are uncommon, being found in <1% of patients undergoing upper GI endoscopy.² According to their composition, bezoars have been classified into 3 major types: phytobezoars, trichobezoars and pharmacobezoars. Bezoars composed of hair or hair-like fibres are called trichobezoars. To the best of our knowledge, trichobezoars formed by blanket's strings are extremely rare with only a few case reports in literature.³ Trichobezoars are formed when hair or hair like fibres are retained in the stomach, escaping its peristaltic activity and get enmeshed into a ball which usually assumes the shape of the stomach. A trichobezoar extending from the stomach into the small intestine has been described as Rapunzel syndrome.⁴ Trichobezoars are most commonly present in adolescents and during the second decade of life. In the early stages, when the bezoar is small, the patient may be asymptomatic. Affected patients may be asymptomatic for several years and develop symptoms insidiously. Larger bezoars may cause abdominal pain, nausea, vomiting, anaemia, weight loss and GI obstruction. Pressure necrosis may lead to mucosal erosions and ulceration.⁵ Most patients with trichobezoars suffer from psychiatric disorders including trichotillomania, trichophagia, pica, depression, obsessive-compulsive disorder or anorexia nervosa. Bezoars have also been described in various clinical settings such as gastroparesis due to underlying organic disease, post surgical gastroparesis and motility disorders. Surgical removal remains the main stay of treatment of large trichobezoars with gastric obstruction. These bezoars are resistant to enzymatic dissolution. Moreover, endoscopic retrieval is often difficult to achieve. Removal of the bezoars does not alleviate the underlying problem. Preventive therapy should be implemented to avoid recurrence. Psychiatric evaluation is essential to prevent recurrence as underlying psychological and emotional disturbance may be a factor.⁶

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Letter to the Editor

Balanoposthitis caused by *Streptococcus mitis/oralis*

Dear Editor,

We herein report a rare case of genital infection caused by *Streptococcus mitis/oralis* that was isolated in our laboratory. A 22-year-old male patient with a history of high-risk behavior reported with complaints of dysuria and pus discharge around the glans penis for the past 7 days. On examination, there was profuse milky white pus discharge around the glans penis. There was no local induration, lymphadenopathy, or any active urethral discharge. He was diagnosed as a case of balanoposthitis.

Pus samples were collected before administration of antibiotics and processed immediately. Gram staining revealed dense PMN infiltration and numerous gram-positive

cocci in pairs; short chains of the cocci were seen both outside and inside the neutrophils (Fig. 1). A clear capsular halo was seen around many diplococci. On sheep blood agar, viridans group streptococci (VGS) were isolated and identified as *S. mitis/oralis* by an automated system (VITEK-2, bioMérieux). The identity of the organism was confirmed by MALDI-TOF (VITEK MS, bioMérieux) with a confidence level of 99.5%. The organism was sensitive to ampicillin, clavulanic acid, erythromycin, clindamycin, cefotaxime, and vancomycin but resistant to penicillin, ampicillin, and ciprofloxacin both by automated and by conventional methods. Urine culture was sterile. The patient was seroreactive for HBsAg but nonreactive to RPR, HCV, and HIV-1/2. He was counseled adequately and placed on parenteral third-generation cephalosporins, and he made a swift recovery.

Fig. 1 – (A) Gram stain of pus sample (oil immersion, 1000×) showing numerous PMN cells. One PMN shows intracellular gram-positive diplococci; (B) pinpoint alpha hemolytic colonies on blood agar; (C) antimicrobial susceptibility pattern for selected antibiotics on blood agar. Sensitive to erythromycin, cefotaxime, cotrimoxazole, clindamycin, vancomycin and resistant to penicillin G; and (D) Gram stain from pure growth showing gram-positive diplococci in pairs and short chains.

VGS are a genetically heterogeneous group of nonfastidious bacteria that are often overlooked in clinical samples because of their ubiquitous presence in oropharynx and genital cavities. VGS infections are being reported with greater frequency from patients with diabetes mellitus, neutropenia, malignancies, and other immunosuppressive conditions. *S. mitis/oralis* can cause a variety of infections that include blood stream infections, infective endocarditis, meningitis, and septicemia. Rare cases of urinary infection and VGS toxic shock syndrome have been reported. Unfortunately, the pathogenic mechanisms in VGS infections remain obscure and correlation between different species of VGS and clinical severity are inconsistent.¹ Genital infection caused specifically by *S. mitis/oralis* is a rarity.

Species level identification of VGS, even by automated systems in a clinical laboratory, remains troublesome. 16S rRNA gene sequencing and multilocus sequence analysis (MLSA) techniques are preferred in a research setting. Though *S. mitis/oralis* exhibits sensitivity to commonly used antibiotics, resistance to beta-lactams, macrolides, and fluoroquinolones are being reported.¹

Recent reviews on *S. mitis/oralis* suggest that the organisms compete with other more pathogenic organisms in the neighborhood employing multiple survival strategies, namely

expression of adhesins, IgA proteases, and enzymes, to evade the host immune response. These mechanisms help the organism to transform into a pathogenic one and cause opportunistic infections in vulnerable patients. The recently published whole genome sequence of *S. mitis* B6 strain may facilitate better understanding of this organism.²

Ours is a case of frank balanoposthitis caused by *S. mitis/oralis* in an immunocompetent young adult. The clinical picture, extensive invasion of the neutrophils by the organism, and its isolation in pure culture confirms the pathogenic role of *S. mitis/oralis*. However, an infection in the genital region by VGS is uncommonly reported despite being a local commensal. One case of UTI caused by *S. mitis* has been reported in India by Swain et al.³ It may be pertinent to add that uncommon infections caused by VGS should be confirmed before discarding it as a contaminant and identified to the species level.

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