In the pediatric intensive care unit, the girl was treated for septic shock. Vancomycin (40 mg/kg), gentamicin (6 mg/kg), cefazidime (100 mg/kg), and dexamethasone (stress doses) were administered intravenously, and she received circulatory and respiratory support. In spite of maximal treatment she died within 1 hour of admission. The presumptive diagnosis was spontaneous gas gangrene with circulatory failure. The diagnosis could not be confirmed because autopsy was not permitted.

To our knowledge, we have described the first case of a fatal infection due to *C. ramosum* in a child with leukemia and chemotherapeutic-induced neutropenia. A number of the >80 known clostridial species have been isolated from soft-tissue infections. They are frequently part of polymicrobial cultures and can act synergistically with other pathogens, thereby worsening the clinical outcome. Underlying illnesses such as cancer are believed to facilitate the development of clostridial infections. Our patient presented with spontaneous gas gangrene. This disorder has been reported in patients with colon cancer and leukemia and other forms of neutropenia. *C. septicum* is the *Clostridium* species most frequently isolated from blood cultures and intraabdominal specimens in these patients [1, 2]. *C. ramosum* has been cultured from gastrointestinal abscesses and ear infections. Since many other *Clostridium* species and non-clostridial bacteria are often present in such infections, it is difficult to assess the pathogenic role of *C. ramosum*. On the other hand, there have been a few reports of unusual infections with *C. ramosum* as the sole microorganism isolated [5, 6]. Bacteremia has been described and is occasionally found in leukemic patients [7].

In healthy persons, *C. albicans* is frequently isolated from gastrointestinal tract specimens as part of the normal flora. Fifty to seventy percent of the stool and throat specimens from immunocompromised patients show colonization with *C. albicans* [8]. The finding of a blood specimen positive for *C. ramosum* in the presence of gas gangrene in the neck and thorax implicates a pathogenic role for *C. ramosum* in this patient with severe neutropenia. *C. ramosum* is able to produce IgA1 and IgA2 proteases that may facilitate mucosal penetration [9]. The (oral) mucositis in our patient—a common feature in patients treated with chemotherapy—was most likely the portal of entry and may have enhanced intravascular invasion with *C. ramosum* and probably also with *C. albicans*. Whether the fungemia due to *C. albicans* played a role in the fatal outcome of the acute infection in this patient remains unclear.

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References


**Disseminated Papulopustular Eruption Due to Mycobacterium fortuitum in an Immunocompetent Patient**

Cutaneous infections due to atypical mycobacteria are well known. However, the frequency of rapidly growing mycobacteria is probably underestimated. Cutaneous or soft-tissue infections are the most frequent human diseases caused by these microorganisms. The lesions are usually nodular, ulcerative, or cellulitic. To our knowledge, we describe the first case of a disseminated papulopustular eruption due to *Mycobacterium fortuitum* without associated systemic infection in an immunocompetent patient.

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A 45-year-old male marine electrician presented with a progressively spreading papulopustular eruption. The first lesions had appeared 2 months earlier on the right arm and had persisted despite local dissection. Gradually, the other arm, the trunk, and the neck had become involved (figure 1). There was no pruritus or fever. Oral antibiotics were administered (oxacillin, 2 g per day for 1 week, followed by pristinamycin, 3 g per day for 2 weeks) without improvement. There was no history of previous surgery, trauma, or injection. The clinical examination did not reveal lymph node involvement or hepatosplenomegaly. Blood cell count, lymphocytic phenotyping, profile of ion concentration, hepatic and renal function, as well as chest radiographs and abdominal ultrasonography were normal. A serology for antibodies to HIV was negative. Cultures of two different specimens from two pustules obtained at 2-week intervals both yielded mycobacteria within 5 days. The strain presented characteristics of *M. fortuitum* group [1]: colonies were nonphotochromogenic, grew on MacConkey agar, and were positive for nitrate, iron uptake, and arylsulfatase. As determined by the Etest method (AB BIODISK, Solna, Sweden), the strain was susceptible to clarithromycin, ciprofloxacin, and minocycline.
Torovirus Gastroenteritis Presenting as Acute Abdomen

Toroviruses are enveloped, positive stranded RNA viruses that are classified as members of the family Coronaviridae [1]. They have been shown to be etiologic agents of gastroenteritis in cattle, and a porcine torovirus has recently been reported [2, 3]. There have been a number of articles describing the detection of torovirus-like particles in children and adults with gastroenteritis [4–7]. It was further shown in a case-control study that torovirus was definitively associated with hospital-acquired gastroenteritis in children [8]. The detection of toroviruses by use of electron microscopy has been substantiated by EIAs using antisera to Breda virus, a bovine torovirus, and by immunospecific and molecular approaches [5, 7]. Herein we describe two patients who presented with gastroenteritis as well as with signs of acute surgical abdomen. In both patients, the detection of torovirus in the stool specimens was the only finding implicating an etiologic agent. To our knowledge, we describe the first cases of torovirus associated with symptoms and signs of peritonitis.

**Patient 1** was a 9-year-old girl with familial Mediterranean fever (FMF), diagnosed at 2 ½ years of age [9], that was well controlled...