ornithine, lysine, and ribose and therefore was not \textit{B. suis}. Because of the high indices with alanine, asparagine, and glutamate and a low index with ribose, it was identified as \textit{B. melitensis} (table 1). Agglutination only with monospecific antiserum to \textit{B. abortus} identified the isolate as \textit{B. melitensis} biovar 2 [2].

To our knowledge, there are no reports of \textit{B. suis} isolation from the Arabian peninsula, and pig farming is forbidden by Muslims; however, \textit{B. melitensis} biovar 2 has been recovered in the Middle East. \textit{B. suis} biovar 3 and \textit{B. melitensis} biovar 2 have similar dye resistance characteristics and are agglutinated only by monospecific antiserum to \textit{B. abortus} [2]. Up to now, they have been distinguished by the resistance of \textit{B. melitensis} to lysis by Fi phage at RTD and to lysis by Tb phage at RTD $\times 10,000$. Most strains of \textit{B. melitensis} are lysed only by Berkeley and Izatinagar phages [2], although some strains from the Middle East and Europe are lysed by Wb phage [3]. However, the oxidative utilization pattern of isolate 92/72 showed that it was a variant of \textit{B. melitensis} biovar 2. We are unaware of any previous report of a strain of \textit{B. melitensis} that was sensitive to Fi and Tb phages. This identification was unlikely to be due to phage variation, as the phage batches were regularly checked against type strains to ensure specificity.

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References

Liver Abscess Due to \textit{Streptococcus sanguis}

We report a case of liver abscess due to \textit{Streptococcus sanguis}. We believe that gastric mucosal biopsy was the most likely source of infection.

A 39-year-old male was admitted to the hospital for investigation of a liver lesion. Two weeks before presentation, he had developed a fever while visiting relatives in another state and was admitted to a hospital there. Abnormal results of liver function tests prompted the performance of abdominal CT, and an 8-cm lesion was found in the right lobe of the liver. Treatment with intravenous ceftriaxone resulted in defervescence, and he was discharged with instructions to take oral cefuroxime; he was scheduled to undergo a liver biopsy as an outpatient. He returned home and was admitted to this hospital for the biopsy and for parenteral antibiotic therapy.

Findings on physical examination were normal. Apart from an elevated serum alkaline phosphatase level (193 U/L; normal range, 36–128 U/L), results of routine biochemistry and liver function tests were normal. An abdominal CT scan revealed an 8-cm lesion in the anterior portion of the right lobe, with multiple hypoechoic areas (figure 1). Ultrasonographically guided aspiration was done, and 60 mL of brown sanguineous fluid was obtained from two of the hypoechoic areas. Inflammatory cells were seen on microscopy, and culture of the aspirate yielded pure growth of \textit{S. sanguis}.

Cytology did not reveal any evidence of malignancy. Serologic tests for evidence of amebic or echinococcal infection were negative. A barium enema study showed diverticulosis of the sigmoid colon.

Two months before this admission, gastroesophageal reflux disease had been diagnosed. Upper gastrointestinal endoscopy with gastric and esophageal mucosal biopsy was done, followed by studies of pH and motility. The patient was taking omeprazole. He had no history suggestive of diverticulitis, and he had no
Obstruction of the Left Main Coronary Ostium Due to an Aortic Vegetation: Survival After Early Surgery

Coronary embolization of vegetations is a frequent complication of infective endocarditis [1], but occlusion of a coronary ostium due to an aortic valve vegetation is a rare and life-threatening event. Death occurred in all nine previously reported cases in which the coronary ostium was occluded by an aortic valve vegetation and who survived after undergoing surgery. We describe, to our knowledge, the first case in which a patient who had an occlusion of a coronary ostium due to an aortic valve vegetation survived.

A previously healthy 43-year-old man was admitted to our hospital in January 1990 for lumbar pain, fever, and chills that occurred a few weeks after he had received a barium enema for evaluation of chronic abdominal pain. Physical examination revealed lumbar stiffness and a systolic and diastolic murmur at the aortic area. An electrocardiogram (ECG) showed sinus tachycardia. A thoracic echocardiogram revealed an aortic vegetation with moderate left ventricular dilatation. Blood cultures yielded Streptococcus bovis.

Treatment with iv amoxicillin (2 g six times daily) and im gentamicin (200 mg daily) was initiated. Complete bed rest was ordered because of the lumbar pain, and thus an anticoagulant (7,500 units of subcutaneous heparin three times daily) was prescribed. Abdominal echography and colonoscopy did not reveal colonic disease. Despite the fact that the results of a blood culture were negative for S. bovis 2 weeks after antibiotic therapy was initiated and that biological parameters of inflammation decreased, a transesophageal echocardiogram showed that the mobile aortic vegetation had increased in size (10 mm × 15 mm), that the posterior aortic valve (figure 1) was perforated, and that there was grade 3/4 aortic regurgitation.

Therapy with oral captopril (12.5 mg twice daily) was initiated. One week later, dyspnea was noted while the patient was resting in bed. A chest roentgenogram revealed severe pulmonary congestion. An ECG showed decreased amplitude of R waves, slight ST segment elevation and inverted T waves in the anteroseptal territory, and ST segment depression and inverted T waves in the