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Cutaneous and Systemic Infection by *Gemella morbillorum*

Sir,

Gemella morbillorum is rarely associated with human infections. However, *G. morbillorum* normally remains unidentified because microbiology laboratories have difficulty in isolating this bacterial agent. We report here a case of cutaneous and systemic infection with *G. morbillorum* following hand trauma sustained by a man while fishing.

CASE REPORT

A previously healthy 24-year-old man, a builder, was admitted to our dermatology department for suspected erysipelas. He was an active fisherman and 5 days before, had repeatedly wounded the fingers of his left hand with a fishing-hook while he was on the river. In the evening of the same day, he developed a strong pain in his left arm, followed a few days later by an increasing cutaneous inflammation.

Clinical observation showed that his left arm and forearm appeared to have homogeneous erythema and oedema, with pain, remittent fever and 2 enlarged lymph nodes in the left armpit, which were about 2 cm in diameter, hard-elastic, moveable and painful.

Routine laboratory tests showed a neutrophilic-leukocytosis (19,400 WBC/mm³, 79.9% neutrophils) and an increase in non-specific inflammation indices (ESR 75 mm/h). The lymphocyte subpopulations and other routine tests were normal. The serology was positive for hepatitis C virus infection with normal transaminases and negative for HIV.

The patient was treated surgically with incision and drainage of an abscess in the left antecubital hollow. There was secretion of pus with a putrid smell.

While waiting for the culture results we began therapy with stearate erythromycin (2 g/day).

Eight days after hospitalization a basal left pleura-pneumonia became evident, probably produced by a secondary localization of septicaemic infection. Blood and broncho-alveolar lavage cultures were negative. The following day a massive haemorrhage occurred with rapid onset of anaemia as a consequence of the erosion of the left-humeral artery. He was treated urgently in surgery with ligation of the damaged arterial branch. Surgical cleansing of the large abscessual cavity, which had caused a large muscle-cutaneous ungluing of the arm from the armpit to the elbow, was carried out. The general condition and pulmonary status of the patient was worsening. On the advice of the pneumologist, therapy with teichoplanin (0.2 mg/kg/day i.m.) and tobramycin (3 mg/kg/day i.m.) was started. After 2 days the fever disappeared and there was a significant improvement in the pulmonary infection. Pus culture resulted positive for *G. morbillorum*, which was sensitive to these antibiotics. Due to the high frequency of

endocarditis caused by this microorganism we performed an echocardiogram, but it did not reveal vegetation.

DISCUSSION

To our best knowledge, this is the first case of cutaneous infection with *G. morbillorum*. In literature, cases are reported of septic arthritis, meningitis (1), pericarditis, sinusitis, peritonitis and, particularly, endocarditis (2). These infections are potentially severe, with the typical formation of abscesses, empyema (3) and septic shock (4). The drained pus has a characteristic putrid smell.

The danger of infection is high in surgery, especially in perianal and mouth surgery (5), diabetic patients, immunodeficiency, neoplasm, drug abuse and trauma. As occurred in our patient, we believe that particular attention must be paid to the possibilities of infection by parenteral inoculation, particularly if the patient takes part in fishing. We suggest that specific research be carried out because of the difficulty of identifying this rare pathogen in the microbiology laboratory.

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