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Hydatid disease has been acknowledged as an important clinical entity since ancient times.[4] The disease is a serious problem in India, where it is endemic. Although hydatid cysts are mostly seen in the liver and lungs, they may also be located in various tissues of the body.[2,3] Extrapulmonary but intrathoracic hydatid cysts are very rare.[3] Cysts of bronchogenic, pleuropERICardial, thymic, intramural, oesophageal, lymphangiomA, anterior meningeocE and enteric origin, as well as other rare types, may be found in the mediastinum of adults and children.[5] In one study, out of 1,619 intrathoracic hydatid cysts, only eight (0.5%) were situated in the mediastinum.[6] Primary hydatid cyst of the mediastinum, although extremely rare, is a distinct clinical entity, which must be considered in a patient with mediastinal mass in endemic regions.[7] In general, mediastinal echinococcosis is neither clinically nor radiologically distinguishable from other mediastinal cystic lesions.[8] Diagnosis can be reached after the combined assessment of clinical, radiological, historical and laboratory data of patients, as in the case presented here.

In conclusion, although very rare, hydatid disease should be considered in the differential diagnosis of a cystic lesion of the mediastinum, especially in endemic regions. Chest CT is the most efficient method of diagnosing these lesions. Surgical removal remains the treatment of choice for mediastinal echinococcosis. To avoid recurrence, additional adjuvant medical therapy is recommended.

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*S Sehgal, B Mishra, A Thakur, V Dogra, PS Loomba, A Banerjee
Department of Microbiology, G.B. Pant Hospital,
New Delhi -110 001, India

*Corresponding author (email: <bobbyf48@yahoo.co.in>)

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OCHROBACTRUM ANTHROPI SEPTICAEMIA

Ochrobactrum anthropi is an emerging opportunistic pathogen in immunocompromised patients. We report a case of septicaemia due to O. anthropi in an elderly male patient with coronary artery disease with severe left ventricular dysfunction admitted in the Intensive coronary care unit. Following intraaortic balloon pump (IABP) insertion, the patient developed a haematoma at the local site, which led to septicemia. In spite of intensive treatment, the condition of the patient continued to deteriorate and he died on the seventh day. This infection with the microbiological characteristics useful for identification of the organism is described.

Key words: Ochrobactrum anthropi, nonfermenter, septicemia

Ochrobactrum anthropi, formerly designated as Centers for Disease Control (CDC) groups Vd-1 and Vd-2, is an oxidase-positive, gram-negative, nonfermenting bacillus that oxidizes glucose and grows readily on MacConkey agar. It is an emerging pathogen in immunocompromised patients and is associated with implantation of foreign bodies particularly indwelling central venous catheters.[1] The organism is capable of survival in water and can adhere to the silicon material of catheters.[2] Acquisition of this pathogen via contaminated pharmaceuticals and puncture wounds has also been reported.[3] We report the clinical and microbiological characteristics of O. anthropi in a patient following intraaortic balloon pump (IABP) insertion.

Case Report

A 64-year-old male, a known case of hypertension, diabetes and coronary artery disease with left ventricular dysfunction, presented with severe chest pain and was admitted in the intensive coronary care unit. The patient
was fully conscious at the time of admission. Laboratory investigations showed haemoglobin (Hb) 10 g/dL, total leucocyte count (TLC) 12,000/mm³, the myocardial form of creatine phosphokinase (CPK-MB) 190 IU/L, random blood sugar 200 mg/dL and blood pressure (BP) of 100/60 mm Hg. Pulmonary oedema was observed in the chest X-ray. Echocardiography showed severe left ventricular dysfunction with LVEF (left ventricular ejection fraction) of 20%. Central venous line was inserted and the patient was started on inj. ciprofloxacin (100 mL intravenous, twice a day [IV bd]) and inj. cefazolin (1 g IV thrice a day ). Due to haemodynamic instability, the IABP was inserted through the left femoral artery. On the day after the insertion of the IABP, the patient started having a swelling at the local insertion site, which led to the formation of a haematoma. The IABP was removed from the left side and inserted through the right femoral artery and a compression bandage was applied at the local site of the haematoma. On the next day, the patient became febrile. The size of the haematoma increased in spite of the compression bandage for which surgical debridement of the wound was done. Infection was indicated by the laboratory investigations which showed that there was leucocytosis (TLC: 21,000 cells/mm³) with a high neutrophil count (differential leucocyte count, DLC N 90%, L₉, M₂, E₀), Hb: 6 g/dL, platelets: 90,000/µL, blood urea: 80 mg/dL and serum creatinine: 2.1 mg/dL. Inj. tazact (2.5 g IV tds), inj. meropenem (1 g IV tds) and inj. metronidazole (100 mL IV tds) were added to the treatment regimen to combat the infection.

