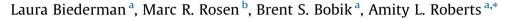
IDCases 2 (2015) 97-98

Contents lists available at ScienceDirect

IDCases

journal homepage: www.elsevier.com/locate/idcr

Bordetella petrii recovered from chronic pansinusitis in an adult with cystic fibrosis



^a Department of Pathology, Anatomy and Cell Biology, Sidney Kimmel Medical College at Thomas Jefferson University, Pavilion Building, Suite 207, Philadelphia, PA 19107, USA

^b Department of Otolaryngology-Head and Neck Surgery, Sidney Kimmel Medical College at Thomas Jefferson University, 925 Chestnut Street, 6th Floor, Philadelphia, PA 19107, USA

ARTICLE INFO

Article history: Received 1 August 2015 Received in revised form 16 September 2015 Accepted 16 September 2015

Keywords: Bordetella petrii Pansinusitis Adult cystic fibrosis MALDI-TOF

ABSTRACT

To date *Bordetella petrii* has infrequently been identified within the clinical setting likely due to the asaccharolytic nature of this organism. We present a case of *B. petrii* recovered on two separate events in a patient with adult cystic fibrosis experiencing chronic pansinusitis.

© 2015 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

Case report

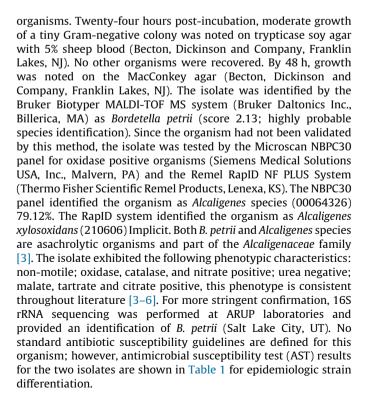
We present a 41-year old female with a 20 plus year history of nasal obstruction and chronic sinusitis. Her clinical history indicated velopharyneal insufficiency (incomplete closure of the velopharyngeal sphincter between the oropharynx and the nasopharynx), severe gastroparesis, significant gastric reflux and asthma contributed to a confirmed cystic fibrosis mutation, Δ F508 gene. Individuals diagnosed with adult cystic fibrosis frequently experience gastroparesis, asthma and chronic sinusitis [1,2].

Historically, the patient underwent several surgical interventions, multiple rounds of antimicrobials, decongestants, antihistamines, topical and oral steroids without improvement of her diffuse pansinusitis. In an attempt to alleviate her chronic sinusitis, revision endoscopic sinus surgery with septoplasty and a turbinectomy was performed during early 2014 (day 0). A right maxillary sinus tissue specimen was sent for aerobic bacterial culture, which was incubated aerobically only with 5% CO₂ at 35 °C. The specimen Gram-stain showed few white-blood cells and no

E-mail addresses: laura.biederman@jefferson.edu (L. Biederman), marc.rosen@jefferson.edu (M.R. Rosen), brent.bobik@jefferson.edu (B.S. Bobik), amity.roberts@jefferson.edu (A.L. Roberts).

http://dx.doi.org/10.1016/j.idcr.2015.09.004

^{2214-2509/© 2015} The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/ 4.0/).







Case Report



^{*} Corresponding author at: Department of Pathology, Anatomy and Cell Biology, Sidney Kimmel Medical College at Thomas Jefferson University, 117 S 11th Street, Pavilion Suite 207, Philadelphia, PA 19107, USA. Tel.: +1 215 955 8726; fax: +1 215 955 2519.

Table 1

Results of antimicrobial su	sceptibility to	esting for both	isolate one and ty	wo.

Antimicrobial agent	Isolate one	Isolate two
	MIC (µg/mL)	MIC (µg/mL)
Ampicillin	>16	>16
Ampicillin/sulbactam	16/8	16/8
Amikacin	≤ 16	≤ 16
Amoxicillin/K Clavulanate	$\leq 8/4$	$\leq 8/4$
Gentamicin	≥ 8	≤ 4
Imipenem	≤ 4	≤ 4
Levofloxacin	≤ 2	≤ 2
Ciprofloxacin	>2	>2
Moxifloxacin	4	4
Gatifloxacin	≤ 2	≤ 2
Norfloxacin	>8	>8
Piperacillin/tazobactam	$\leq 16/4$	$\leq 16/4$
Tetracycline	≤ 4	≤ 4
Ticarcillin/K clavulanate	≤ 16	≤ 16
Tobramycin	≤ 4	≤ 4
Trimethoprim/sulfamethoxazole	≥2/38	≤2/38
Aztreonam	>16	>16
Cefepime	>16	>16
Cefuroxime	>16	>16
Cefazolin	>16	>16
Cephalothin	>16	>16
Cefoxitin	>16	>16
Cefotetan	>32	>32
Cefotaxime	>32	>32
Ceftazidime	≤ 8	>16
Ceftriaxone	>32	>32
Meropenem	>8	>8
Chloramphenicol	>16	>16
Meropenem	≤ 4	≤ 4
Piperacillin	≤ 16	≤ 16
Nitrofurantoin	>64	>64

Microscan NBPC30 for oxidase positive Gram-negative bacteria.

The patient was not treated specifically for *B. petrii* as improvement was noted with the standard post-operative antimicrobial regime of various corticosteroids, oral erythromycin (250 mg/mL, four times a day) and oral cefdinir (300 mg, every 12 h for 10 days). Based on the AST profile of the isolate (Table 1), particularly ceftriaxone and cefotaxime with minimal inhibitory concentrations (MICs) >32 mg/mL, one would expect the organism to be resistant to cefdinir, another 3rd generation cephalosporin. Erythromycin was not tested for this isolate but other studies have shown resistance toward 3rd generation cephalosporins and also toward erythromycin [4,7,8]. One study indicated that piperacillintazobactam is the only effective treatment for *B. petrii* [7].

