Coagulate-Negative Staphylococci in Diabetic Foot Osteomyelitis

To the Editor—In their study on the diagnostic value of swab cultures, compared with percutaneous bone biopsy specimen cultures, for patients with diabetic foot osteomyelitis, Senneville et al. [1] found coagulate-negative staphylococci much more frequently in bone specimens than in swab samples (25.6% vs. 4.6%; P < .001). As outlined in the accompanying editorial, this finding was rather unexpected, because coagulate-negative staphylococci are considered to be contaminants in such conditions.

According to the authors, “the finding of a higher proportion of coagulate-negative staphylococci isolates in bone biopsy samples, compared with swab samples, was independent of the findings of their microbiological laboratory, which identified all of the organisms cultured from both bone and swab samples (including bacteria from the skin flora) in accordance with the protocol they established in 1996 in their diabetic foot clinic” [1, p. 61]. However, in the article they refer to [3], in which Senneville and colleagues discussed similar patients with the same procedure, although they observed similar discrepancies (in 31 patients with both swab and bone biopsy specimen cultures, coagulate-negative staphylococci were never cultured from swabs, despite that they were found in 8 bone biopsies; P < .01). Senneville and colleagues’ interpretation of this finding was much different: “this was likely to be related to the non-report of coagulate-negative staphylococci from superficial samples by our laboratory” [3, p. 929]. Could the authors clarify what made them change their interpretation between the 2 studies?

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Reply to Tattevin et al.

To the Editor—As noted by Tattevin et al. [1], in the 17 patients (not “31 patients,” as they wrote) with 20 episodes of diabetic foot osteomyelitis reported in 2001 by us an our colleagues [2], coagu-
some studies, up to 50% of deep-bone cases of diabetic foot osteomyelitis. In [5, p. 1321]. As indicated in our article [3], all the consecutive patients studied underwent surgical percutaneous bone biopsies, which were only performed by only trained senior orthopedic surgeons in the operating room under surgical aseptic conditions of sampling [3]. We believe that all possible precautions feasible in daily practice were taken to avoid contamination of the bone specimens obtained from our patients.

Unlike Tattevin and colleagues, we are not convinced that, if the coagulase-negative staphylococci strains in bone cultures were considered to be true pathogens, this would have an impact on the choice of antimicrobial regimen. In the present study [3], it would only have led to a change in the antibiotic treatment of 3 of the 10 and 5 of the 17 patients with polymicrobial and monomicrobial bone cultures, respectively, for whom a comparison with swab cultures was feasible.

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References


Efficacy of Short-Course Intramuscular Pentamidine Isethionate Treatment on Old World Localized Cutaneous Leishmaniasis in 2 Patients

To the Editor—Old world localized cutaneous leishmaniasis (LCL) is a protozoan skin infection that may be imported by travelers to Western countries [1, 2]. The treatment of Old World LCL still remains a real challenge, given the lack of efficacy of oral flucloxazole and antimonials (administered either intramuscularly or intralesionnally) and the limitations of local treatments, such as "boiling the boil" [3]. The efficacy of intramuscular pentamidine isethionate (PI) has been demonstrated for New World LCL due to *Leishmania panamensis* [4] and *Leishmania guyanensis* [1, 5]. Therefore, PI may be an alternative for the treatment of Old World LCL. Here, we report 2 cases of Old World LCL that were resistant to first-line treatment and were successfully treated with PI.

Patient 1 was a 19-year-old man who returned from Mali (in west Africa) in December 2004. He presented with a 9-