



Subacute Multifocal Abscesses Related to a *Mycobacterium marinum* Infection in a Child

An 8-year-old boy presented with multiple inflammatory cutaneous lesions on both hands that had been evolving for 4 weeks. At the onset, the child received a 10-day course of amoxicillin/clavulanic acid without improvement. Findings of a physical examination revealed multiple abscesses on both hands (Figure 1) and a suppurative adenopathy of the right arm (Figure 2). The child had no history of fever and was in good health. He had no other symptoms or clinical signs. There were no laboratory abnormalities detected. Conventional bacteriological examination of a hand skin biopsy revealed *Staphylococcus epidermidis* contamination; mycological culture, *Orthopoxvirus*, and *Parapoxvirus* polymerase chain reaction were negative. Inflammatory changes without granuloma were noticed on histologic analysis. An aspirate was collected from the lymph node; after 6 weeks of prolonged culture at 30°C, the laboratory isolated *Mycobacterium marinum* on Coletso solid medium. The child then reported having played in a pond a few weeks before the abscesses. A 1-month course of clarithromycin accelerated the healing process.

M marinum is the most frequent nontuberculous mycobacteria (NTM) involved in skin infection. This cosmopolitan

infection occurs in a patient with a history of minor trauma exposed to soil or more often water containing contaminated fish. It typically affects the exposed areas of the upper limbs and presents as a single nodule that occasionally spreads in a sporotrichoid disposition. Abscessed forms of NTM skin infection usually are associated with rapidly growing NTM and rarely with *M marinum*.¹⁻³ Systemic dissemination of the infection can occur in immunocompromised subjects.⁴ Diagnosis is confirmed in about 75% of cases by solid culture, which may take several weeks. The laboratory should be made aware of the suspicion of *M marinum* infection to perform specific cultures. DNA-specific polymerase chain reaction amplification on skin biopsy may confirm the diagnosis in case of culture negativity.⁵ Histology frequently reveals a granulomatous reaction, but a nonspecific inflammatory infiltrate without granulomatous reaction can be observed.⁵ ■

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Figure 1. Abscesses of the left hand.

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Figure 2. Inflammatory adenopathy of the arm.

Postvoiding Wetting in a Prepubertal Girl



A 7-year-old girl reported a sensation of incomplete bladder emptying with urine leakage after voiding. She had no other low urinary tract symptoms, or urinary tract infection history. She had a daily bowel movement with type-IV stool on the Bristol Stool Scale. Urinalysis did not disclose signs of urinary tract infection. Her voiding diary for 2 consecutive days demonstrated a urinary frequency of 7-8 times per day, with a maximal voided volume of 150 mL.

The results of physical examination were unremarkable, except for nearly complete fusion of labia minora with a pinhole opening and erythema of perineal area (**Figure 1**). Urine leakage was found during examination. Ultrasonography demonstrated an anechoic cystic lesion posterior to the urinary bladder on the transverse view, which became tubular in the longitudinal view but disappeared after voiding (**Figure 2, A and B**), indicating hydrocolpos. Postvoiding residual urine volume was 4.8 mL (within the normal range). Labial fusion was treated through surgical separation, followed by topical estrogen cream application.

Daytime incontinence because of different causes occurs in 3.1%-9.5% of school-age girls.¹ Labial fusion is common among prepubertal girls with incidence rate of 1.8%,² which may be underreported. Postvoiding urine accumulation in



Figure 1. Labia minora fusion.