

associated with faster recovery, but a posterior laminectomy with fusion or a laminoplasty are preferred in patients with 3 or more levels of CSM.<sup>8</sup> In general, a laminectomy with fusion improves neck pain, prevents postlaminectomy instability and kyphosis, and preserves sagittal alignment better than laminoplasty. However, laminoplasty is motion-preserving and results in better range of neck motion.<sup>9,10</sup> While one study found similar outcomes between the procedures,<sup>11</sup> another showed that only laminoplasty consistently halted myelopathic progression, had higher patient satisfaction, and had lower complication rates.<sup>12</sup> Other factors to be considered when choosing a surgical approach include the patient's age, the geometry of the spinal canal (canal size and intrinsic curvature of the cervical spine), and the intrinsic stability of the spine.<sup>12</sup>

**Outcome of the case.** Because of the risk of ongoing degeneration and the possibility of quadriplegia with an extension-flexion injury of the neck, the patient elected to have a posterior laminoplasty (**Figure 2**). Postoperatively, she developed numbness and weakness in her right upper extremity, which may take up to 18 months to stabilize.

This patient's case illustrates that orthopedic injuries may mask the detection of CSM, and that a thorough neurologic examination is important for all patients. ■



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## Propionibacterium acnes Abscess

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**A** 76-year-old woman presented with a 3-day history of a worsening lesion on her right cheek. The area had become reddened and painful. She had no fever, chills, or other

constitutional symptoms. She had no allergies. She was on losartan for hypertension. Two months earlier, she had been exposed to a friend with methicillin-resistant *Staphylococcus aureus* (MRSA).

**Physical examination.** A 2.5-cm, indurated, erythematous nodule with a central crust was present on the woman's right cheek. The lesion was minimally fluctuant and was erythematous, warm, and tender. Superficially, serosanguineous drainage was noted from the center of the lesion, along with erythema of the surrounding tissue. There were no palpable cervical lymph nodes.

The lesion was incised and drained, yielding 2.0 mL of a creamy, yellow-white, purulent drainage. Culture of the drainage grew 3+ *Propionibacterium acnes*.



**Outcome of the case.** The cyst and associated infection completely responded to the surgical procedure along with a regimen of oral doxycycline monohydrate, 100 mg twice daily for 10 days.

**Discussion.** *P acnes* is part of the normal skin flora. This gram-positive organism is normally found on facial skin and hair follicles, and it is mostly recognized in the pathophysiology of acne vulgaris. Systemic infections with *P acnes* are rare but have been implicated in endocarditis of prosthetic valves,<sup>1</sup> endocarditis of native valves,<sup>2</sup> infections related to orthopedic procedures,<sup>3-7</sup> central nervous system and cerebrospinal fluid infections of shunts,<sup>8,9</sup> brain abscesses,<sup>10</sup> bronchopneumonia,<sup>11</sup> and corneal infections.<sup>12</sup> Our patient presented with a *P acnes* abscess of the skin; no cases of *P acnes* cutaneous abscess have been reported in the literature.

Our patient was neither immunocompromised nor taking any medications associated with the development of acne, such as corticosteroids, lithium and other antipsychotics, epidermal growth-factor receptor inhibitors, anticonvulsants, cyclosporine, testosterone and anabolic steroids, tumor necrosis factor  $\alpha$  inhibitors, and antibiotics.<sup>13</sup> Moreover, we do not believe that the presence of *P acnes* was a result of contamination, given the fact that the culture sample was obtained directly from the inside of the abscess.

Although most abscesses require only simple incision and drainage, the cellulitis surrounding our patient's lesion, the degree of associated pain, and her recent exposure to MRSA suggested infection with that pathogen, and cultures were obtained for laboratory testing. ■

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## Tinea Versicolor

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A 53-year-old man presented with a 20-year history of burning, itching, and redness on his back and upper extremities. He reported that the lesions, which occurred seasonally, were worsening in size, color, and elevation. The man had no local access to a dermatologist and had been referred for evaluation to our clinic via store-and-forward teledermatology (SAFT).

**History and examination.** The patient had a past medical history of Graves disease but had no personal history of skin cancer. Past treatments had included topical selenium sulfide shampoo, prescribed by his primary care physician for suspected tinea versicolor, which had led to no improvement. Exam-