Table 1. Summary of data from cases of aeromonas arthritis.

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Reference</th>
<th>Age (y)</th>
<th>Predisposing factor(s)</th>
<th>Extraarticular infection</th>
<th>Blood culture</th>
<th>Portal of entry</th>
<th>Involved joint</th>
<th>Synovial fluid WBC count in mm(^3) (% neutrophils)</th>
<th>Organism</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>[4]</td>
<td>45/M</td>
<td>Alcoholic liver disease</td>
<td>Peritonitis</td>
<td>HS</td>
<td>Bilateral glenohumeral</td>
<td>259,000 (NA)</td>
<td>85,000 (NA)</td>
<td>A. hydrophila</td>
</tr>
<tr>
<td>2</td>
<td>[5]</td>
<td>15/M</td>
<td>None</td>
<td>None</td>
<td>Penetrating wound</td>
<td>Knee</td>
<td>NA</td>
<td>A. hydrophila</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>[6]</td>
<td>65/F</td>
<td>Acute myeloblastic leukemia</td>
<td>Cellulitis</td>
<td>HS</td>
<td>Left knee</td>
<td>9,800 (45)</td>
<td>A. hydrophila</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>[6]</td>
<td>36/M</td>
<td>Chronic myelogenous leukemia</td>
<td>None</td>
<td>HS</td>
<td>Right knee</td>
<td>90,000 (97)</td>
<td>A. hydrophila</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>[7]</td>
<td>16/M</td>
<td>Acute myelogenous leukemia</td>
<td>Cellulitis</td>
<td>HS</td>
<td>Second right metacarpal phalangeal</td>
<td>NA</td>
<td>A. hydrophila</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>31/M</td>
<td></td>
<td>Cirrhosis, OLT</td>
<td>None</td>
<td>HS</td>
<td>Left knee</td>
<td>104,000 (89)</td>
<td>A. veronii (sobria)</td>
<td></td>
</tr>
</tbody>
</table>

NOTE. HS = hematogenous spread; NA = data not available; OLT = orthotopic liver transplantation; + = positive; − = negative.

Intestinal permeability is also elevated in cirrhotic patients and has contributed to bacterial infections [10]. A. veronii biotype sobria differs from the other pathogenic Aeromonas species in that it remains susceptible to first- and second-generation cephalosporins [5]. Co-trimoxazole and ciprofloxacin are good choices for oral therapy [2]. Septic arthritis due to Aeromonas species is rare. This infection usually occurs in immunocompromised patients.

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References

Acute Prostatitis with Prostatic Abscess Caused by Group B Streptococcus

Group B Streptococcus (GBS), or Streptococcus agalactiae, causes puerperal sepsis and neonatal infections [1]. The occurrence of invasive infections due to GBS in nonpregnant adults is now well recognized [2]. Numerous cases of upper and lower urinary-tract infections in nonpregnant adults have been reported, but we have found only two cases in the literature (MEDLINE search) of probable prostatitis due to GBS [3] and none of prostatic abscess. We describe a case of prostatic abscess due to GBS.

A 45-year-old male with diabetes mellitus type II controlled by diet was evaluated for complaints of dysuria and perineal discomfort. He started receiving therapy with ofloxacin as an outpatient. Two days later he presented to the emergency room of University Hospital of Geneva (Geneva) for evaluation of suprapubic pain. An urethral bladder catheter was inserted because of acute urinary retention, and a urine culture yielded pure GBS, >10^5 cfu/mL. This result was neglected for unknown reasons. Four days later, the patient complained of progressive, unbearable perineal pain as well as fever and chills. He was febrile (temperature, 39°C). The prostate was soft and extremely tender on digital examination. Ultrasonography did not reveal signs of abscess. The urethral catheter was replaced by a suprapubic catheter. Two pairs of blood cultures (BACTEC, Becton Dickinson Europe, Meylan, France)
Marburg and Ebola Hemorrhagic Fevers: Does the Primary Course of Infection Depend on the Accessibility of Organ-Specific Macrophages?

Viral hemorrhagic fevers (VHFs) are prime examples of emerging/reemerging infectious diseases that have increased in frequency worldwide in the past. Of the human VHFs, Marburg and Ebola hemorrhagic fevers are characterized by extreme, severe courses and high case-fatality rates. After the onset of nonspecific symptoms (e.g., fever, headache, and asthenia), patients infected with filoviruses (Marburg and Ebola viruses) display generalized fluid distribution problems, hypotension, coagulation disorders, and hemorrhages, finally resulting in fulminant shock and death [1, 2]. These symptoms are comparable to those of the cytokine-induced systemic inflammatory response syndrome that is a surplus reaction of the host triggered by pathogens or their products [3]. Since filoviruses do not produce substances comparable to the endotoxins or exotoxins of bacteria, the pathophysiology of these devastating infections remains unknown. Because filoviruses are classified as

Figure 1. CT scan of a patient with acute prostatitis due to group B Streptococcus demonstrates prostatic abscess (arrow).

Penicillin G is the antibiotic of choice for treatment of infections due to GBS, given that GBS are uniformly susceptible in vitro. High doses (10–12 million units q.d.) are recommended because MICs for GBS are higher than those for group A strains [1]. Quinolones have only moderate in vitro activity against GBS [1, 5].

Our patient developed a prostatic abscess. Diabetes mellitus, insertion of an urethral catheter, and inappropriate initial antibiotic treatment may have all contributed to the occurrence of this rare complication [6, 7]. Various drainage procedures have been described [6, 7]. Although transurethral interventions are preferred, due to the extent of the abscess in our patient, perineal drainage by means of incision was undertaken.

In conclusion, prostatitis, prostatic abscess, or infection due to an unusual pathogen like GBS should be a consideration for male patients with urinary-tract infections that do not respond to standard antimicrobial treatment.

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