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Cervical Cellulitis of Odontogenic Origin☆

Celulitis cervical odontógena

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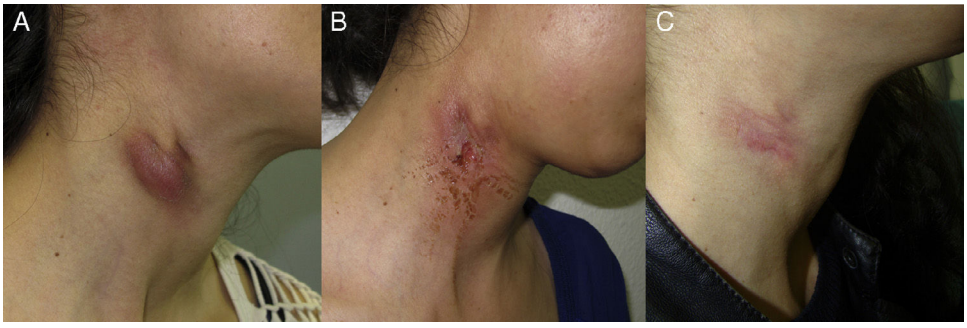

Figure 1

A 25-year-old woman presented with a 3-week history of a lesion that had appeared 2 days after a tooth extraction. In the right neck region, there was an erythematous, indurated subcutaneous tumor that was painful on palpation; adjacent to the lesion were multiple swollen lymph nodes (Fig. 1A). No lesions were observed in the oral cavity, apart from the absence of the mandibular right second molar. Twenty-four hours later, the lesion ruptured spontaneously and oozed an abundant purulent exudate (Fig. 1B). *Streptococcus salivarius* sensitive to β-lactams and quinolones (MicroScan WalkAway 96 Plus, Beckman Coulter Inc.) was isolated in bacterial culture media (blood agar, chocolate agar, MacConkey agar, and Schaedler agar). The fungal and mycobacterial cultures with enriched Sabouraud agar and dermatophyte test medium and MIGT medium (Becton Dickinson and Company) were negative. The skin biopsy showed mixed inflammatory changes in the dermis; no bacilli were observed on Ziehl-Neelsen staining. The Mantoux test was negative and a computed tomography scan ruled out fistulous tracts. Empirical treatment with amoxicillin-clavulanic acid 875 mg/125 mg was prescribed for 10 days and resulted in a favorable outcome (Fig. 1C). Odontogenic cellulitis is caused by the local spread of oral bacteria. It is favored by caries, chronic periodontitis, trauma, and odontologic procedures. The neck is not an uncommon location and the differential diagnosis should include numerous entities, including epidermal cyst, sialadenitis, odontogenic fistula, and tuberculous lymphadenitis. An adequate history and oral examination should be sufficient to establish the diagnosis.

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