cement beads and spacer. Cefazolin therapy was continued, and 4 weeks later a new prosthesis was implanted. The patient currently remains well 1 year after surgery.

Topical nasal steroid sprays have become standard therapy for allergic rhinitis [3]. Intranasal budesonide has been shown to be effective in decreasing nasal blockage, discharge, and sneezing with minimal systemic adverse effects; local adverse effects are limited to nasal irritation, and, occasionally, epistaxis [4].

Recent data indicate that nasal carriage of _S. aureus_ is a major risk factor for wound infections after cardiac surgery [5]. The pathogenesis of these nosocomial infections remains unclear. The temporal relation between our patient’s use of a steroid nasal spray and the development of late prosthetic knee infection, in addition to the isolation of identical strains of _S. aureus_ from the nose and knee, suggest a causal relationship. The suppression of a local inflammatory response in the nose by the topical steroid may have allowed colonizing _S. aureus_ to enter our patient’s bloodstream and invade the prosthetic joint.

Skin colonization and infection of the patient’s right ankle wound, with spread to the prosthetic joint, are also possible but seem less likely in view of the lack of erythema or drainage, the contralateral location of the wound, and the absence of a local inflammatory response. Until further clinical experience is available, we suggest that treatment with topical nasal steroids be avoided or used with caution in patients with prosthetic joints. If a decision to use nasal steroids is made, it might be prudent to perform a nasal culture to determine that there is no carriage of _S. aureus_ before commencing steroid therapy.

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Cutaneous Infection Caused by _Tsukamurella paurometabolum_

_Tsukamurella paurometabolum_ is a gram-positive, slightly or variably acid-fast, nonmotile, obligate, aerobic bacillus that can be isolated from soil. _T. paurometabolum_ was previously known as _Gordona aurantiaca_, _Rhodococcus aurantiacus_, and _Corynebacterium paurometabolum_ [1, 2]; it has caused chronic lung infections [3], subcutaneous abscesses and necrotizing tenosynovitis [4], meningitis in a patient with hairy-cell leukemia [5], and catheter-related bacteremia in patients with cancer [6, 7] and a patient undergoing hemodialysis [8]. We report, to our knowledge, the first case of cutaneous infection due to _T. paurometabolum_.

A 65-year-old Cambodian man who had a history of treated syphilis and who had lived in France for the last 10 years presented to our dermatology clinic because of a 3-month history of asymptomatic erythematous papular and pustular lesions associated with an area of induration on his left wrist (figure 1). The patient was otherwise in good health. He had no antibodies to _Treponema pallidum_. No immunologic abnormalities were found, and he was negative for antibodies to HIV. Skin biopsy specimens for histologic and bacteriologic examination were obtained. Local treatment with hexamidine and fusidic acid was sufficient for healing the lesions, with residual pigmentation. Histologic examination of a skin specimen stained with hematoxylin-eosin revealed hyperkeratosis, inflammatory infiltrates with lymphomononuclear cells in the upper dermis, and granulomas with many peripheral giant cells but no central

References
Bilateral Staphylococcal Axillary Lymphadenitis in a Man with AIDS

Patients with AIDS often have generalized or focal lymphadenopathy. Early in the course of HIV infection, lymphadenopathy is usually a consequence of HIV infection itself. Later, lymphadenopathy is frequently associated with infections and malignancies. To our knowledge, we describe the first reported case of acute axillary lymphadenitis due to *Staphylococcus aureus* in a patient with AIDS.

A 32-year-old man presented to the hospital in June 1995 with non-Hodgkin’s lymphoma. He had antibodies to HIV-1 by ELISA and western blot, and his CD4+ lymphocyte count was 30/µL. Examination of the lymph nodes did not reveal any abnormalities. He was treated with cycles of cyclophosphamide, doxorubicin, vincristine, prednisone, and granulocyte colony-stimulating factor. Three days after the fourth cycle of chemotherapy, the patient developed oral and genital ulcerations due to herpes simplex virus, and he was treated with acyclovir. Two days later, he developed fever and bilateral axillary pain and he noticed three erythematous skin plaques. He had a temperature of 39.1°C; three 2.5-cm plaques with central crusting on the chest, back, and right leg; 0.6-cm erythematous nodules in the anterior axillary folds; and tender, boggy 1–3-cm anterior axillary lymph nodes. Findings on a chest roentgenogram were unremarkable. An intracutaneous tuberculin test was positive, whereas the serum level of angiotensin converting enzyme was low. Examination of a Ziehl-Neelsen-stained skin specimen was negative for acid-fast organisms. Culture of a skin specimen on 5% sheep blood agar and chocolate agar, which was incubated at 37°C, yielded heavy growth of an obligate, aerobic, gram-positive bacillus. The colonies were rough, dry, and tan. Short rods with some branched filaments were observed. The organism was initially identified as a *Nocardia* species.

The bacterium produced catalase and β-galactosidase; did not reduce nitrate; and used sucrose, galactose, and mannitol as carbon sources. HPLC was used to detect bromophenacyl esters of mycolic acids in cell walls. A characteristic profile of the genus *Tsukamurella* was observed [9]. The identification of *T. paurometabolum* was confirmed at the National Scientific Research Centre in Toulouse, France. The bacterium was resistant to penicillins and cephalosporins but was susceptible to amikacin, co-trimoxazole, pefloxacin, and rifampin. It was immediately resistant to fusidic acid.

Granulomas without caseation are predominantly due to sarcoidosis, tertiary syphilis, atypical mycobacterium infections, or actinomycoses infections [10]. Since *T. paurometabolum* can be recovered from the environment, it may be merely a contaminant. However, heavy growth of *T. paurometabolum* in a pure culture and the presence of granulomatous and noncaseous dermic lesions for which no other etiology had been found suggested that our patient's symptoms were caused by infection with this microorganism. Healing of the lesions might have been due to hexamidine treatment and to a high local concentration of fusidic acid.

*Tsukamurella* is considered to be pathogenic in humans with specific conditions such as immunosuppression, an indwelling foreign body, and a postoperative wound [4–6]. However, in our case, there was no underlying disease that could explain the limited lesions and the favorable outcome following local antibiotic therapy. Diagnosis of an infection with an uncommon bacterium is somewhat difficult because of similarities with more common species. In this case, HPLC of mycolic acids proved to be a useful technique for differentiating *T. paurometabolum* from other rapidly growing *Mycobacterium* species, *Nocardia* species, and related species [2] when conventional biochemical tests were not conclusive.