Ochrobactrum anthropi Infection of Retained Pacemaker Leads

SIR—Cieslak et al. [1] described three cases of pyogenic infections due to *Ochrobactrum anthropi*. We describe an additional case to help define the spectrum of disease caused by this organism.

A 40-year-old woman with a history of rheumatic heart disease was admitted to the hospital in March 1996 for evaluation and treatment of an infected pacemaker site. Her medical history was notable for replacement of a St. Jude aortic and mitral valve in 1984. In September 1991, she developed complete heart block, and a pacemaker was placed transvenously from the left. In November 1991, a perivalvular leak of the mitral valve developed, and she was treated with a 6-week course of vancomycin and gentamicin and placement of a new St. Jude mitral valve. Blood and intraoperative cultures were negative; it was believed in retrospect that the dehiscence was due to an undersized prosthetic valve.

In February 1992, the pacemaker was found to be in danger of eroding through the skin at the inferior pole; therefore, the pocket was revised. In November 1992, purulent drainage from the pacemaker pocket was noted. The pacemaker was removed, but its wires were clipped short and left in place. Another pacemaker was placed on the right side without complication (figure 1). The patient remained in good health until December 1995 when the previous pacemaker site became inflamed and drained spontaneously. She began treatment with oral amoxicillin/clavulanate, but her condition did not improve.

In January 1996, incision and drainage of the infected pocket were performed. In February, further debridement was performed, which exposed the proximal retained pacer wires. Because of continued drainage and presumptive infection of the pacer wires, the patient was transferred to our facility.

On arrival, the patient had local drainage from the old pacer pocket but denied fevers, chills, or systemic signs of disease. She had no drug allergies and was afebrile. Physical examination re-

Figure 1. Posteroanterior (left) and lateral (right) chest radiographs demonstrating a functioning pacemaker on the right side and retained pacemaker wires on the left side of a patient with *Ochrobactrum anthropi* infection of the retained leads.

On 16 March, the primary plate on which distal wire-lead specimens were cultured yielded 4+ growth of an oxidase-positive, indole-negative, gram-negative rod in addition to the coagulase-negative *Staphylococcus*. On 18 March, further biochemical and
suspicion regarding their possible role in infections due to these organisms, especially O. anthropi, described catheter-related bacteremias [3].

Two of the three cases of pyogenic infection due to O. anthropi recently reported by Cieslak et al. [1] involved a foreign body (a draining T tube in one case and a chest tube in the other); the third case did not involve a foreign body. Alnor et al. [4] studied bacterial adhesion to silicone tubing by Agrobacterium and Ochrobactrum and found that the binding abilities of both organisms were similar to those of Staphylococcus epidermidis and Staphylococcus aureus. Infections due to all three of the related Achromobacter-like organisms have been shown to be associated with prosthetic cardiac devices; these infections include a postoperative infection of an aortic prosthesis with Agrobacterium xylosoxidans, Agrobacterium radiobacter, and Achromobacter group B. Most of the early reports of infections due to these organisms, especially O. anthropi, have not recurred.

O. anthropi is an oxidase-positive, non-lactose-fermenting gram-negative bacillus. This organism (formerly CDC [Centers for Disease Control and Prevention] group Vd) was named O. anthropi in 1988 and is the only species in the group. Other closely related oxidase-positive nonfermenters are the Achromobacter-like organisms: Achromobacter xylosoxidans, Agrobacterium radiobacter, and Achromobacter group B. Most of the early reports of infections due to these organisms, especially O. anthropi, described catheter-related bacteremias [3].

Kenneth C. Earhart, Ker Boyce, W. Dale Bone, and Mark R. Wallace

Departments of Internal Medicine (Infectious Diseases and Cardiology Divisions) and Clinical Investigation, Naval Medical Center, San Diego, California

References