The complications of intestinal tuberculosis are obstruction, perforation, fistulae, lymphadenitis, malabsorption, and gastrointestinal bleeding [3, 10]. Surgery should be reserved for those cases with complications that do not respond to conservative treatment [1]. In equivocal cases, a therapeutic trial with antituberculous drugs may be undertaken [1, 6]. The response to this therapeutic regimen is usually dramatic, as in our case.

Robert J. Richards, Younan Hamwi, and Pablo S. Rodriguez
Department of Internal Medicine, Texas Tech University Health Sciences Center, Amarillo, Texas

References

Figure 1. Barium study demonstrating a fistula (arrow) between the duodenum and ascending colon in a 25-year-old male with intestinal tuberculosis.

or caseating granulomas is achieved in only 40%–50% of the cases [6]. The presence of central caseation is the hallmark of tuberculous granulomas [7]; however, the absence of this feature does not exclude the diagnosis of tuberculosis [8]. Cultures of biopsy specimens are positive for *M. tuberculosis* in 40%–69% of cases [6]. Crohn’s disease and tuberculosis share several colono-scopic features such as cobblestoning, aphthous ulcers, stricture, and pseudopolyps [9].

**Purulent Pericarditis with Associated Cardiac Tamponade Caused by a *Streptococcus pneumoniae* Strain Highly Resistant to Penicillin, Cefotaxime, and Ceftriaxone**

Purulent pericarditis due to *Streptococcus pneumoniae* is a serious complication of pneumonia. Although the number of cases has decreased significantly since the introduction of penicillin, pneumococcus remains one of the most frequently isolated bacteria [1, 2].

The prevalence of penicillin-resistant pneumococci has increased progressively in the United States. In a recent study of 1,527 isolates collected from outpatients between 1994 and 1996 [3], 14% of the isolates were found to be intermediated resistant, and 9.5% were highly resistant to penicillin. Serious infections caused by *S. pneumoniae* resistant to cefotaxime and ceftriaxone are also a potential problem. There are reports of treatment failure with these antibiotics in cases of meningitis [4] and endocarditis [5] due to *S. pneumoniae*. The increase in strains resistant to penicillin and cephalosporins should alert physicians to the potential for the reemergence of pneumococcal pericardi-tis. We describe a case of purulent pericarditis due to *S. pneumoniae* highly resistant to penicillin, cefotaxime, and ceftriaxone.

A 78-year-old woman with non–insulin-dependent diabetes mellitus was admitted to the hospital with a history of productive cough, fever, chest pain, and progressive dyspnea of 1 week’s duration. Physical examination revealed a temperature of 38°C, pulse of 160 min, blood pressure of 90/50 mm Hg, and respiratory rate of 30. The patient’s neck veins were distended, and bilateral basilar rales were heard on auscultation of the lungs. The heart sounds were irregular and distant, and a friction rub was present.

Laboratory studies revealed the following values: hemoglobin level, 12.9 g/dL; hematocrit, 36.6%; WBC count, 27,000/mm³ (90% granulocytes); serum creatinine level, 3.3 mg/dL; and glu-

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Reprints or correspondence: Dr. Rolando E. Saenz, School of Medicine in New Orleans, Louisiana State University, University Medical Center, 2390 West Congress Street, P.O. Box 4016-C, Lafayette, Louisiana 70506.

Clinical Infectious Diseases 1998;26:762–3
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1058-4838/98/2603–0037$03.00 (50% granulocytes); serum creatinine level, 3.3 mg/dL; and glu-

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Unusual Route of Transmission for *Brucella abortus*

Brucellosis is a zoonotic disease that occurs primarily through contact with infected animals or animal products. Person-to-person transmission of brucellosis is a rare occurrence. A MEDLINE search (1966–1997) revealed only seven reports concerning the sexual transmission of *Brucella melitensis* [1–4]. There are no reports on *Brucella abortus* transmission associated with sexual intercourse. We describe an infection due to *B. abortus* probably acquired via sexual contact in a young Austrian couple.

A 25-year-old man was admitted to our hospital because of fever (temperature, ≤39°C), malaise, headache, arthralgia, and a 6-kg weight loss. His symptoms began 3 months before hospital admission, when he returned from a trip to Syria where he had consumed fresh goat’s milk cheese. Symptomatic treatment consisted of paracetamol and mefenamic acid. Six weeks later therapy was supplemented with roxithromycin, 300 mg/d, but chills and drenching sweats continued. On admission he was in moderate distress. Laboratory studies revealed a WBC count of 5.3 × 10^9/L and a C-reactive protein level of 10.7 mg/dL (normal level, <1.0 mg/dL). A peripheral blood smear was negative for malaria parasites. Results of agglutination tests for antibodies to *Salmonella* species were negative.

A routine blood culture (Vital Aer and Vital Ana, bioMérieux, Marcy l’Etoile, France) was positive for *B. abortus*. The serum agglutination test for *Brucella* antigen was positive (titer, 1:100). Therapy with doxycycline, 400 mg/d, and rifampin, 600 mg/d, was instituted. Within a few days the patient’s condition improved, he became afebrile, and his C-reactive protein level had returned to normal.

Two months after the onset of the patient’s condition, his girlfriend developed the same symptoms: fever, drenching sweats, arthralgia, and cervical lymphadenopathy. Five weeks after the onset of her symptoms, she was admitted to a hospital, where a blood culture was positive for *B. abortus*. She received rifampin and co-trimoxazole because of a known hypersensitivity to doxycycline. She recovered without complications.