3.3 mg/dL; and glu-