tests were within normal limits. Empirical therapy with intravenous penicillin and gentamicin was administered. Blood culture yielded *B. cepacia* after 3 days of hospitalization, and therapy was shifted to ceftazidime. He was discharged after 1 week of antibiotic treatment, at which time his cellulitis was completely resolved.

*B. cepacia* (formerly *Pseudomonas cepacia*) was first isolated from rotting onions (which are black and smell foul) in 1950 by Burkholder [5]. In 1992, Yabuuchi et al. [6] proposed the transfer of seven species of rRNA homology group II, including *P. cepacia*, to a new genus, *Burkholderia*. *B. cepacia* is an aerobic, gram-negative bacillus that does not ferment glucose; it proliferates under conditions of minimal nutrition and can survive even in the presence of certain disinfectants. Outbreaks of *B. cepacia* infection due to contamination of heparin and povidone-iodine solution have been reported [3, 4]. It is non-pathogenic in healthy persons but can emerge as a cause of opportunistic infection in patients with cystic fibrosis [2] and chronic granulomatous disease [1]. By the late 1990s, it was associated with nosocomial infection [7].

Eight cases of community-acquired bacteremia due to *B. cepacia* have been reported [7–9]. Of the 8 community-acquired episodes, 3 were due to urinary tract infection, 2 were due to pneumonia, 1 was due to endocarditis in an intravenous drug user, 1 was due to trench foot after prolonged immersion in contaminated water, and 1 had no definite focus of infection. To our knowledge, this is the first reported case of cellulitis due to *B. cepacia* bacteremia in the English-language literature. The outcome of *B. cepacia* infection in the immunocompetent host is good [10]. However, high fatality rates have been reported for hospitalized patients and immunocompromised hosts [7]. Ceftazidime or piperacillin is the drug of choice for empirical therapy for *B. cepacia* infection.

**Escherichia coli** Meningitis in a Human Immunodeficiency Virus–Infected Man After Outpatient Hemorrhoidectomy

Meningitis caused by *Escherichia coli* is rare in adults, occurring infrequently as a sequel of urinary tract infection or as a complication of neurosurgery and craniofacial trauma [1]. There appears to be no increased incidence associated with HIV infection [2]. The gastrointestinal tract is a potential source for *E. coli* bacteremia, and gastrointestinal translocation is an implicated cause of late-onset meningitis in neonates [3]. Herein, we describe a case of *E. coli* meningitis in a patient with HIV infection that may have been secondary to outpatient external hemorrhoidectomy performed several weeks prior.

On 21 March 1998, a 57-year-old man with AIDS presented to our hospital with fever, chills, lethargy, and severe neck pain worsening over several days. Since undergoing outpatient external hemorrhoidectomy on 29 December 1997, the patient had enjoyed good physical health, and he reported compliance with a medication regimen that included highly active antiretroviral therapy and trimethoprim-sulfamethoxazole. The most recent CD4 cell count was 0.156 × 10^9/L.

At presentation, his temperature was 38.2°C, and the patient was ill-appearing with a waning mental status. Physical examination was notable for nuchal rigidity and tenderness without focal neurological findings; the examination was otherwise notable for marked tenderness at the anal verge and rectum. There was no visible anorectal pathology, and the patient refused anoscopy despite the acuity of his situation. The WBC count was 7,800/mm^3. Examination of CSF showed a WBC count of 62/mL (62% neutrophils) and no bacteria. Blood cultures were negative, but culture of *E. coli* that had high-level resistance to trimethoprim-sulfamethoxazole (MIC, >320 μg/mL).

The patient’s clinical condition rapidly improved with the administration of cefotaxime (2 g intravenously every 4 hours); however, he continued to complain of rectal pain but declined rectal examination. Stool examination for bacterial pathogens, acid-fast bacilli, ova and parasites, and *Clostridium difficile* toxin was negative.
Hemorrhoidectomy is a commonly performed outpatient procedure, and although frank infection of the rectum is rare [6], bacteremia and disseminated infection may occur. Liver abscesses with bacteremia have been reported as rare complications of the procedure [7]. Although there has been a concern for impaired wound healing in HIV-positive patients after hemorrhoidectomy, there appears to be no increased morbidity or mortality in this population, and HIV status does not significantly alter the indications for hemorrhoidectomy [8].

In this case, the clinical and radiographic evidence of rectal inflammation suggests that this site of infection and/or colonization was the likely source of bacteremia and that meningitis with E. coli may have occurred as a complication of hemorrhoidectomy. The resistance of this isolate to trimethoprim-sulfamethoxazole is of clinical significance and points to another potential complication of long-term prophylactic antibiotic administration. Studies employing molecular techniques would be useful to provide further supportive evidence for a gastrointestinal source of CSF infection due to this gram-negative organism.

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Symptomatic Junctional Bradycardia After Treatment with Nelfinavir

We report a case of symptomatic junctional bradycardia secondary to treatment with the HIV type 1 protease inhibitor nelfinavir. On three occasions, initiation of this treatment led to onset of symptoms, which rapidly resolved upon cessation of therapy.

A 45-year-old man with HIV infection was found to have a viral load of 18,640 copies/mL and a CD4 cell count of 200/mm³ while he was receiving a regimen of indinavir, stavudine, and lamivudine. As a result, his treatment was switched to nelfinavir (t.i.d.), saquinavir, nevirapine, and lamivudine. Twelve hours after taking his first dose, the patient noted a “skipping heartbeat.” He had no other chest symptoms or presyncope and sought medical attention after 24 hours of persistent palpitations.