At outpatient follow-up (29 days post-procedure), she underwent endoscopy with collection of a second sinus culture via flocked swab. The direct Gram-stain of the sinus specimen showed few white-blood cells and no organisms. Again, moderate growth of *B. petrii* (MALDI-TOF score 2.00; secure genus identification, probable species identification) occurred, indicating that the initial post-operative antimicrobial therapy did not eradicate *B. petrii*. There was very light growth of normal respiratory flora.

Discussion

There are nine different *Bordetella* species of these *B. petrii* is the only species that does not exhibit a human host tissue tropism [4,6]. This species was first identified in 2001 after isolation from an anaerobic bioreactor enriched with river sediment [6]. Clinically, *B. petrii* has rarely been isolated from clinical specimens and has not been well described as a pathogen. This is likely due to the asacchrolytic nature of the organism in addition to the *B. petrii* not being contained in most automated identification system libraries.

There has been a limited number of case reports with *B. petrii* defined as the etiologic agent [4,5,7–10]. *B. petrii* has been implicated as the causative agent in cases of mandibular osteomyelitis, chronic suppurative mastoiditis, chronic pulmonary obstructive disease and persistent bronchiectasis [4,8–10]. Importantly, it has been previously isolated from in cystic fibrosis patients [5,7].

Because it is uncommon, or likely misidentified, accurate identification of *B. petrii* represents a challenge for traditional automated identification systems. These biochemical or enzymatic systems are only marginally effective, due to the lack of a distinct biochemical carbohydrate profile as well as limited or uncurated databases. Not only was B. petrii mis-identified by MicroScan (NBPC30) and rapID panels in the two described occasions for this patient, but it was also misidentified in other reported cases [10]. Studies show that *Bordetella* species are closely related to Achromobacter (Algaligenes) species [6,11]. The case patient had two sinus isolates identified three years prior as Achromobacter species (90%) by the BD Phoenix NMIC/ID-124 panel (Becton-Dickinson, Sparks, MD). Unfortunately, these isolates are no longer available to determine if they were misidentified. The gold standard method for identification of B. petrii is 16S rRNA sequencing [4,8,10]. At that time the patient was treated postoperatively with 1000 mg of cefazolin (MIC > 16 mg/mL), indicating inadequate coverage.

The importance of *B. petrii* as a clinical pathogen has not been well established; however, it has been described in cystic fibrosis patients [1,2,5,7]. *B. petrii* has been demonstrated to persist despite treatment in patients, as was potentially noted with her previous isolates of *Achromobacter* species [7,10]. By using the MALDI-TOF methodology the clinical laboratory can achieve not only quicker but more accurate organism identifications. More accurate identification can lead to more appropriate treatment and provide insight into the true clinical prevalence of organisms like *B. petrii*, which have been shown to be resilient colonizers especially within cystic fibrosis patients [7,10].

Acknowledgements

No conflicts of interest. No grant funding was utilized for this publication.

References

- Hunt B, Geddes DM. Newly diagnosed cystic fibrosis in middle and later life. Thorax 1985;40:23–6.
- [2] Nick JA, Rodman DM. Manifestations of cystic fibrosis diagnosed in adulthood. Curr Opin Pulm Med 2005;11:513–8.
- [3] Versalovic J, editor. Manual of clinical microbiology. Washington, DC: American Society for Microbiology; 2011.
 [4] Fry NK, Duncan J, Malnick H, Warner M, Smith AJ, Jackson MS, et al. *Bordetella*
- [4] Fry NK, Duncan J, Malnick H, Warner M, Smith AJ, Jackson MS, et al. Bordetella petrii clinical isolate. Emerg Infect Dis 2005;11:1131–3.
- [5] Spilker TLA, Lipuma JJ. Identification of *Bordetella* species in respiratory specimens from individuals with cystic fibrosis. Clin Microbiol Infect 2008;14: 504–6.
- [6] von Wintzingerode F, Schattke A, Siddiqui RA, Rosick U, Gobel UB, Gross R. Bordetella petrii sp. nov., isolated from an anaerobic bioreactor, and emended description of the genus Bordetella. Int J Syst Evol Microbiol 2001;51:1257–65.
- [7] Carleton A. Clustered multidrug-resistant *Bordetella petrii* in adult cystic fibrosis patients in Ireland: case report and review of antimicrobial therapies. JMM Case Rep. 2014. <u>http://dx.doi.org/10.1099/jmmcr.0.000075</u>.
- [8] Stark D, Riley LA, Harkness J, Marriott D. Bordetella petrii from a clinical sample in Australia: isolation and molecular identification. J Med Microbiol 2007;56: 435–7.
- [9] Zelazny AM, Ding L, Goldberg JB, Mijares LA, Conlan S, Conville PS, et al. Adaptability and persistence of the emerging pathogen *Bordetella petrii*. PLOS ONE 2013;8:e65102.
- [10] Le Coustumier A, Njamkepo E, Cattoir V, Guillot S, Guiso N. Bordetella petrii infection with long-lasting persistence in human. Emerg Infect Dis 2011;17: 612–8.
- [11] Gerlach G, von Wintzingerode F, Middendorf B, Gross R. Evolutionary trends in the genus *Bordetella*. Microbes Infect 2001;3:61–72.