SCIENTIFIC LETTERS

Inguinal cellulitis-adenitis in group B streptococcal late-onset sepsis

Celulitis-adenitis inguinal en la sepsis neonatal tardía por estreptococo del grupo B

Dear Editor,

Cellulitis-adenitis syndrome is a well-known presentation of Group B Streptococcus (GBS) late-onset sepsis in children. Although face and neck are most frequently involved, other locations can also be affected. Inguinal presentation is uncommon, but it may be the first clinical manifestation of a GBS bacteremia. We present two cases of cellulitis-adenitis syndrome with inguinal involvement in two female infants with GBS late onset sepsis.

Case 1

A 13-week-old female was born prematurely at 34 gestational weeks due to premature rupture of membranes. GBS maternal status was unknown. A dose of corticosteroids was administered to the mother antepartum, followed by a dose of ampicillin to the girl after delivery. In the 13th week of life, the girl presented to hospital with fever, fussiness and a swelling erythematous region in the left inguinal skin, accompanied by local lymphadenopathy. Inguinal ultrasound confirmed soft tissue edema with inguinal adenopathy. Laboratory tests showed 25,300 WBC/mm³ with 67% of segmented neutrophils, and CRP of 0.14 mg/dl. Ampicillin and cefotaxime were started, and GBS was isolated from blood cultures. CSF culture resulted negative. After the isolation of GBS, cefotaxime was stopped and ampicillin was given for a total course of 14 days. Skin lesions resolved completely after 6 days of treatment.

Cellulitis-adenitis syndrome is a well-described presentation of GBS late onset sepsis that occurs in 2%–4% of cases. It has been considered as an early indicator of GBS bacteremia in infants of which 24%–33% present meningeval involvement.2,3 The age of onset ranges from 1 to 13 weeks.2,3 Most cases affect the face and neck regions, being inguinal involvement an uncommon presentation. To this day, only 9 cases of inguinal cellulitis-adenitis have been published in the literature (Table 1).1-10

Besides the cutaneous lesion, clinical presentation does not differ from other GBS infections, with fever, poor feeding, and fussiness. As described in the cervical region, the rate of meningeal involvement in inguinal cellulitis-adenitis is high (27%) (Table 1), therefore a lumbar puncture is mandatory in order to rule out meningitis. A previous history of preterm delivery and/or perinatal antibiotic treatment is present in most inguinal cases, being also associated with other manifestations of late-onset GBS disease.4,9 Particularly striking is the predominance of the female gender in inguinal cellulitis-adenitis syndrome (9/2). The pathogenesis of this finding may be related to an early colonization of female genital mucosa, leading to an initial inflammatory response in the lymph nodes, followed by bloodstream dissemination. This hypothesis could also be an explanation for the delay between the onset of local symptoms (cellulitis-adenitis) and clinical manifestations of sepsis.

In conclusion, inguinal cellulitis-adenitis is a poorly-understood manifestation of a GBS late-onset sepsis, taking...
Table 1  Clinical features, gestational age, prior use of antibiotics and source of isolation in children with inguinal GBS cellulitis-adenitis.

<table>
<thead>
<tr>
<th>Author</th>
<th>Case</th>
<th>Year</th>
<th>Age (wk)</th>
<th>Sex</th>
<th>Gestation (wk)</th>
<th>Prior use of antibiotics (weeks of age)</th>
<th>Isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rand</td>
<td>1</td>
<td>1988</td>
<td>11</td>
<td>F</td>
<td>31</td>
<td>Ampicillin + Gentamicin (1)</td>
<td>Blood</td>
</tr>
<tr>
<td>Baker</td>
<td>2</td>
<td>1982</td>
<td>4</td>
<td>F</td>
<td>Term</td>
<td>Unknown</td>
<td>Blood and aspirate</td>
</tr>
<tr>
<td>Albanyan</td>
<td>3</td>
<td>1998</td>
<td>2</td>
<td>F</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Blood, aspirate and CSF</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>M</td>
<td>34</td>
<td>Unknown</td>
<td>Blood</td>
</tr>
<tr>
<td>Rouland</td>
<td>5</td>
<td>1987</td>
<td>1</td>
<td>F</td>
<td>Term</td>
<td>Unknown</td>
<td>Blood</td>
</tr>
<tr>
<td>Soler</td>
<td>6</td>
<td>2007</td>
<td>6</td>
<td>F</td>
<td>33</td>
<td>Yes (1)</td>
<td>CSF</td>
</tr>
<tr>
<td>Mittal</td>
<td>7</td>
<td>1996</td>
<td>4</td>
<td>F</td>
<td>Unknown</td>
<td>CSF, blood, aspirate</td>
<td></td>
</tr>
<tr>
<td>Chen</td>
<td>8</td>
<td>1995</td>
<td>2</td>
<td>M</td>
<td>29</td>
<td>Ampicillin + Amikacin (1)</td>
<td>Blood</td>
</tr>
<tr>
<td>Case 1</td>
<td>10</td>
<td></td>
<td>12</td>
<td>F</td>
<td>34</td>
<td>Vancomycin (1)</td>
<td>Blood</td>
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<tr>
<td>Case 2</td>
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<td>13</td>
<td>F</td>
<td>34</td>
<td>Ampicillin (delivery)</td>
<td>Blood</td>
</tr>
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</table>

place in children under 4 months of age. In most cases it presents as a bacteremic disease with high rates of meningeal involvement. Thus, having a high index of suspicion is of paramount importance for an early recognition of the disease and to establish appropriate antibiotic therapy.

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References


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