Since 1990, we have isolated >4000 strains of Campylobacter, Helicobacter, and Arcobacter species from cultures of diarrheic stool specimens and blood samples obtained from our patients [4, 5]. Nearly 1000 strains of C. upsaliensis comprised >23% of the total number of Campylobacter isolates and, similar to the observations of Labarca et al. [1], C. upsaliensis was the second most common Campylobacter species identified, after C. jejuni [4]. Our C. upsaliensis strains have clinical and pathogenic properties similar to those of the universally acknowledged pathogen, C. jejuni [5]. The Cape Town protocol is a simple, cost effective, and efficient means to isolate fastidious species or particularly fragile strains of Campylobacteraceae. We suggest that use of this protocol in future Los Angeles County–area studies will improve the ability to isolate Campylobacter species and provide a much better understanding of the role of all Campylobacter species that are involved in human disease in this area.

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References

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Reply
Sir—We agree with Lastovica and Le Roux [1] that recovery and identification of Campylobacter upsaliensis is important because it is the second most frequent cause of human disease due to Campylobacter species, after Campylobacter jejuni. There have been several previous reports in support of this statement [3–5]. Why this has not been reported in several countries, including the United States, is unknown. Possible explanations include the following: (1) of the relatively small number of Campylobacter isolates detected in most clinical laboratories, most of them are C. jejuni, so the probability of recovering C. upsaliensis is very low; (2) the intrinsic antibiotic susceptibility of C. upsaliensis explains why the rate of recovery is affected by the antibiotic-containing medium commonly used for culture of stool specimens, as was pointed out by Lastovica and Le Roux [1]; and (3) most clinical laboratories do not identify the species of Campylobacter isolates, except to identify whether they are C. jejuni.

Our protocol was designed to study the antimicrobial susceptibility of Campylobacter species in the Los Angeles County area. We received isolates from 5 participating centers that used routine methods for cultivating Campylobacter species. There are differences in the culture methods used by these laboratories, and the methods are most likely not optimal for the recovery of C. upsaliensis, as was suggested by Lastovica and Le Roux [1]. Many changes in the culture method, including changing the membrane filtration procedure, lowering the incubation temperature, and increasing the incubation time, could improve the rate of recovery of C. upsaliensis by research and clinical laboratories [2]. On the basis of these observations, we think that more research is needed in this area, especially because human disease associated with C. upsaliensis has been reported to be a potential problem in the United States since 1989 [6].

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Dedicated Catheter Lumens for Parenteral Nutrition
Sir—The recently published guidelines for the prevention of intravascular catheter–related infection are silent on the topic of use of dedicated lumens for parenteral nutrition [1]. Some hospitals have
policies requiring that parenteral nutrition be administered only through catheter lumens that have not previously been used for other purposes. This may require the placement of new central venous lines in patients who already have functional multilumen central lines in place at the time that the decision is made to initiate parenteral nutrition. Although 1 lumen from an existing line conceivably could be dedicated to parenteral nutrition, if that lumen has already been used for another purpose, its subsequent use for parenteral nutrition would be disallowed by a “dedicated lumen” policy, thus necessitating insertion of a new line. This adds cost and risk. Whether the putative benefits (i.e., infection prevention) outweigh these negatives is unclear and can lead to contention among health care providers. The guidelines committee’s opinion regarding the appropriate role for such a “dedicated lumen” policy and the quality of evidence supporting it would be valuable information for many clinicians, infection-control practitioners, and nutrition support teams to have.

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Reference


Reply

Sir—Dr. Johnson [1] raises an issue related to the use of a dedicated lumen for administration of parenteral nutrition. The recently published guidelines for the prevention of catheter-related infections address the issue specifically. The recommendation reads, “Designate one port exclusively for hyperalimentation if a multilumen catheter is used to administer parenteral nutrition” [2, p. 1296–7]. This received a category II recommendation. The strength of the evidence was modest and based only on a single study.

The practice of using 1 lumen is logical: it would limit the number of manipulations made to the lumen and thus decrease the likelihood of introducing bacterial contamination. Whether this lumen has to be untouched before starting the administration of parenteral nutrition has never been studied. There simply are no data comparing the risk of inserting a new catheter to have a “clean” lumen with the risk of infection associated with use of a lumen that has already been violated. There are also no data comparing the cost of either practice.

We share Dr. Johnson’s concerns. This topic is one of many that needs to be studied prospectively so that clinicians and patients could benefit from an evidence-based strategy. We all need to emphasize to funding agencies the vital importance of such studies. Dr. Johnson [1] suggests that the guidelines should reflect the committee’s opinion on a “dedicated line” policy. Although we could offer individual opinions in another forum, this type of evidence-based document must adhere to recommendations that can be based on data.

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References