

J Antimicrob Chemother 2010
doi:10.1093/jac/dkq241
Advance publication 1 July 2010

Human infection associated with methicillin-resistant *Staphylococcus pseudintermedius* ST71

Ramona Stegmann¹, André Burnens²,
Christian A. Maranta³ and Vincent Perreten^{1*}

¹Institute of Veterinary Bacteriology, Vetsuisse Faculty, University of Berne, Berne, Switzerland; ²Medica, Medical Laboratories Dr F. Kaeppli, POB, 8024 Zürich, Switzerland; ³Orlpraxen Küssnacht, Seestr. 29, 8700 Küssnacht, Switzerland

*Corresponding author. Tel: +41-31-631-2430; Fax: +41-31-631-2634; E-mail: vincent.perreten@vbi.unibe.ch

Keywords: MRSP, zoonosis, antibiotic resistance

Sir,
Staphylococcus pseudintermedius is one of the most common pathogens isolated from skin and post-operative infections in dogs and cats^{1,2} and can also occasionally cause infections in humans.^{3,4} People working or living with animals are more

likely to be colonized with *S. pseudintermedius* in their nasal cavities⁵ and human infection acquired from dogs has been recently reported.⁴ In recent years, there have been increasing numbers of infections in dogs and cats caused by methicillin-resistant *S. pseudintermedius* (MRSP) and a predominant MRSP clone is disseminating in dogs and cats throughout Europe.^{1,2} This MRSP clone belongs to the multilocus sequence type (MLST) ST71, *spa* type t02 and SmaI PFGE group J (ST71-t02-J) and contains the staphylococcal cassette chromosome element SCCmec II-III.¹ It displays resistance to many classes of antibiotics and represents a challenge for therapy. Here, we report, to our knowledge, the first case of a human infection caused by MRSP ST71 emphasizing its zoonotic potential and therapeutic challenge.

An adult patient presented to the doctor in 2009 with headache, watery eyes and a small oedema over the right eye. The patient had a history of recurrent rhinosinusitis and three surgical interventions had been performed over the previous 6 years, the last one in 2005. CT illustrated an obliteration of the right sinus frontalis with an expansive mucocele. Yet another surgical intervention was absolutely essential and post-operative treatment for 3 weeks with 500 mg of ciprofloxacin twice per day and 300 mg of clindamycin three times per day was given. Five weeks post-operatively, a purulent infection appeared. After 10 days of treatment with 875 mg of amoxicillin/125 mg of clavulanic acid twice daily and 300 mg of clindamycin three times daily and no improvement, a sample was sent for bacteriological analysis. The laboratory identified a multidrug-resistant

Table 1. MICs of 22 antibiotics and antibiotic resistance genes in *S. pseudintermedius* ST71, strain 27366

Antibiotics	Resistance breakpoints ^a (mg/L)	MICs (mg/L)	Resistance genes
Amikacin	≥64	≤16	—
Amoxicillin/clavulanic acid	≥8/4	8/4	<i>mecA</i>
Cefalotin	≥32	32	<i>mecA</i>
Chloramphenicol	≥32	8	—
Clindamycin	≥4	>8	<i>erm(B)</i>
Enrofloxacin	≥4	>16	<i>grIA</i> (Ser80Ile); <i>gyrA</i> (Ser84Leu)
Erythromycin	≥8	>16	<i>erm(B)</i>
Fusidic acid	NA	≤0.12	—
Gentamicin	≥16	16	<i>aac(6′)-Ie-aph(2)-Ia</i>
Kanamycin	≥64	>128	<i>aph(3′)-III</i>
Linezolid	≥8	≤1	—
Mupirocin	NA	≤4	—
Nitrofurantoin	≥128	≤16	—
Oxacillin	≥0.5 ^b	>8	<i>mecA</i>
Penicillin	≥0.25	8	<i>blaZ</i> ; <i>mecA</i>
Quinupristin/dalfopristin	≥4	1	—
Rifampicin	≥4	≤0.12	—
Streptomycin	≥32	>32	<i>ant(6)-Ia</i>
Tetracycline	≥16	>32	<i>tet(K)</i>
Trimethoprim/sulfamethoxazole	≥4/76	>8/152	<i>dfr(G)/ND</i>
Trimethoprim	≥16	>128	<i>dfr(G)</i>
Vancomycin	≥32 ^b	≤1	—

NA, not available; ND, not determined; —, no gene was detected.

^aResistance breakpoints were those recommended for *Staphylococcus* spp. in the CLSI Informational Supplement M100-S20 (www.clsi.org), except for streptomycin, for which the breakpoint from the French Society for Microbiology (www.sfm.asso.fr) was used.

^bThis breakpoint is applicable to CoNS.

Staphylococcus belonging to the *Staphylococcus intermedius* group (SIG) using the ID 32 STAPH system (bioMérieux, Marcy l'Étoile, France) and disc diffusion susceptibility testing (Oxoid Ltd, Basingstoke, UK). Based on these results, a local treatment with fusidic acid gauze and application of 2% mupirocin ointment four times a day for 8 days followed by a topical glucocorticoid/antibiotic combination therapy (0.5 mg/g fluocinonide, 2.5 mg/g neomycin, 0.25 mg/g gramicidin and 100 000 IU/g nystatin) packing for 4 days improved the local condition. Six weeks after the purulent infection, the wound had healed with scarring and no bacterium was detectable in a repeat smear. Local follow-up treatment with steroids and routine check-ups confirmed the absence of residual infection.

