six (susceptible to ethambutol, isoniazid, rifampin, streptomycin, and pyrazinamide) and a few colonies of Staphylococcus aureus, for which no treatment was given. Histological examination did not reveal acid-fast bacilli or granulomas. The findings on a repeated chest radiograph were unchanged. Throughout this period the patient did not produce sputum. He received a 12-month course of antituberculous therapy and responded well.

A detailed medical history revealed that the patient had been born in Lithuania in 1938. At the age of 6 years, he “dislocated” his hip, which resulted in a “shorter” leg. His family escaped to Germany, where, in 1947, he underwent fusion of the hip. In 1950, while he and his family were in a displaced persons’ camp in the American zone, he had a reaction to a tuberculin test after pulmonary tuberculosis was diagnosed in his brother. In 1954 he and his family emigrated to the United States. He had never received treatment for tuberculosis. In 1970 he underwent repeated hip fusion (the medical record was not available). He lives with his wife, two children, and mother in one household, and none of the family members have been ill during a 2-year period of follow-up. He works in a print shop.

We believe our patient had dormant sternal tuberculosis, which was reactivated following the trauma of surgical sternotomy. Tuberculous involvement of the sternum is rare, particularly in the absence of clinically obvious disease elsewhere [1, 2]. Blunt and penetrating trauma are well-recognized causes of reactivation of a dormant focus of tuberculosis [3, 4]. However, to our knowledge, infection of the sternum due to M. tuberculosis following surgical sternotomy has not been previously described. Post-surgical sternal tuberculosis infections due to acid-fast bacilli are usually acquired nosocomially and are due to mycobacteria other than M. tuberculosis, in particular Mycobacterium fortuitum [5]. There was no evidence to suggest nosocomial or community acquisition of tuberculosis in our patient. The development of bacillemia after a CABG procedure, with seeding of a recent sternotomy wound, is a theoretical possibility, but we believe it to be very unlikely in this case.

It would be intriguing to know whether the patient’s dislocated hip was actually tuberculosis of the hip, which he acquired during childhood. Unfortunately, he was unable to provide precise details, and pathological and microbiological reports regarding the two surgical procedures performed on the hip were not available. The hip had been stable for the past 20 years.

Patients with infected sternotomy wounds that do not respond to the usual measures should be evaluated for infection with acid-fast bacilli. A history of a previous tuberculous infection may be of great importance and should be sought from patients at risk for tuberculosis.

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The patient had a long history of smoking and alcohol abuse. Physical examination revealed that a nasotracheal tube had been placed and that he had poor dentition and diminished breath sounds at the right apex. There was a nonerythematous, fluctuant area (10 cm × 13 cm) over the right posterior hemithorax. The WBC count was 16,700/mm³ with 96% neutrophils. A chest radiograph revealed a cavitary lesion (10 cm × 10 cm) in the right upper lobe and bullous emphysema. CT showed a cavitary lesion in the right upper lobe, destruction of the 7th right rib, and a low-density fluid collection in the extrapleural tissue of the right hemithorax contiguous with the pleural space, consistent with empyema necessitans (figure 1). Percutaneous aspiration of the fluctuant area yielded purulent material. A gram stain showed gram-positive cocci in small chains. Cultures yielded a penicillin-susceptible Streptococcus species identified as S. milleri with the API 20 STREP biochemical identification system (bioMérieux Vitex, Hazelwood, MO).

The patient underwent open drainage and resection of the 7th right rib and received 24 million units of intravenous penicillin daily; a radiograph showed resolution of the right upper lobe cavity and extrapleural fluid collection. The hemothysis resolved, and he was successfully weaned from ventilatory support after 21 days. He was discharged with a prescription for oral penicillin (500 mg four times daily) and was doing well 8 weeks after initiation of antimicrobial therapy.

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Empyema Necessitans Due to Streptococcus milleri

Streptococcus milleri has a tendency to cause the formation of abscesses in the abdomen, brain, and joint spaces but is an uncommon cause of empyema [1, 2]. We describe a patient who presented with massive hemoptysis and was found to have empyema necessitans due to S. milleri.

A 56-year-old male with emphysema was admitted to the hospital for evaluation of massive hemoptysis. He denied fevers, purulent sputum, or cough. One month before this presentation, he was treated for necrotizing pneumonia with an unknown antibiotic. At that time bronchoscopy revealed purulent material draining from the anterior, apical, and posterior segments of the right upper lobe. During the current presentation, an attempt at bronchoscopy precipitated hypoxemia, which necessitated intubation and mechanical ventilation. He was transferred to our facility for further care.
Empyema necessitans results when an empyema dissects from the pleural space into the chest wall [3]. Most cases result from inadequate treatment of an empyema and occur following necrotizing pneumonia or lung abscess [3, 4]. Before the antibiotic era, *Streptococcus pneumoniae* and *Streptococcus pyogenes* caused the majority of empyemas [5]. Currently, streptococci other than *S. pneumoniae* account for <10% of empyemas [4]. Most empyemas are polymicrobial, and up to 75% contain such organisms as *Escherichia coli* and *Pseudomonas* species [5]. Hocken and Dussek reported that *S. milleri* was involved in 25% of cases of empyema in a community hospital in London [6]. However, there have been no reported cases of empyema necessitans associated with *S. milleri*.

Members of the *S. milleri* group are viridans streptococci characterized by minute, nonhemolytic colonies dependent on carbon dioxide for adequate growth [6, 7]. The organisms are commensals of the oropharynx, auditory canal, gastrointestinal tract, genitourinary tract, and umbilicus [2, 4]. *S. milleri* has a propensity to cause the formation of abscesses and is the most likely of the viridans streptococci to cause suppurative abdominal infections, notably appendiceal abscesses [2, 4].

*S. milleri* usually reaches the lung by aspiration of oral contents but may also be directly implanted during surgery, by extension of a liver abscess, or by hematogenous spread [6]. When recovered, *S. milleri* usually is isolated in pure culture [6, 8]. The ratio of males to females who develop *S. milleri* empyema is 5:1 [2, 4, 6]. Factors predisposing to *S. milleri* empyema include consumption of alcohol, esophageal carcinoma, and mental retardation; patients with these conditions have a tendency to aspirate oral contents [1]. Empyema due to *S. milleri* usually progresses rapidly and may cause toxic symptoms if not treated quickly [2, 4]. Hemoptysis occasionally is a presenting feature of lung abscess [9]; however, we are unaware of any cases of *S. milleri* lung abscess or empyema necessitans presenting as hemoptysis.

Treatment entails open or closed drainage to prevent fibrosis of the pleural space [1, 2, 4]. Rib resection facilitates drainage postoperatively, especially when an empyema has a thick fibrous capsule [10]. Penicillin is the antimicrobial of choice [2, 4, 6]; however, susceptibility testing is encouraged because of a few reports of penicillin-resistant isolates [4].

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