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Diphtheria-like Disease Caused by Toxigenic Corynebacterium ulcerans Strain

To the Editor: Toxigenic Corynebacterium ulcerans is an increasingly reported cause of diphtheria in the United Kingdom and is often associated with a zoonotic origin (1,2). Here, we report a case of diphtheria caused by toxigenic C. ulcerans in a woman, 51 years of age, from Scotland, UK, who was admitted to a hospital in August 2013 with a swollen, sore throat and a gray-white membrane over the pharyngeal surface. The patient had returned from a 2-week family holiday in the state of Florida, United States, before the admission and also reported recent treatment of a pet dog for pharyngitis.

The patient was believed to have been vaccinated against diphtheria during childhood. She was immediately admitted to an isolation ward and treated with a combination of clindamycin, penicillin, and metronidazole.

Microscopic examination of the throat biofilm (collected by using a swab) showed gram-positive bacilli; swab samples from the exudative membrane and throat produced small, black colonies indicative of Corynebacterium spp. on Hoyle medium. Further efforts to identify the strain by using VITEK MS and VITEK2 ANC card systems (bioMérieux, Marcy l’Étoile, France) to evaluate the swab samples suggested that the infection was caused by either C. ulcerans or C. pseudotuberculosis (50% CI). The isolate detected from this process was sent to the Streptococcus and Diphtheria Reference Unit, Public Health England, Colindale, UK, and was confirmed to be a toxigenic C. ulcerans strain that we designated RAH1. Throat swab samples were collected from family members of the patient and were negative for C. ulcerans. The family dog was not tested for presence of the organism, although it is known that C. ulcerans infections are often of a zoonotic nature (1,2). After treatment, the patient made a full recovery.

Toxigenic C. ulcerans can produce both diphtheria-like and Shiga-like toxins (3); to identify the genetic basis of toxin production and other potential virulence factors in this strain, a whole genome sequencing approach was applied to the isolate. The genome was sequenced by using an Ion PGM System (Thermo Fischer Scientific, Loughborough, Leicestershire, UK) and resulting reads (2,965,044 reads, 190× coverage. Data are available on GenBank SRA: high-throughput DNA and RNA sequence read archive (http://www.ncbi.nlm.nih.gov/Traces/sra/sra.cgi?view=search_obj, accession no.: SRR1145126) and were mapped onto the published genome sequences of a Shiga-like toxin–producing clinical isolate 809, asymptomatic canine strain BR-AD22 (3), and diphtheria-like toxin–producing strain 0102 (4). Most of the previously identified virulence genes (3,4) were present in the patient isolate (Table). The tox gene, encoding diphtheria toxin, was present, which verified the diphtheria-like disease in the patient. The rhp gene, responsible for Shiga toxin–like ribosome-binding protein, was absent. However, strain RAH1 also possessed the venom serine protease gene (vsp2), which, in C. ulcerans strain 809, has been implicated in the increased virulence in humans. The tox gene was present in a prophage that showed similarities to FCULC8091 (3) and FCULC0102-I (4). Genome-based phylogenetic analysis of the RAH1 strain (ClonalFrame analysis [5]) and strains 809, BR-AD22, and 0102 indicates a much wider phylogenetic diversity of C. ulcerans strains than previously appreciated (data not shown).

This case raises the issue of waning vaccine protection in older patients and suggests that toxin-mediated corynebacterial disease remains a threat to public health. The declining costs of next-generation sequencing and availability


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EMERGING INFECTIOUS DISEASES

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LETTERS
of easy-to-handle bioinformatics tools emphasize the suitability of deep-sequencing technology for rapid diagnostics and for the development of high-resolution genotyping. It is time for the wider introduction of this technology into public health investigations.

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References


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Death of Woman with Peripartum Influenza B Virus Infection and Necrotizing Pneumonia

To the Editor: Pregnant women are at increased risk for severe influenza-related complications (1). Bacterial pneumonia with Panton-Valentine leukocidin-producing (PVL) Staphylococcus aureus is infrequently described in the literature as occurring concurrently with influenza B virus infection (2–4). Additionally, only 2 occurrences of peripartum PVL-methicillin-resistant S. aureus (MRSA) pneumonia have been described (5,6). We report a case of influenza B virus and PVL-MRSA coinfection during pregnancy.

In December 2012, a previously healthy pregnant woman, 38 years of age, at 37 weeks’ gestation and in active labor, sought treatment in a New York hospital reporting 2 days of fever, productive cough, shortness of breath, and pleuritic chest pain. Household contacts included children with influenza-like illness. The patient had declined influenza vaccination while receiving prenatal care. On arrival, examination showed that her temporal temperature was 101.6°F, blood pressure was 122/71 mm Hg, pulse was 121 beats per minute, respiratory rate was 40 breaths per minute, and oxygen saturation was 89% on room air; bilateral inspiratory crackles were heard on lung auscultation. Rapid influenza screening of a nasopharyngeal swab sample by using ELISA was negative for influenza A and B viruses. Culture of the patient’s nares was positive for MRSA colonization. Laboratory evaluation showed leukopenia of 1500/mL, and although imaging was limited by the patient’s lead apron, a chest radiograph demonstrated bibasilar opacities (Figure, panel A).