



## Short reports and correspondence

### Streptococcal myositis

I read with interest the case of streptococcal myositis that was recently reported by Dalal et al.<sup>1</sup> The authors are correct in stating that, 'Emerging antibiotic treatment for severe group A streptococcal infections includes adding clindamycin to high doses of penicillin.'

My colleagues and I recently completed a population-based retrospective study of invasive group A streptococcal (GAS) infections in the southern state of Florida, USA (population of Florida in 2000: 15 658 227).<sup>2,3</sup> A total of 257 cases of invasive GAS infection were identified. These cases were patients who were hospitalised throughout Florida between August 1996 and August 2000 and were reported to the Florida Department of Health. The overall hospital mortality rate was 18% (41/228). We found that treatment with clindamycin strongly protected against hospital mortality in patients who had necrotising fasciitis (adjusted odds ratio = 0.11,  $p = 0.038$ ) but not in patients who did not have necrotising fasciitis (adjusted odds ratio = 1.01,  $p = 0.989$ ).<sup>2</sup> Both of these odds ratios were adjusted for the use of beta-lactam antibiotics and other relevant variables.

Mr Dalal and colleagues wisely point out the need for the rapid diagnosis of an invasive GAS infection. I re-examined our case series and found that invasive GAS infection was suspected in only 2% (5/228) of these patients at the time of admission to hospital. Two of the 257 cases had streptococcal myositis (both of these patients also had GAS bacteraemia). The outpatient clinician needs to be aware of this rare but potentially fatal manifestation of invasive GAS disease.

### References

1. Dalal M, Sterne G, Murray DS. Streptococcal myositis: a lesson. *Br J Plast Surg* 2002;55:682-4.
2. Mulla ZD, Leaverton PE, Wiersma ST. Invasive group A streptococcal infections in Florida. *South Med J* 2003; in press.
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### About a case of parotid gland abscess by *Bacillus Licheniformis*

Parotid abscesses are a very uncommon pathology, which may occur in immuno-incompetent patients or might sometimes be related to foreign body injuries.

At the Department of Maxillofacial Surgery of the School of Medicine and Surgery of 'Federico II', University of Naples, we recently observed an interesting case of parotid abscess caused by *Bacillus Licheniformis*, previously unreported as a pathologic agent of parotid infections.

The patient, a 48-year-old Caucasian male, presented with a swelling in the left parotid region. The lesion grew in about 2 months, until it reached the dimension of  $2.5 \times 2 \text{ cm}^2$ .

The patient was in good general health and there were no signs of injuries in the parotid region.

The lesion was covered by normal skin, smooth in appearance, painful, tender and well circumscribed; no sign or symptom of facial nerve involvement was present.

The patient had already undergone a CT scan, with intravenous iodine medium infusion, which revealed an enlargement of the left parotid gland due to the presence of a 2.5 cm roundish mass of the inferior parotid portion, with peripheral contrast enhancement; a bilateral swelling of the lymph nodes of the neck was also present (Fig. 1).

Ultrasound examination of the left parotid gland revealed a  $2.3 \times 1.7 \text{ cm}^2$  nonhomogeneous hypoechoic ovoid mass. Fine Needle Aspiration Cytology (FNAC) was inconclusive.

Under general anaesthesia, the parotid mass was