Retropharyngeal Abscess Due to Gemella morbillorum

SIR—We read with interest the article by Vasishtha and colleagues [1] on septic shock due to Gemella morbillorum in children. We describe a case of septic shock from a retropharyngeal abscess due to G. morbillorum in an immunocompetent adult. To our knowledge, there are no previous reports of retropharyngeal abscess caused by Gemella species [1–9].

A previously healthy 55-year-old male presented with respiratory distress and cardiovascular collapse. He had had a sore throat and progressive dysphagia for 5 days. He did not have fever or chills. Anterior fullness and severe tenderness on the right anterior triangle of the cervical area were noted. Laryngoscopy revealed erythema of the oral cavity and edema of the posterior palatal wall, which extended down to the epiglottis and vocal cords. A CT scan of the neck showed a retropharyngeal abscess with extension into the superior mediastinum. A large quantity of purulent material was drained, and tracheostomy was performed. No rash or other significant findings were observed.

The WBC count was $12.6 \times 10^9/L$ with 61% polymorphonuclear leukocytes and 31% band forms. Gram staining of the drained material showed a moderate number of gram-positive cocci and gram-negative rods; repeated cultures yielded only numerous isolates of G. morbillorum. The organisms were found to be susceptible to penicillin, cephalosporins, and clindamycin by use of the Kirby-Bauer disk diffusion method; MICs were not determined. Blood cultures were negative, and findings on a chest radiograph were normal. An echocardiogram did not reveal any vegetations.

In view of the patient’s renal insufficiency, treatment with iv clindamycin (900 mg q8h) and iv ceftriaxone (2 g/d) was decided upon and continued for 3 weeks. His hospital course was complicated by upper gastric bleeding, klebsiella pneumonia, and line-related bacteraemia due to meticillin-resistant Staphylococcus aureus. The results of T and B cell studies were normal. The patient refused testing for antibodies to HIV. He was discharged in stable condition on the 90th hospital day and has been asymptomatic since that time.

The findings in this case further illustrate that G. morbillorum can cause life-threatening infections. Most reports of gemella infections describe endocarditis and localized infections such as intracranial abscess, sinusitis, arthritis, and meningitis [1–9]. Septic shock caused by Gemella species has been observed mostly in immunocompromised patients [8].

There are several noteworthy points in this case. First, viridans streptococci and Gemella species are indigenous in the mouth, the upper respiratory tract, and the gastrointestinal tract. Vasishtha and colleagues [1] state that gemellae may be initially identified as viridans streptococci on the basis of colonial morphology. Viridans streptococci isolated in cultures of sinus or oropharyngeal abscess aspirates may be reported as normal flora. If clinically indicated, further identification to the species level should be done to distinguish Gemella species from abscess-forming viridans streptococci; the latter have commonly been ascribed to the species Streptococcus milleri [6].

Second, our patient responded to treatment with clindamycin and a cephalosporin. These less nephrotoxic drugs can be treatment options in cases of severe gemella infection. Vasishtha et al. [1] suggested a $\beta$-lactam and an aminoglycoside or vancomycin as initial therapy for G. morbillorum infections as resistance to penicillin is common in this organism.

G. morbillorum, found in the normal mouth flora, is a potential pathogen. Surveillance (i.e., inclusion of this organism among those causing reportable diseases) would define the role...
of Gemella species in the formation of abscesses and in other serious infections.

Ramarao Pradeep, Muhammad Ali, and Carol F. Encarnacion
Division of Infectious Diseases, Long Island College Hospital, Brooklyn, New York

References