Hydatid Cyst. Case Report

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A 47-year-old female was admitted to emergency room due to dyspnea hypotension and stupor. Medical history of sulfonamide allergy, Hemolymphangioma diagnosed and treated with thoracic laminectomy. She was healthy until 15 days before admission. She began with dyspnea, triggered by postural changes, increasingly severe. Three days later, nausea, fever and night sweats were added to the initial symptoms; five days prior to admission fatigue, weakness, and pulsatile headache began. Finally, she presented discomfort, acute loss of consciousness and was admitted to our hospital. At arrival, her vitals were BP 90/50 mmHg, HR 124 bpm, RR 32 bpm, SPO2 80% ambient air. She presented difficulty breathing, audible inspiratory stridor and stupor. Endotracheal intubation was performed. Bilateral expiratory wheezing was found, rest of physical examination was unremarkable. Chest radiography showed no infiltrates, and properly positioned endotracheal tube; hemoglobin 18.2 g/dl, WBC 14.2 k/l, neutrophil 13.5 k/l, platelets 196 k/l, glucose 104 mg/dl, BUN 17 mg/dl, creatinine 1.1 mg/dl, albumin 3.1 g/dl, AST 74 IU/l, ALT 36 IU/l, FA 60 IU/l, bilirubin 0.9 mg/dl. Salbutamol, Hydrocortisone and Norepinephrine were administered to treat anaphylactic shock. On Angio-CT we observe a hint of a hepatic lesion. Abdominal ultrasound found a cystic lesion 7.7 x 7.3 x 5.5 cm, visible wall with anechoic content; hydatid cyst CE3a, according to WHO classification is diagnosed. Albendazole 400 mg BID, was administered, ELSA IgG vs Echinococcus granulosus reported positive. She was discharged and staffed in outpatient follow-up during 3 months.

QuantiFERON-TB Gold In-tube testing took from healthy blood donor were recruited from blood bank at King Saud University (KSU) and volunteers from Riyadh region, with further contact to the TB patients represented by 33 (5.9%) and 7 (1.2%) had a previous history of TB infection. Nearly forty-six percent of the isolates were found to be biofilm producers and 36 (53.7%) biofilm non-producers. Klebsiella pneumoniae, Pseudomonas aeruginosa and Burkholderia cepacia complex were found to be the most frequent biofilm producers. The TA method can be an economical and effective alternative to TCP method. For the detection of biofilm production, Gram-positive isolates were Vancomycin and Tigecycline, and that for biofilm producing strains. Due to its morphology, it is often misidentified as staphylococci. On blood agar it causes alpha hemolysis and may also be mistaken for Streptococcus viridans. It also shares similar antibiotic resistance patterns as Enterococci spp and may be misidentified as such. This has therapeutic implications. We review and discuss the infections caused by Aerococcus Urinae, its diagnosis and management.

Biofilm Production and Antibiotic Resistance Pattern in Clinical Isolates from Indwelling Medical Devices

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Background: Microbial biofilms pose great threat for patients requiring indwelling medical devices (IMDs) as it is difficult to eradicate them. Besides, sublethal concentration of some antibiotics has been shown to induce biofilm in bacteria. It is, therefore, crucial to follow an appropriate and relevant method for the detection of biofilms and hence the clinician can choose appropriate antibiotic for the treatment.

Methods: This prospective analysis included 65 prosthetic samples. After isolation and identification of bacteria following standard methodology, antibiogram of the isolates was performed. The antibiotic susceptibility pattern in the present study showed Amoxicillin to be an ineffective drug for isolates from the IMDs. For the detection of biofilm production, Gram-positive cocci in clusters in blood culture: It Ain’t Always Staphylococcal Spp! A Review of Aerococcus Urinae Infections

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Case report: A previously healthy 36 year old male presented with difficulty passing urine after sexual intercourse. This was associated with fever and dysuria. On examination, he was febrile at 37.9 degrees but did not appear septic. There was no loin tenderness, palpable bladder or prostatic tenderness; other systems were normal. He had raised white count of 16,000 (90% poly) and procalcitonin of 23.7. Urine microscopic examination showed pyuria. Blood cultures isolated gram-positive cocci in clusters. He was given empirical vancomycin to cover for Staph. Aureus and Coagulase-Negative Staphylococci. The gram-positive organism was subsequently identified as Aerococcus Urinae. Aerococcus Urinae, first described in 1992, as a catalase-negative environmental Gram-positive coccus growing in clusters; and colonizer of the urinary tract, is increasingly reported to cause urinary tract infections. It can also cause invasive infections such as bacteremia and infective endocarditis. Due to its morphology, it is often misidentified as staphylococci. On blood agar it causes alpha hemolysis and may also be mistaken for Streptococcus viridans. It also shares similar antibiotic resistance patterns as Enterococci spp and may be misidentified as such. This has therapeutic implications. We review and discuss the infections caused by Aerococcus Urinae, its diagnosis and management.

Gram-positive cocci in clusters in blood culture. It Ain’t Always Staphylococcal Spp! A Review of Aerococcus Urinae Infections