Escherichia vulneris associated suppurative lymphadenopathy

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DESCRIPTION

A woman in her fifties with a medical history of gastro-oesophageal reflux disease, hypertension, type 2 diabetes mellitus presented after noticing a painful lump in her right axilla. Despite her primary care physician prescribing antibiotics and anti-inflammatories, she noticed that the lump continued to grow, and she developed subjective fevers and severe night sweats along with vomiting and diarrhoea. At this point, she was directed to seek hospitalisation.

She presented with right axillary painful lymphadenopathy. On physical examination, the patient was afebrile, appeared acutely ill and had tender adenopathy in the right axilla. The rest of the physical exam, including abdominal examination and breast exam, was unremarkable. Diabetes was well controlled with the most recent HbA1c being 6.7%. She denied any sick contacts or unusual exposures, such as contact with dead animals, fleas or rabbits. She recalled eating seafood and homecooked barbecue but denied any abnormal taste. Baseline laboratory parameters are as follows: CBC 6.4 × 10⁹/L, haemoglobin 12.7 g/L, platelet count 139 × 10⁹/L. Complete metabolic profile revealed mildly elevated glucose at 118 mg/dL and slightly elevated total protein at 8.2 g/dL, but was otherwise normal. C-reactive protein was 2.9 mg/dL (upper range of normal 0.744 mg/dL). CT of the chest performed in the emergency department revealed adenopathy in the right axilla with some inflammatory stranding (figure 1). Lidocaine patch was applied and empiric cefepime, vancomycin and ciprofloxacin were initiated for broad-spectrum coverage including tularaemia.

Blood cultures that were collected before starting broad-spectrum antibiotics on admission to the hospital revealed a non-lactose fermenting gram-negative rod (NLFGNR) later identified to be Escherichia vulneris (figure 2), and ciprofloxacin and vancomycin were discontinued. The isolate was susceptible to all beta-lactams, fluoroquinolones, trimethoprim-sulfamethoxazole and aminoglycosides. Given the unusual characteristics of this presentation, fourth-generation HIV testing was considered, however, was not done as it was decided to monitor the patient’s status as she was treated for the bacteraemia. The painful axillary lymphadenopathy improved significantly while hospitalised, and the patient was discharged on levofloxacin 500 mg every 24 hours for 7 days. Symptoms were found to be completely resolved on 2 week outpatient follow-up, with complete resolution of the right axillary adenopathy. Diarrhoea improved, abdominal pain resolved and there was no further fever or chills. Therefore, aspiration and biopsy of the lymph node and further testing were not pursued. The source was unclear but was suspected to be foodborne.

E. vulneris, formerly called enteric group 1, was described as a new species of Escherichia in 1982, found mainly in human wounds.1 E. vulneris is an opportunistic gram-negative bacterium, typically observed as an invasive infection in the immunosuppressed.2 E. vulneris strains have been found...
be resistant to one or more antimicrobial agents, including ampicillin, tetracycline and trimethoprim/sulfamethoxazole.3

Cases of invasive E. vulneris infections are few and include meningitis,4 osteomyelitis,5 urosepsis,6 bacteraemia,7 peritonitis8 9 and septic shock.2 10 A review of the English-language literature revealed no other accounts of E. vulneris associated with suppurative lymphadenopathy. The majority of patients were adults, and invasive infections were seen in the immunosuppressed, including patients with type 2 diabetes mellitus.11

Contributors

Caitlyn Hollingshead planned the case report, participated in the patient’s care, and completed edits. Victoria Soewarna acquired patient information from the electronic health record and completed edits. Victoria Starnes compiled research and patient information to write the case report.

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Case reports provide a valuable learning resource for the scientific community and can indicate areas of interest for future research. They should not be used in isolation to guide treatment choices or public health policy.

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REFERENCES