ascribed to her uraemia. Treatment was commenced with sulindac.

Several days later she was admitted with fever and diarrhoea. Stool and blood cultures grew *Salmonella dublin* which was treated with a 3-week course of ampicillin. The source appeared to be precooked turkey bought in a local shop. A good clinical recovery was made. One month later, however, the patient re-presented with chest pain and dyspnoea. Pericardial tamponade was suspected and emergency pericardiocentesis was performed releasing 500 ml of pus. Culture of this revealed growth of *Salmonella dublin* and *Morganella morganii* which was treated with intravenous antibiotics. The blood film revealed a recurrence of her myeloma and despite therapy death occurred several days later.

Non-typhoidal salmonella pericarditis is very rare, with less than 25 cases reported in the literature. This is the first case reported due to *Salmonella dublin* which is endemic in cattle causing acute enteritis and spontaneous abortion. Human isolations are uncommon, but in one third of cases this organism was grown from the blood, making this a relatively invasive organism with commensurate ability for causing serious extra-intestinal disease.

Our patient had a number of features predisposing to infection including renal failure, multiple myeloma and previous immunosuppressive therapy. Presumably the area of pericardial inflammation due to uraemia was a fertile nidus for infection during the bacteraemic phase. The failure of ampicillin to eradicate the organism in spite of *in vitro* sensitivity, may have been due to her immunosuppression although relapse after treatment is well-known, even in healthy individuals. A longer course of antibiotic treatment with the addition of a second agent such as co-trimoxazole or chloramphenicol may be desirable.

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Reference


Primary abdominal actinomycosis – an unusual presentation

Sir,

We report a case of primary actinomycosis that presented in a unique manner that suggested a rectus sheath haematoma.

A 61 year old man presented with a 3-week history of increasingly severe right sided abdominal pain. It began after an episode of heavy lifting, was worse on coughing and moving and was not relieved by a 7 day course of erythromycin. On examination he had a pyrexia of 37.5°C with a tender fluctuant swelling overlying the right rectus abdominus muscle. A diagnosis of rectus sheath haematoma was made but incision of the anterior rectus sheath revealed a large cavity containing foul smelling pus. A small yellow granule was seen and this was sent with the pus for immediate microbiological examination. The posterior rectus sheath and peritoneum were intact. The cavity was cleaned and a corrugated drain inserted. Microscopy of the ‘sulphur granule’ and pus revealed Gram-positive branching bacilli but no growth of actinomyces was obtained on culture. The patient was started on penicillin and was discharged from hospital after 5 days. A barium meal, follow-through and enema were all normal, confirming the diagnosis of primary actinomycosis. He remained well and was discharged from follow up after 3 months treatment.

Actinomycosis is an infectious disease, usually caused by *Actinomyces israelii*, a Gram-positive branching anaerobic bacterium. Abdominal actinomycosis has a predilection for the right iliac fossa and occurs following appendicectomy or abscess drainage. When the intestinal mucosal barrier is destroyed by disease or trauma the actinomyces can penetrate into adjacent tissue and become pathogenic. The resulting pus contains ‘sulphur granules’, which are hard, gritty, yellow granules 2 mm in diameter. Each represents a mycellial mass cemented together by host calcium phosphate in response to inflammation. Treatment is by surgical drainage followed by a prolonged course of high-dose penicillin. Primary actinomycosis of the abdominal wall is extremely rare. Its occurrence in the absence of an associated lesion in the gastro-intestinal tract is unexplained. In the few reported cases it has presented as a chronic disease mimicking an intra-abdominal malignancy. Actinomyces was not cultured in this case, but any antibiotic treatment is likely to suppress growth sufficiently to render cultures negative. We can find no previous report of primary abdominal actinomycosis presenting with acute abdominal pain.

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References


Intestinal spirochaetosis in HIV infected homosexual men

Sir,

Digestive tract infection is frequent in human immunodeficiency virus (HIV) seropositive subjects and numerous microorganisms have been implicated. Intestinal spirochaetosis should probably be added to the list.

We recently diagnosed intestinal spirochaetosis in two
homosexual men aged 32 and 33 who were examined for an episode of diarrhoea persisting for a 3 month period without fever nor significant modification of general health. Their HIV infection was classed in the CDC group III for the first patient and group IV CI for the second with 469 and 67 T4 lymphocytes/mm³ respectively and a positive HIV antigen test in both cases. No pathological agents could be isolated from stools. Gastric and colic fibroscopies were normal as were duodenal biopsies. However, the surface of the colonic epithelium presented a bluish border formed by multiple rod shaped formations (Figure 1) which electron microscopy identified as spirochaetes. After anaerobic culture in calf blood enriched medium, they were identified as close to the Brachyspira gender described earlier.1 Syphilis, leptospirosis and borreliosis serological tests were negative as was the search for all other pathological agents. Macrolide therapy in the first patient and cycline in the second were unsuccessful and clinical and bacteriological cures were obtained only after the prescription of metronidazole.

Spirochaete infection of the human digestive tract has been known since the end of the 19th century2 and its frequency can reach 36% in homosexuals.3 Certain authors3-6 doubt any pathogenic role due to the absence of histological signs of invasion or inflammation or clearly correlated clinical symptomatology. Conversely, others5-6 believe it could be a cause of diarrhoea as in animals (swine dysentery). To our knowledge, human intestinal spirochaetosis has been described three times in cases of HIV infection.5-8 Systematic colonic biopsy when no endoscopic abnormality is observed could be useful to determine the incidence and responsibility of spirochaetes in diarrhoea syndromes of unexplained origin.

![Figure 1](http://pmj.bmj.com/)

**Figure 1** Presence of a bluish border on the edge of the colonic epithelium corresponding to the spirochaetes (Haematoxylin and eosin × 450).

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A. Lafeuillade, R. Quilichini, T. Benderitter, E. Delbeke, C. Dhiver and J. A. Gastaut

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