Tropical pyomyositis, a disease often seen in tropical countries, is characterised by suppurative within skeletal muscles, manifesting as single or multiple abscesses. The most common organism implicated is Staphylococcus aureus. In 20%–50% of cases there is a history of trauma to the affected muscles. Commonly involved muscles are quadriceps, glutei, pectoralis major, serratus anterior, biceps, iliopsoas, gastrocnemius, abdominal and spinal muscles. Early diagnosis is often missed because of lack of specific signs, unfamiliarity with the disease, atypical manifestations, and a wide range of differential diagnosis. Diagnostic techniques like ultrasound and computed tomography/magnetic resonance imaging are very useful in diagnosis. The diagnosis is confirmed either by biopsy or aspiration of pus from the affected muscles. The initial antibiotic of choice is cloxacinil. Incision and drainage are important components of management. Treatment for Gram negative or anaerobic organisms should be instituted, whenever indicated. Physicians should become more familiar with this potentially life threatening but curable infective disease entity.

PREVALENCE AND INCIDENCE
Tropical pyomyositis is common throughout the tropics and has been widely reported from Asia, tropical Africa, Oceania, and the Caribbean islands. It accounts for 1%–4% of all hospital admissions in some tropical countries. In Uganda about 4% of all hospital admissions and in Ecuador 2.2% of all surgical admissions have been reported as due to tropical pyomyositis. In India it has not been widely reported but there have been sporadic case reports. Tropical pyomyositis is also being increasingly reported from temperate regions. Recent data indicate that up to 75% cases of tropical pyomyositis in temperate areas are immunocompromised—HIV infected, or with diabetes, leukaemia, chronic renal failure, asplenia, scleodermatous, rheumatoid arthritis, or Felty’s syndrome—while some patients have been on cancer chemotherapy or immunosuppressive drugs after transplantation of solid organs. Tropical pyomyositis has also been described after bicycle accidents and vigorous exercise. The incidence of tropical pyomyositis in HIV infected patients with or without AIDS is around 31%. Although cases are seen throughout the year, maximum incidence is from July to September (the monsoon season).

AETIOLOGY
Staphylococcus aureus is the organism most commonly cultured from the abscess. It is seen in up to 90% of cases in tropical areas and 75% of cases in temperate countries. Group A streptococcus accounts for another 1%–5% of cases and other organisms uncommonly implicated are streptococcus (groups B, C, G), pneumococcus, neisseria, haemophilus, aeromonas, serratia, yersinia, pseudomonas, klebsiella, and escherichia. Rarely salmonella, citrobacter, fusobacterium, anaerobes, and mycobacterium are seen.

In tropical regions, pus cultures are sterile in 15%–30% cases and 90%–95% of patients also, have sterile blood cultures. Blood cultures are positive in 20%–30% of cases in temperate regions. Better microbiological culture techniques in the temperate regions may account for these variations.
Pyomyositis is an intriguing disease of unclear pathogenesis. Organisms reach skeletal muscles during transient bacteremia. Skeletal muscle tissue is intrinsically resistant to bacterial infections under normal circumstances. It is thought that there is sequestration of iron by myoglobin, which is an essential nutritional requirement of proliferating bacteria. This results in slower growth of bacteria, allowing bacterial infections under normal circumstances. It is postulated that abundant iron is available after trauma, resulting in profuse growth of bacteria.

It has also been suggested that an abnormality of the immune system may be the underlying cause in many cases. Some researchers have observed that the lymphocytes, particularly T-cells, in patients with pyomyositis are not primed adequately against staphylococcus during the course of infection. Other predisposing factors include a preceding viral infection (especially arbovirus) or nematode infection (Dracunculus medinensis) but their role in pathogenesis is uncertain. Moreover, as these abscesses are intermuscular rather than intramuscular, they should not be included under tropical pyomyositis.

Intravenous drug abuse is another important risk factor for pyomyositis. The factors responsible are impaired cellular and humoral immunity, defective bactericidal capacity of neutrophils, increased bacterial colonisation of skin, and direct injection of contaminated materials.

Tropical pyomyositis is also increasingly documented in persons infected with HIV. Mechanisms include muscle damage caused by HIV infection per se, zidovudine therapy, infections caused by parasites and mycobacteria, and impaired host defences including dysfunction of helper T-cells and granulocytes. In some studies, it has been demonstrated that the CD4 counts are less than 150/μl in such cases. Also, those with HIV infection have an increased incidence of staphylococcus carrier state compared with those not infected with HIV.

