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A Pilot with Pain in His Leg: Thigh Abscess Caused by *Salmonella* enterica Serotype Brandenburg

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*Salmonella enterica* serotype Brandenburg is one of the more uncommon serotypes isolated from patients with gastroenteritis. Few cases of extraintestinal infections with serotype Brandenburg have been documented. The first case of a serotype Brandenburg-dependent thigh abscess originating from an atherosclerotic pseudoaneurysm of the femoral artery is reported.

**CASE REPORT**

During a medium-distance flight, a 57-year-old male Caucasian pilot suddenly experienced sharp pain in his right thigh followed by fever. The patient had hypercholesterolemia and non-insulin-dependent diabetes mellitus regulated by diet. In addition, he had previously experienced mild claudicatio intermittens in his right leg and had thus been prescribed acetylsalicylic acid. On the following day, he was seen by his general physician, who found no signs of deep venous thrombosis and prescribed diclofenac for symptomatic relief. During the subsequent week, the thigh swelling increased and the fever persisted. Five days after the initial symptoms, a tender nonfluctuating mass measuring 10 by 15 cm was found in the right thigh adjacent to the groin. A fine-needle puncture of the mass yielded blood only. A week later, magnetic resonance tomography of the thigh showed an extensive swelling surrounded by soft-tissue edema (Fig. 1A and B). A pseudoaneurysm of the right femoral artery with collateral circulation was identified by intravenous angiography (Fig. 1C). Empirical antibiotic therapy with difloxacillin (750 mg three times orally) was initiated. However, the patient’s condition deteriorated with expansion of the soft tissue mass and persistent fever. The patient was admitted to the hospital. On admission, the leukocyte count was 16.6 × 10⁹/liter with a predominance of neutrophils, the erythrocyte sedimentation rate and C-reactive protein level were 84 mm/h and 160 mg/liter, respectively, and the hemoglobin level was 124 g/liter. Liver and renal function tests were normal. Therapy with intravenously administered cefuroxime was initiated, after which the fever disappeared; line titers of 1/40 (cutoff 1/10) for typhoid and paratyphoid O antigens were observed. The qualitative agglutination test (Bio-Rad) consisted of antigens recognizing, among others, the O antigens 1, 4, and 12 and H antigens l, v (phase 1), e, n, and z15 (phase 2). The organism was susceptible to ampicillin, piperacillin, cefuroxime, cefotaxime, ceftazidime, imipenem, tobramycin, co-trimoxazole, and the fluoroquinolones, and furthermore was intermediately susceptible to doxycycline as examined by disk diffusion tests (Biodisk). Fecal specimens were negative for growth of salmonella or any other pathogens, including *Yersinia, Shigella*, and *Campylobacter* spp. In addition, urine culture and four aerobic blood cultures were all negative.

The bacterial organism was isolated from the abscess fluid after 4 days of incubation using aerobic flasks with liquid medium (BacT/Alert; Organon Teknika). The isolate was subcultured onto supplemented human blood agar plates containing Columbia II agar, L-cysteine, hemin, and vitamin K₁. Subtyping according to Kauffmann-White (10 and references therein) using specific antisera revealed that the isolate was *Salmonella enterica* serotype Brandenburg with the O antigens 1, 4, and 12 and H antigens l, v (phase 1), e, n, and z15 (phase 2). The organism was susceptible to ampicillin, piperacillin, cefuroxime, cefotaxime, ceftazidime, imipenem, tobramycin, co-trimoxazole, and the fluoroquinolones, and furthermore was immediately susceptible to doxycycline as examined by disk diffusion tests (Biodisk). Fecal specimens were negative for growth of salmonella or any other pathogens, including *Yersinia, Shigella*, and *Campylobacter* spp. In addition, urine culture and four aerobic blood cultures were all negative.

To monitor the humoral immune response against the *Salmonella* infection, a serological analysis was done approximately 3 weeks after detection of the first symptoms. Borderline titers of 1/40 (cutoff 1/10) for typhoid and paratyphoid O antigens were observed. The qualitative agglutination test (Bio-Rad) consisted of antigens recognizing, among others, the serotypes for typhoid O antigen 12 and paratyphoid O antigens 4 and 12, which all cross-react with serotype Brandenburg.

**Discussion.** To our knowledge, this is the first report of a muscle infection caused by serotype Brandenburg.
and 40 cases of muscle infections caused by Salmonella species have been published during the last 40 years (for a review see reference 6). Extraintestinal manifestations of serotype Brandenburg are rare, and in a recent paper only two cases of bacteremia with serotype Brandenburg were found out of a total of 32 cases of Salmonella bacteremia (11). The low incidence of serotype Brandenburg bacteremia is reflected by the few reports on focal extraintestinal infections. However, case reports have been published on isolation of serotype Brandenburg in a ruptured abdominal aorta (3), in an ovarian cyst due to endometriosis (9), and finally in acute suppurative thyroiditis (4).

Serotype Brandenburg belongs to genomic group XVIII when defined according to biotype, serotype, and randomly amplified polymorphic DNA typing (11). Although most cases of serotype Brandenburg are sporadic, the species has also been described in national epidemics (1, 14). An extensive study in New Zealand including pulsed-field gel electrophoresis and macrorestriction fragment length polymorphism revealed that, among 115 isolates, seven clusters were defined during a 5-year time period (14).

Extraintestinal manifestations of salmonella are found mainly in immunocompromised hosts (11) or in patients with atherosclerosis. Diabetes mellitus and human immunodeficiency virus infection are the most frequent predisposing conditions for systemic salmonella infections (6). Salmonella is a facultative intracellular bacterium salmonella has developed a sophisticated mechanism for surviving and replicating in macrophages (8), a phenomenon that might explain the organism’s preference for atherosclerotic plaques, which contain numerous phagocytic cells (7).

Our case illustrates that Salmonella infection has to be considered in the differential diagnosis of muscle infections, especially in patients with predisposing conditions such as atherosclerosis. Apart from surgical drainage of abscesses, correct identification of the causative organism is of utmost importance, especially for the long-term outcome of endovascular infections.

REFERENCES