The multidrug-resistant *Staphylococcus* isolate was further identified as MRSP ST71-t02-J containing SCCmec II–III using MLST typing, *spa* typing, PFGE and SCCmec typing methods described previously.¹ MICs of antibiotics were determined in Mueller–Hinton broth using custom Sensititre susceptibility NLV73 plates (Trek Diagnostics System, East Grinstead, UK) except for rifampicin, trimethoprim, kanamycin and fusidic acid, which were tested using home-made microbroth dilution plates. Antibiotic resistance genes were detected using a microarray.⁶ Mutations in topoisomerase genes *gyrA* and *griA* were identified by sequencing of PCR products⁷ (Table 1). The isolate was susceptible to the antibiotics amikacin, chloramphenicol, fusidic acid, linezolid, nitrofurantoin, the combination quinupristin/dalfopristin, rifampicin and vancomycin (Table 1).

The patient owned a male dog that needed home care because of various clinical problems such as diabetes, recurrent warts and abdominal tumour. The dog had consultations in various clinics and underwent several antibiotic treatments (details of substances could not be ascertained). The dog was euthanized before samples could be taken to determine whether it was a carrier of the strain. The patient also owned horses and cats; all of them were in good health without clinical signs. Even if the ultimate source of the MRSP infection could not be identified, the patient was infected with the same MRSP clone (ST71-t02-J with SCCmec II–III) that has been disseminating in dogs over Europe in recent years.¹

A case similar to the one reported here has been described in the USA, where a woman developed sinusitis caused by a methicillin-resistant SIG whose origin could be attributed to her pet dog.⁸ In that case, vancomycin and linezolid were used for treatment.

The increasing number of dogs carrying MRSP constitutes a risk for pet owners to become colonized with MRSP, and MRSP infections in humans may also increase in the near future. It is therefore important to recognize MRSP as a zoonotic pathogen and have antibiotics available for the treatment of MRSP infections in humans. Therefore, antibiotics such as mupirocin, linezolid, quinupristin/dalfopristin, rifampicin and vancomycin that are used for decolonization or as 'last resort antibiotics' against methicillin-resistant staphylococci in humans should not be used for treatment in animals.

Acknowledgements

We are grateful to Anne-Sylvie Passen-Borel, Veterinary Practice Rütli, for providing clinical information on the dog and to Russell Kempker, Emory

University School of Medicine, Atlanta, who kindly gave us information related to the SIG case in the USA.

Funding

This study was partially supported by the installation grant of the Vetsuisse Faculty of the University of Berne to V. P.; some of the data have been generated as part of our routine work.

Transparency declarations

None to declare.

References

- Perreten V, Kadlec K, Schwarz S et al. Clonal spread of methicillin-resistant *Staphylococcus pseudintermedius* in Europe and North America: an international multicentre study. *J Antimicrob Chemother* 2010; **65**: 1145–54.
- Kadlec K, Schwarz S, Perreten V et al. Molecular analysis of methicillin-resistant *Staphylococcus pseudintermedius* of feline origin from different European countries and North America. *J Antimicrob Chemother* 2010; **65**: 1826–8.
- Van Hoovels L, Vankeerberghen A, Boel A et al. First case of *Staphylococcus pseudintermedius* infection in a human. *J Clin Microbiol* 2006; **44**: 4609–12.
- Chuang CY, Yang YL, Hsueh PR et al. Catheter-related bacteremia caused by *Staphylococcus pseudintermedius* refractory to antibiotic-lock therapy in a hemophilic child with dog exposure. *J Clin Microbiol* 2010; **48**: 1497–8.
- Weese JS, van Duijken E. Methicillin-resistant *Staphylococcus aureus* and *Staphylococcus pseudintermedius* in veterinary medicine. *Vet Microbiol* 2010; **140**: 418–29.
- Perreten V, Vorlet-Fawer L, Slickers P et al. Microarray-based detection of 90 antibiotic resistance genes of Gram-positive bacteria. *J Clin Microbiol* 2005; **43**: 2291–302.
- Descloux S, Rossano A, Perreten V. Characterization of new staphylococcal cassette chromosome *mec* (SCCmec) and topoisomerase genes in fluoroquinolone- and methicillin-resistant *Staphylococcus pseudintermedius*. *J Clin Microbiol* 2008; **46**: 1818–23.
- Kempker R, Mangalat D, Kongphet-Tran T et al. Beware of the pet dog: a case of *Staphylococcus intermedius* infection. *Am J Med Sci* 2009; **338**: 425–7.

J Antimicrob Chemother 2010

doi:10.1093/jac/dkq224

Advance publication 16 June 2010

Successful treatment with tigecycline of two patients with complicated urinary tract infections caused by extended-spectrum β -lactamase-producing *Escherichia coli*

Suzanne E. Geerlings^{1*}, Karlijn A. M. I. van Donselaar-van der Pant² and Ingrid Keur²