Skin and Soft-tissue Infections Caused by Aeromonas sobria

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To the Editor We read with great interest the article by Chang et al. that described three cases of Aeromonas sobria (A. sobria) necrotizing fasciitis in neutropenic patients (1). They found that shock, multiple organ failure and ultimately fatal outcomes developed in all cases. Additionally, the clinical isolates of A. sobria were resistant to most antibiotics (1). In our recent work, we reported several different findings regarding skin and soft tissue infections (SSTI) caused by the Aeromonas species (2); however, we did not focus on A. sobria infection. Therefore, we performed a subgroup analysis of 22 cases of A. sobria SSTIs to help us better understand this clinical disease.

We conducted this study at Chi Mei Medical Center, Liouying branch, a 900-bed hospital located in southern Taiwan. Between January and December 2009, patients with A. sobria SSTIs were identified from the hospital’s computerized database. Through this survey, 22 cases of A. sobria SSTIs were identified. The clinical characteristics of all patients are shown in Table.

Malignancy was the most common underlying disease, followed by diabetes mellitus and liver cirrhosis. Approximately 30% (n=7) of the patients had a history of exposure to aqueous environments prior to infection and 64% (n=14) of the patients had trauma-related wound infections. Only two patients presented with necrotizing fasciitis. The majority (n=15, 68%) of patients had polymicrobial SSTIs, and the most common isolate obtained from the patients with polymicrobial infections was Klebsiella pneumoniae (n=5). Only one patient had concomitant A. sobria bacteremia. Overall, three patients were admitted to the intensive care unit, all of whom had acute respiratory failure. However, none of the patients required amputation or experienced mortality.

All of the 22 clinical isolates were susceptible to ceftazidime, cefpirome, imipenem, amikacin and gentamicin. More than 90% of the clinical isolates were susceptible to piperacillin-tazobactam and ciprofloxacin. In contrast, none of the isolates were susceptible to ampicillin or ampicillin-sulbactam.

In the present work, the clinical courses of the patients were not as fulminant as those observed in the study by Chang et al. (1). This difference may be attributed to different study populations and the fact that most of the patients in our study received surgical intervention. Moreover, the clinical isolates of A. sobria in this study still remained susceptible to 3rd generation cephalosporin in addition to fluoroquinolones. In conclusion, this clinical entity is uncommon; therefore, further large-scale studies are warranted.

The authors state that they have no Conflict of Interest (COI).

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