and those in other disciplines. Inhaled pentamidine is a convenient and useful intermittent therapy, which the majority of individuals find acceptable.

In our study we were concerned to identify a relatively large minority of individuals in whom the justification for pentamidine prophylaxis was not adequately documented or substantiated and this has led to a review of our procedures and a formalisation of our criteria for admission to the pentamidine clinic.

The default rate on attendance for the clinic was worst in the HIV positive population and reflected the rather haphazard and chaotic lifestyles of some of these patients rather than any apparent difficulty in accessing the service for other reasons.

The minimum cost of a single monthly appointment at the pentamidine clinic was £47.00, which compares with £2.81 for a one-month course of cotrimaxazole, 960 mg taken three times weekly. Thus pentamidine is an expensive alternative to the gold standard therapy. Highlighting this has been a trigger to initiating a review of reasons why patients are on pentamidine rather than alternative drugs. The identification of the proportions of patients coming from different disciplines has been of value in establishing payment pathways to support the service.

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Simkania negevensis infection among Brazilian children hospitalized with community-acquired pneumonia

Dear Editor,

Simkania negevensis is an obligate intracellular microbe, related to the chlamydiae. It has been found in domestic water supplies of infected children and this finding raises the possibility of transmission to children from the water of their homes. S. negevensis respiratory infections have been described from Europe, Japan and North America. In New York it was not a significant pathogen. We analyzed if S. negevensis acute infection occurred in Brazil.

Children aged under five years hospitalized with community-acquired pneumonia (CAP) were enrolled in
<table>
<thead>
<tr>
<th>Age (month)/gender</th>
<th>IgM titer</th>
<th>Complaints on admission</th>
<th>Physical findings on admission</th>
<th>Chest X-ray findings on admission</th>
<th>Family and personal past history</th>
<th>Additional infectious agents</th>
<th>Follow up evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>58\textsuperscript{a}/female</td>
<td>5\textsuperscript{b}</td>
<td>fever, cough, dyspnoea for 7 days</td>
<td>RR\textsuperscript{b} 60, temp 37.5°C, well nourished, chest retractions and indrawing, crackles</td>
<td>Alveolar infiltrate in left and right bases</td>
<td>day care centre attendance, no previous respiratory disease; 4 people at home, 1 child (the patient) who sleeps with 2 adults; mould at home</td>
<td>none</td>
<td>18 days after discharge, only with cough, RR 27 \textsuperscript{c}</td>
</tr>
<tr>
<td>24/female</td>
<td>40</td>
<td>fever, cough, dyspnoea for 3 days</td>
<td>RR 68, temp 39.8°C, well nourished, chest retractions and indrawing, crackles, wheezing, lethargy</td>
<td>Alveolar infiltrate in the left base</td>
<td>no day care centre attendance, 4 previous respiratory discomfort episodes during the last 12 months, without hospitalization; 1 brother with asthma; 4 people at home, 2 children &lt;5 years of age, the patient sleeps alone; no mould at home</td>
<td>respiratory syncytial virus</td>
<td>30 days after discharge, difficult breathing for the last 2 days, RR 48, wheezing</td>
</tr>
<tr>
<td>52/female</td>
<td>160</td>
<td>cough for 15 days, fever and dyspnoea for 3 days</td>
<td>RR 36, temp 38.9°C, malnutrition\textsuperscript{c}, chest retractions and indrawing, crackles, prolonged expiration</td>
<td>alveolar infiltrate in the right base; pleural effusion in the right hemithorax</td>
<td>day care centre attendance, 12 previous respiratory discomfort episodes during the last 12 months, persistent cough, no hospitalization; 1 brother with asthma; 5 people at home, 1 child (the patient), everybody sleeps in the same room; no mould at home</td>
<td>respiratory syncytial virus and influenza B</td>
<td>18 days after discharge, no complaints, receiving prednisone, RR 23</td>
</tr>
</tbody>
</table>

All three patients lived in Salvador, received penicillin G IV followed by amoxicillin PO and there were no smokers in the children’s homes.

\textsuperscript{a} Total white blood cell count 29,200/mm\textsuperscript{3}, 12% immature neutrophils, 75% mature neutrophils.

\textsuperscript{b} Respiratory Rate (breaths/min).

\textsuperscript{c} Weight 10.8 kg, Height 95 cm.
Salvador, Brazil, because of respiratory complaints. CAP was diagnosed when pulmonary infiltrate was described by a paediatric radiologist, blind to clinical information, on the admission chest X-ray (CXR). The investigation for other aetiologies has been published. An in-house microimmunofluorescence test was used to measure IgG and IgM antibodies to Chlamydia pneumoniae and to Simkania negevensis, using purified, formalized elementary bodies of strains K6 in C. pneumoniae tests and ATCC strain Z (ATCC, Catalog no. VR-1471) in S. negevensis tests in paired serum samples, at the National Public Health Institute, Oulu, Finland. Informed consent was requested before enrolment and the study was approved by the Ethics Committee of the Federal University of Bahia.

Acute pneumonia was radiologically confirmed in 184 patients. Three (1.6%) patients were diagnosed to have acute S. negevensis infection. Their characteristics are presented in Table 1. One patient had acute C. pneumoniae infection based on a 4-fold IgG titer rise between paired sera. There were no cases with simultaneous acute S. negevensis and C. pneumoniae infection.

