In conclusion, the present report demonstrates the importance of considering the possibility of cutaneous lesions due to unusual mycobacteria in HIV-infected patients and the need for sensitive and specific diagnostic assays.

Stefano Rusconi, Andrea Gori, Luca Vago, Giulia Marchetti, and Fabio Franzetti
Institute of Infectious and Tropical Diseases, and Pathology Department, “L. Sacco” Hospital, University of Milan, Milan, Italy

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Coagulase-Negative Staphylococcus Species as Unusual Causes of Infection

STR—Although the utility of the precise identification of all coagulase-negative Staphylococcus species in the clinical laboratory has not met with universal agreement [1, 2], commercial kits and automated systems have provided virtually every diagnostic laboratory the ability to identify a number of Staphylococcus species that would be otherwise unidentifiable in routine laboratory practice.

We read with interest the report by Mastroianni et al. [3], in which they describe the first reported case of primary septic arthritis caused by Staphylococcus cohnii in a patient with AIDS. These authors have also reported the first case of a pancreatic pseudocyst resulting from infection due to Staphylococcus xylosus in an HIV-infected patient [4]. However, although, in both instances, the focus of interest is clearly the uncommon nature of the Staphylococcus species involved, no information was provided in either case about how these unusual species were identified. Because any extensive identification based on taxonomically relevant phenotypic and molecular characteristics would probably have been stated explicitly, it appears that the species were identified by use of a commercially available kit or automated system.

Commercial biochemical test systems can identify a number of the Staphylococcus species with an estimated accuracy of 70% to >90% [1, 2]. For the identification of certain species, however, accuracy may diminish considerably in the absence of additional tests (e.g., coagulase production or novobiocin resistance) [1, 2, 5]. Our institute often receives Staphylococcus strains that have been isolated in clinical and veterinary diagnostic laboratories in Italy and tentatively identified by use of rapid commercial systems; our facility confirms the identification by use of extensive phenotypic and molecular characterization. In our experience, misidentifications are common with the use of these commercial systems, especially for minor coagulase-negative species, and in most instances pass unnoticed. During the last 3 years, only one of the three isolates received by our institution as S. cohnii were confirmed; the two isolates misidentified as S. cohnii were actually Staphylococcus epidermidis and Staphylococcus capitis, and the isolate misidentified as S. xylosus was appropriately identified as Staphylococcus aureus.

Furthermore, the S. xylosus isolate, the subject of one [4] of the two reports by Mastroianni et al., was said to be resistant to vancomycin. This finding, noted incidentally in the report, does not support the identification of the isolate as S. xylosus, given that, among the coagulase-negative Staphylococcus species, resistance to glycopeptides (usually to teicoplanin rather than to vancomycin) has been documented thus far with certainty only in strains of Staphylococcus haemolyticus and S. epidermidis [6]. On the other hand, vancomycin resistance in a clinical isolate of S. xylosus, if confirmed, is probably of even greater interest than the isolation of this species from a particular infection site.

Pietro E. Varaldo and Francesca Biavasco
Institute of Microbiology, University of Ancona Medical School, Ancona, Italy

References

Reprints or correspondence: Dr. Pietro E. Varaldo, Institute of Microbiology, University of Ancona Medical School, Via Ranieri, Monte d’Ago, I-60131 Ancona, Italy.

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