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screening tool for reasons of economy and easy availability. Hypoechoic areas with an increase in muscle bulk are seen on ultrasound. 57 Computed tomography/magnetic resonance imaging (MRI) are the best imaging techniques for early diagnosis. 36 Computed tomography shows areas of low attenuation with loss of muscle planes and a surrounding rim of contrast enhancement as characteristic of pyomyositis. Computed tomography is also useful in differentiating tumours, haematoma, and thrombophlebitis from abscess. 37 However, at times a computed tomogram alone may be unreliable in distinguishing muscle abscess from swollen muscles. 36 MRI shows hyperintense rim on T1 weighted images with peripheral enhancement on gadolinium DTPA scan. 57 A case has been reported in which areas of signal attenuation were visible on MRI but a computed tomogram was normal. 64 Also, MRI is the imaging modality of choice for pelvis. 57 Therefore, MRI may be a better modality than computed tomography for early diagnosis. Gallium scintigraphy is an extremely sensitive tool, but its inability to provide anatomic details, lack of specificity, and high cost reduces its usefulness. It is best reserved for a group of patients in which clinical suspicion is high but computed tomography/MRI is inconclusive. It is also utilised for detecting unsuspected but possible metastatic abscess. 61–63

Laboratory investigations reveal anaemia, leucocytosis (shift to the left), raised erythrocyte sedimentation rate, and acute phase reactants. In an asymptomatic patient with muscle mass and no other features of infection (fever, chills, erythema) but who has leucocytosis and raised erythrocyte sedimentation rate, pyomyositis should be suspected. In cystickercosis and trichinosis, eosinophilia is present. Blood cultures have low positivity, varying from 5%–10% in the tropics to 20%–30% in temperate regions 60 70 but are essential in all suspected or proven cases. Serum levels of muscle enzymes—that is, aldolase, creatine phosphokinase, amino-transferase, and lactate dehydrogenase—are normal or slightly raised despite evidence of muscle destruction. 64 Raised creatine phosphokinase along with characteristic electromyography changes (short duration, low amplitude polyphasic potentials), favour the diagnosis of polymyositis. Deranged liver and renal functions, along with fever and severe diffuse muscle pain, must be considered in leptospirosis that is confirmed by serological tests. Immunodeficient states must be ruled out and tests for HIV, diabetes, rheumatological disorders, and malignancies should be carried out, along with immunoglobulin levels.

TREATMENT

Once diagnosis is established, attention should turn to aggressive management. Surgical debridement and drainage, accompanied by parenteral antistaphylococcal β-lactamase resistant penicillin (cloxacillin 1–2 g every six hours), is the initial recommended treatment. Diffuse myositis without abscess may respond to an antimicrobial agent alone but abscess may develop eventually requiring drainage. In most clinical settings, treating S aureus infection with more than one drug, to which the organism is known to be susceptible, attains no significant benefit. Penicillin is the drug of choice for infections caused by penicillin susceptible staphylococcus. Drug combinations of penicillin with β-lactamase inhibitor are also effective but are best reserved for treatment of mixed infections. In case of penicillin allergic subjects, first generation cephalosporin (cefaclor) may be preferred for reasons related to cost, potency, and breadth of spectrum. For methicillin resistant staphylococcus, vancomycin in a dose of 15 mg/kg to a maximum of 1 g, given every 12 hours is a suitable alternative. Another glycopeptide, teicoplanin, in a dosage of 400 mg/day in a single dose is equally effective. For vancomycin intermediate sensitive staphylococcus, linzolid or dalfopristine-quinupristine are effective alternatives. 57

If group A streptococcus is isolated from the pus, treatment should be changed to crystalline penicillin, while awaiting culture and sensitivity reports. 49 For Gram negative bacilli, addition of an aminoglycoside, that is, gentamicin in doses of 5–6 mg/kg/day intravenously, should be considered in addition to cephalosporins. The possibility of associated anaerobic infection is an indication for introducing metronidazole (20–30 mg/kg/day) intravenously or orally at intervals of eight hours.

For HIV infection and immunosuppressed patients, broad spectrum empirical antibiotics against Gram positive, Gram negative and anaerobic organisms should be administered. In addition to antistaphylococcal antibiotics, patients should also receive aminoglycosides and clindamycin.

Secondary spread of metastatic infection from involved muscles usually requires four to six weeks of parenteral high dose antimicrobial therapy. Otherwise, treatment should be continued till wound is clean, the leucocyte count becomes normal, and the patient is afebrile for 7–10 days. Continuation or recurrence of fever after surgical drainage while the patient is receiving appropriate antimicrobials suggests the presence of other foci, development of drug resistance or, less commonly, drug fever.

Although there are no recommendations to prevent pyomyositis, it is believed that nasal carriage should be eliminated in patients with a history of pyomyositis or beta-lactamase staphylococcal infection. 55 It should be treated with topical mupirocin nasal formulation. Alternatives include rifampicin (600 mg each day) or cloxacillin (500 mg four times a day) for 10 days.

PROGNOSIS

The natural history is progressive suppuration with either spontaneous drainage and gradual resolution or eventual bacteraemia, and secondary infection leading to fatal outcome. Despite advances in diagnosis and treatment, mortality varying from 0.5% to 2% still occurs. 7 12

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