The prevalence of acute S. negevensis infection was low (1.6%). Two studies reported 10% and 5% prevalence for acute S. negevensis infection among 174 Finnish and 101 Italian children with CAP, respectively. In the Finnish study, the prevalence of acute S. negevensis involvement was highest (15%) at the age group from 10 years onwards, and 67% of the 18 cases were aged older than 4 years. In the Italian study, the mean age was 4.7 years (range 0.3–16 years). Yamaguchi et al. reported that the seropositivity rate of S. negevensis increased sharply in the middle age. The acquisition of S. negevensis infection is probably more frequent among older patients.

Our case with S. negevensis as the only etiological agent among 15 excluded pathogens (influenza A and B viruses, respiratory syncytial virus, parainfluenza virus types 1, 2, and 3, adenovirus, rhinovirus, enterovirus, Streptococcus pneumoniae, Haemophilus influenzae, Moraxella catarrhalis, Chlamydia trachomatis, C. pneumoniae, Mycoplasma pneumoniae) studied had severe clinical presentation, the involvement of both lungs (Fig. 1), and acute inflammatory response (Table 1). Therefore, our results corroborate that S. negevensis may be a real cause of CAP among children.

All patients received penicillin and full recovery was achieved (Table 1). Interestingly, S. negevensis is totally resistant to penicillin and macrolides are the choice options. In a Canadian study, 64% of 22 infants hospitalized with acute bronchiolitis had S. negevensis acute infection and all of them recovered without specific antibiotic treatment. Apparently, the health assistance in the hospital ensured the improvement of the cases, but one may raise the question if an appropriate treatment could shorten the duration of the disease. Our study being, according to our knowledge, the first report of S. negevensis infection in the Central and South Americas adds a new continent to the geographical distribution of S. negevensis infection in the world.

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Water-borne Sphingomonas paucimobilis epidemic in an intensive care unit

Sphingomonas paucimobilis, previously known as Pseudomonas paucimobilis, is a gram-negative, oxidase positive bacterium. Sphingomonas typically produces yellow-pigmented colonies on blood agar. The bacterium, commonly observed in land and water habitats, can occasionally lead to hospital infections.1,2 S. paucimobilis epidemics have particularly been reported in hospital departments where immune-suppressed patients are monitored, such as the hematology and oncology clinics, and intensive care units (ICUs).3–5

In the last week of April 2007, S. paucimobilis was isolated from two of the three patients at the Kocaeli University Medical School Hospital, Cardiovascular ICU within three days interval. From the environmental samples that were collected to investigate the origin of the strains, S. paucimobilis with the same antibiotic susceptibility was isolated. The present study aimed to investigate the genotypic relationship of S. paucimobilis strains isolated from clinical and environmental samples with the PFGE method, and to prevent the spread of the strain among patients.

The cardiovascular ICU of the Kocaeli University Medical School Hospital is a six-bed, open and invasive ICU. The unit was established two years ago and it has been used only for patients requiring intensive care following cardiovascular surgery. The ICU run two shifts per day, with 1 doctor, 2 nurses and 1 nursing assistant working on each shift. Until the day of the particular epidemic, no cases of S. paucimobilis infection had been observed in the unit.

The first patient infected with Sphingomonas was a 62-year-old male. He was on mechanical ventilation following arterial embolectomy. He had an Acute Physiological Assessment and Chronic Health Evaluation (APACHE) II score of 16 in the first 24 h, and a Glasgow coma score of 3. An increase in the tracheal secretion was observed on the third day of admittance, accompanied by fever and high white blood cell count (WBC: 14.6 × 109/L). Pneumonic infiltrations were identified on chest x-ray and meropenem (3 × 1 g/day, intravenously) was started empirically with the diagnosis of pneumonia. On the following day, 105 cfu/ml of S. paucimobilis was isolated from the tracheal aspirate specimen and trimethoprim-sulfamethoxazole (2 × 80/400 mg/day, intravenously) was added to the therapy. Urine, wound, and blood cultures revealed no pathogenic microorganism. On the third day of therapy, the patient’s fever resolved, and his WBC count decreased to 9.6 × 109/L. The pneumonia symptoms receded and therapy was completed in 14 days. The patient had a Glasgow coma score of 3 throughout the period of stay in the unit. Two days after completion of the therapy, the patient died due to cardiopulmonary arrest.

The second patient was a 22-year-old woman who had undergone mitral valve replacement surgery. She had an APACHE II score of 14 in the first 24 h, and a Glasgow coma score of 12. Average post-operative body temperature was 39 °C and 105 cfu/ml of Acinetobacter baumannii was isolated from tracheal aspirate culture. The patient had a WBC count of 30 × 109/L, was diagnosed as pneumonia and cefoperazone/sublactam (2 × 2 g/day, intravenously) was initiated. S. paucimobilis growth was detected in the two blood samples drawn on the same day. Trimethoprim-sulfamethoxazole (2 × 80/400 mg/day, intravenously) was added to the therapy. On the third day of therapy, fever resolved, a WBC count of 9 × 109/L was detected. The therapy was completed on the 14th day and the patient was discharged.

After detection of S. paucimobilis growth in clinical samples, within the same week, a total of 15 smear samples were collected from soap and detergent, povidone iodine