patient’s illness—rapid onset and spread along the fascial planes—was characteristic of a necrotizing process. The preceding swelling of the ankle probably represented edema, which may have predisposed to the development of infection. S. marcescens was implicated as the single pathogen on the basis of the gram stain morphology and the pure growth in a series of cultures without any evidence of anaerobic organisms.

S. marcescens has rarely been reported as the cause of cellulitis and secondary infection of preexisting skin ulcers [6]. In addition, S. marcescens may be encountered along with other pathogens in synergistic infections. However, the monomicrobial nature of our patient’s necrotizing infection makes this case exceptional. Only one other case of necrotizing fascitis in which S. marcescens was implicated as the pathogen has been reported [2]. The case was described only briefly, and whether the authors attempted to exclude the presence of anaerobes was not stated.

In summary, this case illustrates that S. marcescens should be considered as a possible single cause of necrotizing fasciitis, especially in diabetic or otherwise immunocompromised hosts.

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References
Our case serves to emphasize the problem of emerging amphotericin B resistance in AIDS patients with late-stage disease who have fluconazole-resistant C. albicans isolates. The use of in vitro susceptibility studies might help in the confirmation of this multidrug resistance and in finding a susceptible antifungal agent.

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**References**


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**Moraxella catarrhalis Bacteremia as a Cause of Erythema Nodosum**

Erythema nodosum is a common dermatologic manifestation of several systemic illnesses. It is considered to be an immunologic response and is most commonly seen in association with streptococcal pharyngitis, sarcoidosis, and treatment with certain medications. Other frequent etiologies of erythema nodosum include tuberculosis, fungal infections, and inflammatory bowel disease. Erythema nodosum presents clinically as tender erythematous nodules usually located on the extensor aspects of the lower extremities, and pathological examination of subcutaneous adipose cells demonstrates inflammation of the septa [1].

*Moraxella* species are normal inhabitants of the upper respiratory tract and in the past were considered harmless commensal organisms. Since the 1980s, *Moraxella* (formerly *Branhamella*) *catarrhalis* has been increasingly recognized as a potential respiratory tract pathogen in certain clinical settings, particularly in children with sinusitis or otitis media and in adults with chronic obstructive pulmonary disease. In addition, it has rarely been reported as a cause of invasive infections, including meningitis, bacteremia, and endocarditis [2–4]. Occasionally patients with *M. catarrhalis* bacteremia have been described as having an accompanying petechial or purpuric rash. *M. catarrhalis* bacteremia has not been reported to be associated with erythema nodosum [5]. We recently treated a patient with a unique personal habit who presented with erythema nodosum, which we believe was a direct consequence of *M. catarrhalis* bacteremia.

A 19-year-old female presented with a 7-week history of fever, chills, night sweats, and myalgias; she also had a 10-pound weight loss and had developed several tender, nonpruritic swellings on her skin. She denied any preceding respiratory or gastrointestinal symptoms, she did not have a history of medical problems, and she denied use of illicit drugs, oral contraceptives, or antibiotics. On admission to the hospital, physical examination revealed a thin young woman who appeared chronically ill and had a temperature of 101°F. No heart murmur or other abnormality was noted except for the presence of multiple tender erythematous nodules predominantly located on the extensor aspects of her arms and legs.

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**Figure 1.** Endoscopy of the esophagus of a 26-year-old HIV-infected male showing diffuse, confluent, raised white plaques associated with hyperemia and edema. The plaques are distributed from the proximal to the distal esophagus.

It is clear that in our patient’s case treatment of esophageal candidiasis with amphotericin B resulted in clinical failure and that our patient’s *C. albicans* isolates were exhibiting increasing in vitro resistance to amphotericin B.