Urine and blood were sent to the microbiology laboratory for culture and sensitivity. No growth of pyogenic organisms was found on culturing the urine. However, turbidity and haemolysis were seen in the blood culture bottle, which was further subcultured on blood agar and MacConkey agar media. Colonies about 1 mm in diameter, circular, low convex, smooth, shining, nonhaemolytic and having entire margins grew on blood agar medium. Mucoid, nonlactose fermenting colonies were found on MacConkey agar medium. On Gram staining, gram-negative bacilli with no specific arrangement were seen. The organism was motile, oxidase-positive, catalase-positive, nonfermenter (alkaline butt and alkaline slant on triple sugar iron (TSI) medium), utilized glucose, xylose and mannitol oxidatively on Hugh-Leifson oxidative/fermentative (OF) medium, hydrolyzed urea and reduced nitrate to nitrite. Esculin hydrolysis was not observed. The isolate was presumptively identified as \textit{O. anthropi}, which was further confirmed by RapID NF Plus system (a combination of conventional tests and single substrate chromogenic tests based on the microbial degradation of specific substrates detected by various indicator systems).

Antibiotic sensitivity was determined by Kirby Bauer's disc diffusion method. The isolate was found to be sensitive to ciprofloxacin (1 µg/disc), sulbactam-cefoperazone (30 µg/75 µg/disc) and imipenem (10 µg/disc), moderately sensitive to tobramycin (10 µg/disc) and resistant to piperacillin (30 µg/disc), ticarcillin (75 µg/disc), cefotaxime (10 µg/disc), cefoperazone (75 µg/disc), amikacin (30 µg/disc), gentamicin (10 µg/disc) and aztreonam (30 µg/disc). In spite of intensive treatment, the condition of the patient continued to deteriorate and he died on the seventh day.

**Discussion**

\textit{Ochrobactrum anthropi} is an aerobic, gram-negative bacillus widely distributed in aquatic environments. This organism rarely causes human infections but when encountered, it is frequently found to involve contaminated medical materials/devices and immunocompromised patients. It is generally believed that \textit{O. anthropi} is the only pathogenic species in the genus \textit{Ochrobactrum} that is most commonly encountered in clinical settings. Most reports of \textit{O. anthropi} bacteraemia are associated with intravenous line infections. In the present study, the organism was isolated from an elderly male suffering from coronary artery disease and having multiple predisposing factors. The patient died of septicaemia following surgical debridement of the haematoma, which had developed due to invasive procedures performed in the hospital.

Chertow has reported catheter-associated bacteraemia due to \textit{O. anthropi} in a haemodialysis patient with unexplained fever.[4] Another study reports the clinical and microbiological characteristics of \textit{O. anthropi} bacteraemia in 15 patients having serious underlying diseases.[1] Over a study period of two years, Kern et al.[5] have detected catheter-related bacteraemia due to \textit{O. anthropi} in four patients of acute leukaemia as the underlying disease. A case of life-threatening septic shock that occurred in an otherwise healthy host after administration of a peripheral venous infusion of a solution contaminated with \textit{O. anthropi} has also been reported.[6]

\textit{O. anthropi} appears to be an emerging opportunistic pathogen associated with the implantation of intravenous catheters or other foreign bodies in patients of debilitating illness. Although the organism seems to be of relatively low virulence, it can produce clinically significant, fatal infections in immunocompromised patients. Therefore, it is very important to implement effective methods of sterilization and infection control guidelines to prevent infection.

**References**


Intestinal maggots were isolated from a patient, who had reported to the Department of General Medicine of Sri Manakula Vinayagar Medical College, Puducherry, in southern India with complaints of abdominal distress, bloating of abdomen and intestinal hurry following a meal. He was diagnosed as a case of intestinal myiasis. M. stabulans is reported here because of its rare occurrence and the need to establish a correct diagnosis.

Key words: Albendazole, intestinal myiasis, Muscina stabulans

Maggots obtained from his stool were identified as Muscina stabulans based on characteristic patterns of posterior spiracles. Albendazole, intestinal myiasis, Muscina stabulans

Results

A repeat fresh sample collected on the same day within two hours after hospitalization, also confirmed the presence of maggots. He was diagnosed as a case of intestinal myiasis. The maggots were isolated from his stools, washed in normal saline (0.9%) and again in distilled water and then preserved in formalin (10%). The maggots were isolated from his stools, washed in normal saline (0.9%) and again in distilled water and then preserved in formalin (10%) and submitted to the Vector Control Research Centre (VCRC), Puducherry for identification of the species. At Vector Control Research Centre, the maggots were washed in distilled water again and soaked in 10% sodium hydroxide for six hours. The last segment of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of the maggots consisted of 11 apparent segments. Each segment had a belt of well-developed minute spines towards its posterior margin, except the anal segment, which had frontal concavity (Fig. 1). Both anterior and posterior ends of

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