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About the Author

Dr. Kuchta is a researcher at the Institute of Parasitology in the Czech Academy of Sciences. His research interests include parasite biology, phylogeny, and molecular diagnosis of parasitic diseases, mainly diphyllobothriosis and sparganosis.

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Address for correspondence: Roman Kuchta, Biology Centre of the Czech Academy of Sciences, Institute of Parasitology, Branišovská 31, České Budějovice 370 05, Czech Republic; email: krtek@paru.cas.cz

LETTERS

Achromobacter xylosoxidans Infections after Prostate Biopsies, France, 2014

Lucie Amoureux, Julien Bador, Catherine Neuwirth

Author affiliation: University Hospital of Dijon, Dijon, France

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To the Editor: We read with interest the article by Haviari et al. concerning a health care–associated outbreak of *Achromobacter xylosoxidans* infections after prostate biopsies (*1*). Although noteworthy, the description lacks some data.

First, the isolates of *Achromobacter* cannot be referred to as *A. xylosoxidans* from just the method used in this study, API 20 NE mass spectrometry (bioMérieux, https://www.biomerieux.com). Since 2012, a total of 18 species have been defined in the genus *Achromobacter* (*2*). Only multilocus sequence typing or sequencing 765 bp of the housekeeping gene *nrdA* enables the identification of the isolates to the species level (*3*). To date, in the few studies available, a great variety of species have been detected in clinical samples, with *A. xylosoxidans* the most predominant (*4,5*). Correct identification of the isolates involved in all types of infection is necessary to help understand the epidemiology, pathogenicity, and resistance pattern of the various species.

Second, the antimicrobial drug resistance profiles are not given (except for ceftriaxone, which is an intrinsic resistance, and ofloxacin) but again are valuable epidemiologic data. This information might help in detecting the emergence of new cases in the unit or in other hospitals, as well as in discussing the therapeutic options.

Finally, all the bacteria recovered in the container belonged to environmental waterborne genera frequently encountered in wet sites in hospitals. As discussed by the authors, these microorganisms have been involved in contamination of antiseptic solutions containing quaternary ammonium compounds or chlorhexidine. Unfortunately, the authors did not mention which disinfectants were used in the biopsy room (for hands, sinks, surfaces, or containers)

and did not investigate for these potential sources of contamination. In the absence of identification of any reservoir and despite the new measures adopted, new cases might still occur.

In conclusion, these missing data are needed for other hospitals to identify epidemiogenic *Achromobacter* isolates. Complete information would help in implementing control measures to contain and prevent outbreaks.

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Address for correspondence: Lucie Amoureux, Hôpital Universitaire Laboratoire de Bactériologie, Plateau Technique de Biologie, BP 37013, 21070, Dijon, CEDEX, France; email: lucie.amoureux@chu-dijon.fr

Macrolide-Resistant *Mycoplasma genitalium* in Southeastern Region of the Netherlands, 2014–2017

Marta Adelantado, Ana Navascués, Xabier Beristain, Alberto Gil-Setas, Maria E. Portillo, Aitziber Aguinaga, Carmen Ezpeleta

Author affiliation: Complejo Hospitalario de Navarra Department of Clinical Microbiology, Pamplona, Spain

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To the Editor: We read with interest the article by Martens et al., which analyzed the frequency of macrolide resistance–mediating mutations in *Mycoplasma genitalium* infections in the southeastern region of the Netherlands during 2014–2017 (*1*). The authors reported high rates of macrolide resistance in *M. genitalium* infections (281/827; 34.0%) and observed a decrease in the rate in 2017 (115/290; 39.7%) compared with 2016 (92/207; 44.4%), after an increase in the number of tests of cure performed.

Increasing rates of macrolide resistance in *M. genitalium* are a problem not only in the Netherlands but also worldwide: 77.4% in New Zealand (*2*) and 41% in the United Kingdom (*3*). Macrolide resistance in *M. genitalium* as a consequence of single-dose azithromycin treatment has been previously reported (*4*). European Academy of Dermatology and Venereology guidelines recommend azithromycin in an extended regimen (500 mg day 1,250 mg days 2–5, orally) as a first-line treatment, followed by a test of cure 4–6 weeks after treatment (*5*).

In northern Spain, local protocols for the treatment of *M. genitalium* infections are based on the European guideline. We performed a prospective/retrospective study during August 2015–October 2018. We confirmed 173 cases of *M. genitalium* infection; mean patient age was 29.4 years, and 57.2% (99/173) were male. We found macrolide-resistant *M. genitalium* strains in 21.8% (27/124) patients, which is a lower rate than was found in the Netherlands. Most of the patients attending posttreatment follow-up showed wild-type *M. genitalium,* and only 10.9% (5/46) became resistant to azithromycin treatment, in contrast with 89.6% (60/67) reported by Martens et al. We suggest that the decrease in macrolide resistance resulted from the increased number of posttreatment follow-ups. Our data confirm this. We believe that giving local advice on the basis of extended azithromycin treatment and posttreatment follow-up can limit the spread of macrolide resistance.