Perianal Streptococcal Cellulitis: Treatment with Topical Mupirocin

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In 1966 Amren et al. [1] reported 10 cases of perianal erythema caused by group A β -hemolytic streptococci. Usually it is observed in prepuberal males and is characterized by well-demarcated perianal erythema without satellite lesions. Occasionally patients have fissures, painful defecation with secondary constipation and rectal bleeding.

A 4-year-old boy had a 3-month history of perianal redness, pruritus and occasional bleeding. No treatment was tried previously. Physical examination showed perianal erythema sharply demarcated from the normal skin, and there were no satellite lesions. Fissures were observed (fig. 1). A surface culture from the perianal area was positive for group A β -hemolytic streptococci.

The patient was treated with 2% mupirocin ointment, twice a day for 10 days. The erythema and pruritus resolved. Repeated cultures 1 week and 1 month later were negative.

Perianal streptococcal cellulitis usually presents as prolonged perianal redness, pruritus, painful defecation and rectal bleeding. It is often unsuspected and confused with psoriasis, candidiasis, seborrheic dermatitis, inflammatory bowel disease, pinworm infection or a behavioral problem [2]. Culture of perianal skin confirms the diagnosis [1].

Treatment of this condition with oral penicillin for 10 days is usually successful [2, 3], and oral erythromycin is also effective [4]. Posttreatment culture should dictate the length of therapy [4].

Mupirocin (pseudomonic acid) is an active antibiotic produced by *Pseudomonas fluorescens*.

This drug inhibits protein synthesis in the bacterial cell by preventing the incorporation of isoleucine into the protein chain. It is very effective against gram-positive cocci, staphylococci and streptococci (except *Streptococcus faecalis*), and no evi-

Fig. 1. Perianal erythema with well-demarcated margins.

dence of cross-resistance between mupirocin and other antibiotics was observed [5].

Mupirocin has been tested in the treatment of primary and secondary skin infection with excellent results [6]. It is equal to oral erythromycin [7] and better than oral clox-acillin in some studies [8].

The adverse effects of mupirocin (burning, pruritus and local erythema) are uncommon and probably related with polyethylene glycol[9].

In our patient a 10-day course of topical mupirocin induced clinical and bacteriological resolution. Because of the efficacy and minimal adverse effects of topical mupirocin, we suggest this drug as a treatment of perianal streptococcal cellulitis.

References

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