Local Spread of Molluscum Contagiosum by Electrolysis

Molluscum contagiosum is a communicable viral disease that is confined to the skin. Molluscum contagiosum manifests itself as smooth-surfaced, firm, spherical papules with umbilication of the vertex [1]. The lesions may be flesh-colored, white, translucent, or yellow and range from 1 mm to 15 mm in diameter, although most are 2 mm to 5 mm in diameter [1–3].

We report herein a case of molluscum contagiosum, likely contracted through sexual contact, that was subsequently disseminated and exacerbated by electrolysis for permanent hair-removal.

A 24-year-old man presented with complaints of a rash on his lower abdomen, pubic area, and both inner thighs. He stated that 6 months previously, the rash appeared as three pimples: two located on his lower abdomen and one on his penis. Two months before presentation, he began undergoing electrolysis (thermolysis) to remove the hair from both inner thighs for cosmetic purposes. During this time, the patient had nine electrolysis treatments. The patient indicated that during one treatment the electrologist mistakenly interpreted the abdominal “pimples” as ingrown hairs and inserted the electrolysis needle to remove the hairs in order to expedite healing. Using the same presumably contaminated needle, the electrologist continued to remove the hair from the inner thighs.

Physical examination revealed that the patient had ~200 firm, raised flesh-colored papules ~1–2 mm in diameter in clusters throughout the area of his inner thighs, lower abdomen, and genitals. Lesions were restricted to the genital area and areas where the patient received electrolysis treatments. The diagnosis of molluscum contagiosum was made clinically on the basis of the appearance of multiple umbilicated papules.

The patient reported multiple sexual contacts, was counseled regarding the risks of infection with HIV and other sexually transmitted diseases, and was referred for HIV infection testing. Upon follow-up, this test result was negative by ELISA. The lesions were treated topically with cantharidin 1% (a blistering agent) six times over 2 months, resulting in complete resolution. There has been no recurrence in >1 year of follow-up.

Electrolysis, a permanent hair-removal technique, involves the use of any of three different methods: galvanic electrolysis, thermolysis, or the blend method. In galvanic electrolysis, a needle (0.005–0.015 mm in diameter) is inserted into the hair follicle and a direct electric current acts on the tissue to produce sodium hydroxide (lye), which destroys the hair bulb [2]. During thermolysis, a high-frequency alternating current is passed down the needle to produce heat in the follicular tissue by molecular vibration [2]. The blend method combines galvanic electrolysis and thermolysis.

Despite relaxed guidelines and training requirements, there have been no reports of HIV infection, hepatitis B, hepatitis C, or other infectious complications associated with electrolysis, as there have been with tattooing, body-piercing, and intramuscular injection [3–4]. However, previous reports described the spread of sporotrichosis [5] and flat warts (verrucae planae) [6] through electrolysis.

We believe that our patient had sexually transmitted molluscum contagiosum that was locally disseminated by direct and repeated percutaneous reinoculation with an electrolysis needle. Electrologists and health care workers need to be aware that the percutaneous exposures of depilatory needles used during electrolysis can spread and transmit infectious agents. In this case, molluscum contagiosum was spread locally in the same individual. However, the spread of infection from one individual to another should be considered by cosmetic professionals whose occupation involves percutaneous exposure.

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References

Guillain-Barré Syndrome as First Manifestation of Typhoid Fever

Guillain-Barré syndrome (GBS) is an immune-mediated polyneuropathy that has often been associated with a variety of infectious agents [1, 2]. There are, however, very few reports of GBS associated with typhoid fever [3–6], and in these cases, GBS occurred generally as a late complication of the infection. We report here on GBS as the first manifestation of typhoid fever.

A 47-year-old woman was admitted to the hospital because of progressive weakness of her limbs, which had begun a week previously. She had initially presented with cervical pain and paresthesias in both legs, and later developed progressive ascending weakness that finally involved all four limbs. There were neither gastrointestinal symptoms nor fever. On admission, she was afebrile, and a neurological examination showed peripheral right facial palsy, flaccid tetraparesis (mainly in her lower limbs), and
areflexia. Her sensation was normal, and the physical examination was otherwise unremarkable. Testing of CSF revealed albuminocytologic dissociation (protein concentration of 419 mg/dL, and no cells). An electrophysiological study showed increased distal motor latencies, slowed motor conduction velocities, and absence of F waves; sensory parameters were normal. MRI of her neck revealed normal findings. A diagnosis of GBS was made, and she was given intravenous human immunoglobulin (0.4 g/[kg·d]). However, her clinical condition deteriorated over the next 3 days; she developed respiratory failure and had to be ventilated. At that time, extensive laboratory investigations gave the following cross-reacted with myelin gangliosides [1, 2], leading to the development of GBS.

The sequence of events in the present case was, therefore, compatible with such a mechanism. In other words, non–T cell–dependent IgM antibodies generated against certain components of the bacterial capsule would have cross-reacted with myelin gangliosides [1, 2], leading to the development of GBS.

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References

Bacteremia Due to *Capnocytophaga* Species in Patients with Neutropenia: High Frequency of β-Lactamase-Producing Strains

Anaerobes and fastidious gram-negative bacteria are rarely responsible for bacteremia in patients with neutropenia. Their incidence was found to be 3% in 909 episodes of bacteremia in the experience of the M. D. Anderson Cancer Center [1] and to be 0.5% in 513 febrile neutropenic episodes in a recent French survey [2]. *Capnocytophaga* bacteremia has been reported occasionally in neutropenic patients with hematologic malignancies. In 1992, Bilgrami et al. [3] collected 15 reports of infection occurring in 44 immunocompromised patients. Most of these patients had chemotherapy-induced oral mucositis. Recently, the emergence of β-lactamase-producing strains of *Capnocytophaga* has been suggested in several microbiologic studies, but in only a few clinical reports in neutropenic patients [4–6]. The present report is the largest original series of neutropenic patients with *Capnocytophaga* bacteremia to date.

Between November 1987 and April 1997, in the adult and pediatric (ages, 1–51 years) departments of hematology of our institutions, *Capnocytophaga* species were isolated from at least one blood culture sample during 25 febrile episodes occurring in 24 patients. During the last 6 years, *Capnocytophaga* bacteremias represented 1.3% of the bacteremic episodes in our patients.

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