

HAEMOPHILUS INFLUENZAE SALPINGITIS AND SEPTICEMIA IN AN ADULT

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Haemophilus influenzae is a small gram-negative rod that commonly inhabits the upper respiratory tract. It is a common respiratory tract pathogen in children. In rare instances, *H influenzae* can cause tubo-ovarian abscess or salpingitis. There have been scattered reports of *H influenzae* as the causative agent in cases of salpingitis, tubo-ovarian abscess, endometritis, and other genital tract and obstetric infections. Most cases of serious gynecologic infections caused by *H influenzae* reported previously have occurred in association with an intrauterine device or septic abortion.¹ Recently, we treated a patient with *H influenzae* acute salpingitis and septic shock who had no predisposing condition.

Case

A 48-year-old Hispanic child care worker, with a 72-hour history of vague lower abdominal pain and a 24-hour history of fever, presented to the emergency department with fever, hypotension, and confusion. Before admission, she reportedly experienced worsening abdominal pain, fever, and chills, culminating in hallucinations and syncopal collapse. Her past medical history was notable only for bilateral tubal ligation. Upon arrival, her temperature was 38.6C, blood pressure 88/55 mmHg, and heart rate 140 beats per minute. She was diaphoretic and confused, but responsive. Clinically significant physical findings included rebound tenderness throughout the lower abdomen. Laboratory studies revealed leukopenia with a white blood cell count of 2500/ μ L with 92% neutrophils, anemia with a hematocrit of 29%, and a platelet count of 196,000/ μ L.

Fluid resuscitation and broad-spectrum antibiotics were instituted, and the patient was taken to the operating room for exploratory laparotomy with a diagnosis of abdominal sepsis.

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Findings at laparotomy included an inflamed, necrotic mass involving the right salpinx and ovary. We also noted severe retroperitoneal edema and hemorrhagic cellulitis, which extended throughout the pelvis and up to the level of the pancreas. A right salpingo-oophorectomy was performed. Paired blood and peritoneal fluid cultures grew a β -lactamase-positive, ampicillin-resistant *H influenzae*. The pathology specimen revealed acute salpingitis. The patient's septic response resolved slowly over the subsequent 6 days. She required 5 days of inotropic support and 6 days of mechanical ventilation secondary to adult respiratory distress syndrome. She was continued on intravenous antibiotics (piperacillin, gentamicin, and cefotaxime) for 8 days and was discharged home to complete a 7-day course of intramuscular ceftriaxone.

Comment

As with the case presented here, another group reported that the clinical course of *H influenzae* tubo-ovarian abscess or salpingitis can be severe and life-threatening.¹ In cases of septic abortion, Berczy et al² suggested the role of orogenital sexual contact in the transmission of *H influenzae*. Kristensen³ suggested a reservoir of *H influenzae* in the colon to explain urogenital colonization and infection. This theory concurs with the emergence of *H influenzae* strains with plasmid-mediated β -lactamase activity identical to that found in some enteric organisms, such as *Escherichia coli*. Our case is unique because there was no association with an intrauterine device or any other predisposing condition.

References

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