References


Prosthetic Valve Endocarditis Due to Staphylococcus saccharolyticus

Anaerobic gram-positive cocci rarely cause endocarditis. Staphylococcus saccharolyticus, previously known as Peptostreptococcus saccharolyticus, has been reported as a cause of native valve endocarditis (NVE) [1] but not, to our knowledge, as a cause of prosthetic valve endocarditis (PVE).

A 57-year-old woman with a prosthetic mitral valve that had been implanted several years previously was found to have fever, a systolic murmur, tender hepatomegaly, anemia, and leukocytosis. A transesophageal echocardiogram revealed a large mass that partially obstructed the tilting-disc-type prosthetic valve, as well as several mobile masses in the mitral outflow tract. Blood cultures yielded S. saccharolyticus from all bottles (Bactec NR 730 System; Becton Dickinson, Cockeysville, MD) under anaerobic conditions at 24 hours and under aerobic conditions after 11 days of incubation. The organism was identified as S. saccharolyticus by two anaerobic biochemical profiles (RapID ANA II System, Innovative Diagnostic Systems [Atlanta] and An-Ident, Analytab Products [Plainview, NY]). The organism was resistant to all β-lactam agents including oxacillin (MIC, >32 μg/mL) and all cephalosporins (MICs, >64 μg/mL) and to metronidazole and tetracycline (MIC of each drug, >16 μg/mL). It was susceptible to vancomycin (MIC, 2 μg/mL; MBC, 8 μg/mL), clindamycin (MIC, <0.5 μg/mL), and chloramphenicol (MIC, 8 μg/mL). Susceptibility tests were performed by means of breakpoint MIC determinations and by the Kirby-Bauer agar dilution method on Mueller-Hinton me-
Iatrogenically Induced Spondylodiskitis Due to Mycobacterium xenopi in an Immunocompetent Patient

Mycobacterium xenopi is usually a nonpathogenic bacterium in humans [1], but this organism can induce pulmonary infections, especially in immunocompromised patients and patients with underlying pulmonary disease [2]. Osteoarticular infections due to M. xenopi have rarely been reported [1–7]. We report a case of iatrogenically induced vertebral osteomylitis due to M. xenopi.

A 28-year-old man underwent percutaneous nucleotomy as treatment of sciatica at the L5 level due to a herniated disk at the L4–L5 level. One month later he began to have pain in his lumbar spine. Physical examination revealed a palpable mass at the L5 level. There was no fever. Skin testing for tuberculosis was positive. Routine laboratory tests showed the following: erythrocyte sedimentation rate (ESR), 32 mm/h; C-reactive protein level, 10 mg/L; and WBC count, 7,500/mm³. Blood cultures, serology for HIV type 1, and analyses of urine and sputum for Mycobacterium tuberculosis were all negative. Roentgenograms of the lumbar spine revealed spondylodiskitis (disk space narrowing and erosions of vertebral end plates) at the L4–L5 level; CT confirmed this finding and also showed an epidural lesion, a subcutaneous abscess, and an abscess in the right psoas muscle (figure 1). MRI of the lumbar spine demonstrated the typical aspect of vertebral osteomyelitis. Punctuative diskovertebral biopsy revealed a granulomatous lesion with focal caseation. Cultures of specimens from the subcutaneous abscess and the disk both yielded an acid-alcohol-resistant germ.

Vertebral tuberculosis was diagnosed, and the patient was first treated daily with rifampin (600 mg), ethambutol (1,500 mg), isoniazid (300 mg), and pyrazinamide (2 g). Despite a 2-month course of treatment, the patient’s condition worsened, and the ESR was still 24 mm/h. MRI showed extension of the infection to both psoas muscles. Three months after the initial diagnosis of tuberculosis, the isolate was identified as M. xenopi. The patient was then treated daily with pefloxacin (800 mg), clarithromycin (2 g), and ethambutol (1,400 mg). The pain progressively disappeared, and the ESR returned to normal within a few months. The abscesses