Escherichia fergusonii: an Emerging Pathogen in South Orissa

Dear Editor,

Escherichia fergusonii and Enterobacter taylorae have recently been recognised as emerging pathogens. Formerly known as Enteric Group 10 and 19, these are new species in the family Enterobacteriaceae.1,2 By DNA hybridization, strains of E. fergusonii were found to be 90-97% related to the type strain (holotype) ATCC 35469 and most closely related to E. coli. E. fergusonii can be differentiated from E. coli by being sorbitol and lactose negative but adonitol positive.3 In the present study, 104 E. fergusonii strains were isolated from 600 clinical specimens processed at the Department of Microbiology MKCG medical college, during a period of one year (April 2003 to March 2004). Majority were isolated from wound infection (63) followed by urine (37), pleural fluid (3) and blood (1). E. fergusonii, E. hermannii and E. vulneris have been isolated from clinical specimens and from the intestinal contents of humans and warm blooded animals. They are opportunistic pathogens and have occasionally been associated with wound infections in humans.4 Isolation of E. fergusonii has also been reported from four different sites (gall bladder fluid, blood, faeces and superficial wound of abdomen) in a patient with pancreatic carcinoma and cholangiosepsis. Biochemical, antimicrobial susceptibility and susceptibility to polyvalent phage 0-1 and r RNA restriction analysis suggested that the four strains were of clonal origin, which ultimately proved a pathogenic potential in humans.5 Studies have reported E. fergusonii associated with bacteraemia, wound infection and UTI to be susceptible to Chloramphenicol, gentamicin and resistant to ampicillin.1 In the present study, 83% of the isolates were susceptible to amikacin followed by cephalorazone sulbactam combination (79%) and gatifloxacin (73%). Susceptibility to cefotaxime, ciprofloxacin and ampicillin was 53 and 33% respectively. Gentamicin and chloramphenicol were proved to be the least effective drugs against E. fergusonii. To the best of our knowledge E. fergusonii has not been reported earlier from this part of the world.

References


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Salmonella Nomenclature seen in the Literature

Dear Editor,

Approse the case reports/correspondence published in July 2003, April and July 2004 issues1-3 the nomenclature system used at CDC for members of the genus Salmonella has undergone certain changes based on recommendations from the WHO collaborating center, which have been neglected in the cited articles. According to this system, genus Salmonella has two species S. enterica and S. bongori. Further, S. enterica has six subspecies I, II, IIa, IIIb, IV and VI. CDC uses names for serotypes in subspecies I and uses antigenic formulae for unnamed serotypes described after 1966 in the subspecies II, IV, Viand in S. bongori. At the first citation of a serotype the genus name is given, followed by the word “serotype” or the abbreviation “ser” and then the serotype name (for example Salmonella serotype or ser. Typhi). Subsequently, the name may be written with the genus followed directly by the serotype name which is capitalized not italicized for example

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Salmonella Paratyhi A or S.Paratyphi A. In 1999, at the ASM Publication Board Meeting, a proposal that all relevant ASM journals adopt the Salmonella nomenclature currently used at CDC, was unanimously endorsed by the board with plans to update 2000 ASM Instruction to authors. Currently, most of the journals all over the world have adopted this system.

Salmonella nomenclature is complex and scientists use different systems to refer to and communicate about the genus. However, uniformity in this regard is necessary for communication between scientists, health officials and public. The Salmonella nomenclature currently used at CDC adequate addresses the concern and requirements of clinical and public health microbiologists.

References

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Keratitis due to Colletotrichum dematium

Dear Editor,

We read with great interest the case report by Mendiratta et al. Concerning keratitis due to Colletotrichum dematium. Although two such studies2,3 have already been reported from India, we appreciate the authors’ interest in reporting the clinical features and microbiological aspects of another patient with Colletotrichum keratitis, particularly since this patient is from a different region of India. We would, however, like to offer a few comments:

1. It would have been very useful if further details on the clinical aspects, particularly the outcome of therapy, had been provided. What was the rationale for treating the patient with antibacterials, in conjunction with antifungals?
2. Was there any special reason for the authors to use three slants of the same medium (Sabouraud dextrose agar) for inoculation of the corneal scrapings? Although slants are helpful to ensure that contamination is minimised, it is very difficult to determine the significance of primary growth appearing on slants. Hence, plate cultures are encouraged to assess whether the growth is from the inoculated specimen or is a contaminant (the corneal scrapes are inoculated in the form of “C” streaks on the plate; only growth on the ‘C’ streaks is deemed significant).
3. The criteria followed to consider the growth to be significant are not stated.
4. The photographs are excellent. However, the legends do not correspond to the figures as they appear in the manuscript. For example, in figure B, the reverse of the colony, as it appears in the photograph, does not exhibit a deep brown colour; in figure C, the shape of the C.dematium conidia is not clearly visible in the picture. There are also a few spelling mistakes in the legends to the figures. The spelling of “appresorium” should be “appressorium”, similarly the “conida” should be “conidia” and “acervullus” should be acervulus”.
5. The authors have described the setae as being non-septate; however, line drawings of the setae, as they appear in a standard atlas of mycology by de Hoog and Guarro, suggest that these are, in fact, septate.
6. There are some mistakes in the references cited.
   a) In reference no.4 (Kaliamurthy et al), the journal number should be 23 and not 21.
   b) We believe that the citation of reference no.6 is also wrong. The cover of the book ‘Atlas of Clinical Fungi’ clearly states ‘edited by G.S. de Hoog and J.Guarro’ and not the other two names. Similarly, we believe that the authors have referred to the first edition of the book, which was published in 1995, and not to the second edition, which was published in 2000.
   c) In reference no. 5 cited, fungus name should be “Colletotrichum dematium” and not “Colletotrichum dematius” (as printed).