CASE REPORT

Penile Cellulitis Due to Methicillin Resistant *Staphylococcus aureus* MRSA in a 15 Month Old Uncircumcised Boy: A Case Report

Abiezer Disla*, Ester Flores, Carlos Guerra, and Evan Finlay

Department of Pediatrics, Family Health Care Network, California, USA

*Corresponding author: Abiezer Disla, Department of Pediatrics, Family Health Care Network, California, USA, E-mail: abiezerd20@gmail.com

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Within 24 hours the swelling and redness of the penis showed evidence of improvement. He was able to void without difficulty and was discharged home after 48 hours of intravenous antibiotics. He completed a 7-day outpatient course of oral Clindamycin. Upon follow-up, patient had recovered without any complications.

**Discussion**

Penile cellulitis presents as swelling of the penis and may be associated with discharge as well as inguinal lymphadenopathy. It may also produce urinary symptoms as well as systemic toxicity. Although uncommon, is predominantly seen in sexually active young men. It can, however, affect all age groups including pediatric population such as newborns and young children [1].

Physiology phimosis is a common finding in uncircumcised newborn males. Due to this, the foreskin is unable to be retracted and adhesions are visualized. If the prepuce is forcefully retracted, it may cause micro traumas which are a predisposing factor causing balanoposthitis. If balanoposthitis not treated adequately, it can lead to cellulitis of the penis.

Given penile cellulitis is usually transmitted sexually, Streptococci are the most common causative organisms isolated. B-hemolytic Group B Streptococci (GBS) is the likely pathogen as it can be...
transmitted from the female oral cavity or vagina. If purulent discharge is present a sample should be sent to the laboratory for gram staining and culture [1].

In pediatric populations, however, GBS has been reported only in young infants and is exceedingly uncommon in toddlers [2]. Infections caused by Community Acquired Methicillin Resistant *Staphylococcus aureus* (CA-MRSA) are an emerging problem and is increasing in prevalence among staphylococcal infections [3]. Currently, it has been reported in young pediatrics population, more common in children in day care centers [4].

A recent antibiogram study has reported a new increase in Trimethoprim/Sulfamethoxazole (TMP-SMX) resistance in *Methicillin Resistant Staphylococcus aureus* (MRSA) isolate [4]. In the absence of treatment, penile cellulitis may progress rapidly. It should be promptly identified and properly treated to prevent rare severe complications such as gangrene [5]. After proper antibiotics have commenced, there is usually a rapid response and improvement of the symptoms [1].

This case highlights the importance of obtaining cultures from secretions and genital lesions to guide treatment and the need to choose empiric antibiotics based on local resistance patterns [3].

### Conclusion

Prompt evaluation and identification of penile lesions in uncircumcised males should be priority in any male genital exam. Proper management includes evaluation of secretions, culture of the secretions, and initiation of empiric antibiotics. Treatment should be based on local antibiograms. Therapy should be administered rapidly to avoid potential complications. If clinical response is delayed, different coverage should be considered.

Parents of an uncircumcised male should be routinely educated to avoid forceful retractions of the prepuce to prevent microabrasions and penile skin infections.

### References