At day 150 after aortic valve replacement, the *E. faecium* strains were both found to be resistant to teicoplanin. By day 180 after aortic valve replacement, the patient’s temperature had increased to 105°F, and her clinical condition had deteriorated. Treatment with intravenous RP 59500 (5 mg/kg q12h) was started. The patient’s clinical condition gradually improved over the course of treatment. Blood cultures became negative by the eighth week of treatment. (VREF) to alternative antimicrobial agents singly and in combination was continued to improve.

References

First Case Report of Melioidosis in Guadeloupe, a French West Indies Archipelago

*Burkholderia pseudomallei* is the causative agent of melioidosis, an infectious disease of humans and animals that has been documented from regions that lie 20° north and south of the equator. Although this agent has rarely been isolated from the Western Hemisphere, it has been found in Panama, Ecuador, Haiti, Brazil, Peru, and Guyana. Cases of melioidosis have also been reported from the Lesser Antilles; one case was reported from Aruba [1], and, more recently, another case was reported from Martinique [2]. We report the third documented case of melioidosis in the Lesser Antilles and the first documented case in Guadeloupe, an archipelago of the French West Indies.

A 4-year-old child was admitted to the hospital because of a 4-day history of fever (maximum temperature of 40.8°C); he did not have chills or sweats. This young child was from Le Havre, France, and was on a 3-week vacation in a small island of the Guadeloupe archipelago. Clinical examination and a chest roentgenogram revealed a right pleural effusion associated with a right-lower-lobe infiltrate. The WBC count was 6.6 × 10⁹/L with 58% neutrophils. The erythrocyte sedimentation rate was 110 mm/h, the C-reactive protein level was 298 mg/L, and the fibrinogen level was 4.69 g/L; these findings were indicative of a severe inflammatory process. Blood samples for culture were drawn at the time of admission, and pleural fluid was aspirated to obtain specimens for microbiological examination. Blood samples were sterile, although examination of pleural fluid revealed numerous neutrophils and gram-negative bacilli. With use of the results of biochemical tests and the drug susceptibility profile (notably colistin resistance), we identified this gram-negative bacilli as *B. pseudomallei*.

Intravenous cefotaxime and netromycin have been empirically used to treat melioidosis, but as our patient’s symptoms persisted 48 hours after treatment, antimicrobial therapy was switched to cefotaxime, fosfomycin, and pristinamycin. In addition, therapy with ceftriaxone and trimethoprim-sulfamethoxazole was administered on the basis of antibiotic susceptibility test results. The patient’s clinical condition initially improved rapidly, but fever and chills associated with peritoneal effusion and hyperleukocytosis occurred 5 days later. A laparotomy revealed diffuse visceral inflammation, but no visceral abscess formation was observed macroscopically. *B. pseudomallei* was isolated again from peritoneal effusion.

After intravenous injections of cefazidime and trimethoprim-sulfamethoxazole, the child’s condition improved and his fever resolved. He returned to France and continued to receive therapy with these two drugs for 1 month. He received treatment with oral trimethoprim-sulfamethoxazole for 6 months, and his condition continued to improve.

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Melioidosis can be clinically inapparent, but three clinical presentations are recognized in patients in whom illness develops [3, 4]. We described herein a case of the acute form of melioidosis; this form of the disease can produce infection at local cutaneous sites, acute pneumonia, or septicemia and may be fulminating and complicated by visceral abscess formation. These clinical forms of melioidosis have largely been encountered in Southeast Asia and in northern Australia, where they constitute an important health problem [5]. Respiratory localization occurred extensively during the Vietnam War in French and American soldiers who were infected by aerosolization of contaminated water in paddy fields by helicopters [1]. Veterans of the Vietnam War have also developed two other forms of melioidosis, subacute and chronic; the prevalence of both of these forms in Southeast Asia was identical.

B. pseudomallei can be transmitted through the skin as well as by inhalation, by ingestion of contaminated food or water, or by insect bites [6]. This organism may remain latent for many years, thus causing recrudescent melioidosis. Imported cases from areas of endemicity are well documented, but the occurrence of a native case is exceptional in Guadeloupe.

In our case, meticulous questioning of the patient’s family revealed no potential source of contamination in France as the child lived in a city and neither traveled to areas of endemicity nor was in contact with persons with suspected cases of melioidosis. On the other hand, the child was frequently exposed to potential sources of contamination during his vacation in one of the islands of the Guadeloupe archipelago. Inhabitants of this little tropical island live in a rural environment; children play games in the soil and in the proximity of large rainfall water tanks and domestic animals such as pigs, sheep, and goats. This environment is favorable for B. pseudomallei, a saprophytic bacillus that is generally isolated from both surface water and soil in areas of endemicity.

Consequently, investigations were conducted to determine the source of this child’s contamination. Samples of soil, animal feces, animal litter, water tanks, ponds, and gutters were submitted for microbiological examinations. However, cultures on selective medium have not revealed the presence of B. pseudomallei.

Although the source of contamination remains obscure in our case, the presence of two other documented cases in the Lesser Antilles led us to believe that this is a native case of melioidosis. Melioidosis may result from either acute exposure to the organism in soil and water or from reactivation of an asymptomatic form of the disease several years later. In view of these data, melioidosis must be considered in the differential diagnosis for natives of Guadeloupe or tourists who are staying on this island.

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Prevalence of Hepatitis G Virus Among Intravenous Drug Abusers in Los Angeles

A novel RNA virus provisionally designated hepatitis G virus (HGV) was recently cloned and sequenced. Risk factors for HGV infection appear to be similar to those for hepatitis C virus infection. A diagnostic reverse transcription-polymerase chain reaction (RT-PCR) procedure has been developed for the detection of unique HGV RNA sequences in serum specimens [1]. We determined the prevalence of HGV in a group of intravenous drug abusers (IVDAs) with use of RT-PCR to detect HGV RNA.

We prospectively studied 124 unselected IVDAs (mean age, 44 years; 86 males) who were undergoing treatment at a methadone clinic in Los Angeles. The mean duration of drug use was 21 years. All but 16 patients were actively using iv drugs.

RNA was extracted from serum specimens, and cDNA was generated from viral RNA by RT with use of random hexamers. DNA was amplified with use of nested primers from the NS5 region [1] and nested primers from the core region of the HGV genome. Sera were tested for antibodies to HGV by ELISA with use of synthetic peptides from the core, NS4, and NS5 regions of the HGV genome. In addition, sera were tested for antibodies to HCV (HCV Version 3.0 ELISA; Ortho Diagnostics, Raritan, New Jersey). RT-PCR for HCV RNA and hepatitis B surface antigen (HBsAg) testing (Ortho Diagnostics) were performed for all patients who were positive for HGV RNA and for 20 randomly selected patients from this cohort of patients who were negative for HGV RNA.

HGV RNA was detected in the serum of 12 (9.7%) of 124 patients. However, reactivity to any of the HGV synthetic peptides tested was noted for only one of the 12 patients. The demographic and epidemiological features of the HGV-positive and HGV-negative patients were similar. Eleven (92%) of these 12 patients had reactivity to HCV antibodies, and 10 of these 12 had concomitant hepatitis C viremia. One patient who was positive for HGV...