taneous drainage specimen yielded Enterococcus faecalis as well as another unidentified microorganism, which did not fix the aniline dyes of the gram stain and was isolated from anaerobic specimens plated on blood agar. Because of persistent fever, the therapeutic regimen was changed to that with iv imipenem, vancomycin, and metronidazole, and surgical drainage of the abscesses was performed. The patient became afebrile. Three days later, cultures of surgical specimens and the initial percutaneous drainage yielded M. hominis that was susceptible to pristinamycin. Treatment was changed to that with oral pristinamycin (2 g/d) in combination with iv amoxicillin (3 g/d). Five days later, therapy with iv amoxicillin was stopped, and because of nausea and vomiting, therapy with pristinamycin was discontinued and replaced by iv quinupristin/dalfopristin, 350 mg q8h for 15 days, until pristinamycin could be tolerated. The patient was treated with streptogramins for 36 days. There was no fluid collection evident on a repeated CT scan. The patient was alive and well after a follow-up period of 1 year.

In this case intrapelvic and wound abscesses due to M. hominis were found after removal of a transplanted kidney. M. hominis was isolated from deep-tissue spaces. The samples were plated on conventional media and therefore grew slowly. The source of M. hominis was unknown. It is possible that the infection originated in the genitourinary tract, but hematogenous dissemination and transmission from donor to recipient cannot be ruled out [6]. In our case, M. hominis infection was treated successfully with streptogramins.

To our knowledge, there are nine reported cases of infection due to M. hominis in patients who have undergone renal transplantation [1, 7]. Adequate data are available for eight patients, five of whom were women. The mean age of the eight patients was 44 years. Predisposing factors were immunosuppressive treatment and urinary tract manipulation. Infection occurred ≤3 weeks after kidney transplantation and developed in most patients within 6 days after surgery. All of the patients were febrile. Delays in diagnosis are common, given that M. hominis grows aerobically slowly and poorly on conventional blood agar. The organism was isolated from blood cultures (n = 1), joints (n = 1), peritoneal and perinephric fluids (n = 6), and wound abscesses (n = 3). M. hominis was the only pathogen isolated from the site of infection in five cases and was associated with a copathogen in three cases. One patient underwent nephrectomy without antimicrobial therapy; the remaining seven patients received combined surgical and medical treatment. In four cases, surgery consisted of drainage and removal of the transplanted kidney. Medical treatment consisted of doxycycline alone (n = 5) or doxycycline plus clindamycin (n = 2). When antibiotic treatment data were available, the duration of treatment was always noted to be >3 weeks. Of the eight patients, four lost allografts, and one died of cerebral infarction 84 days after the onset of infection.

M. hominis is a possible source of infection in patients who have undergone renal transplantation. Treatment of these infections may present a challenge because of the difficulty in making bacteriologic diagnoses and increased resistance to antibiotics. Streptogramins can be effective in treating extragenital M. hominis infections in immunocompromised hosts.

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References

Furunculosis Associated with Repeated Courses of Omeprazole Therapy

We report a case of recurrent furunculosis that was associated with omeprazole therapy.

A gastroenterologist developed severe gastroesophageal reflux disease (GERD), for which ordinary histamine H 2-receptor blockers were insufficient in preventing symptoms. Only omeprazole was effective. During the first course of omeprazole therapy over a 3-month period in 1990, he developed furunculosis. Omeprazole therapy was discontinued to determine if the GERD symptoms might resolve and not require continuous treatment. The furunculosis resolved during the period without omeprazole therapy. He had no prior history of furunculosis, carbuncles, or other evidence of staphylococcal skin infections or pyoderma. Upon reinstation of omeprazole therapy, the furunculosis quickly recurred. Over the next few years, at least five cycles of furunculosis occurred at the nape of the patient’s neck, and a few lesions developed on other parts of the body. The episodes of furunculosis developed within 1–2 weeks of starting omeprazole therapy and continued to be present throughout the duration of therapy, resolving within 1–2 weeks of discontinuation of the agent.

We report this observation because there is limited evidence that omeprazole impairs neutrophil function [1, 2]. Although clinical
reports relating omeprazole to infectious complications are rare, in a recent case-control study of 211 patients, a 10-fold increase in the risk of gastroenteritis due to *Campylobacter* species was reported among patients treated with omeprazole [3]. There have been two reports, two cases each, of esophageal candidiasis associated with omeprazole treatment [4, 5]. These patients lacked other risk factors for esophageal candidiasis. A case of septicemia due to *Yersinia enterocolitica* associated with omeprazole treatment has been reported [6], as has salmonellosis [7]. These cases, reminiscent of earlier reports, indicate that salmonellosis is more common after exposure in achlorhydric patients and in volunteers taking tetracycline. Bacillary and amebic dysentery, typhoid, salmonellosis, cholera, and now, infections due to *Campylobacter* and *Yersinia* species are more likely in achlorhydric individuals, presumably whether naturally occurring or omeprazole induced [8]. Susceptibility to infection in these cases is attributed to the loss of protective acid from the stomach rather than another defect in host defenses. Neutrophil function in these intraluminal circumstances has not been investigated or impugned. Two cases of severe postoperative infections, one of which was fatal, were attributed to prolonged preoperative therapy with omeprazole without preoperative antibiotic prophylaxis [9].

Reports implying an increased susceptibility to infection associated with omeprazole therapy are scant, but perhaps this brief but definite report of recurrent furunculosis related to repeated courses of omeprazole will encourage other investigators to report similar phenomena.

**Pseudo-Outbreak of Tuberculosis Infection Due to Improper Skin-Test Reading**

During 1995, a prison with an 1,800-inmate capacity that incarcerated ~6,000 persons per year reported 24 inmates and one staff member with new, positive tuberculin skin tests (TSTs), identified during routine annual screenings. From January to July 1996, the same prison reported 123 inmates and eight of 493 staff members with new positive TSTs during routine annual skin testing and a specially scheduled June 1996 inmate screening (an increase of 400% over the number of positive TSTs in 1995). None of the inmates or staff had active tuberculosis diagnosed during the 1995–1996 period. An investigation was undertaken to determine the source of the tuberculous infection.

A positive TST was defined in prison screening as an induration of ≥5 mm, and conversion was defined as an increase in induration of ≥5 mm after a previously negative TST within 1 year. Inmates were tested during their birth month, and records of all positive TSTs were kept, although there were no records of the exact numbers of inmates tested. Staff members were tested annually each April. To identify potential tuberculous cases, the 1993–1996 Illinois tuberculosis registry was crossmatched with the prison inmate and staff lists for June 1995 to August 1996. All inmate deaths (1995–1996), pharmacy records (July 1995 to August 1996), autopsy records (June 1995 to August 1996), and medical records of inmates currently at the prison with positive TSTs or HIV tests were reviewed. Inmate housing and work assignments and staff assignments were evaluated to identify possible clustering of positive TSTs, and 151 inmates and 17 staff members at the prison were interviewed, including those with positive skin tests (both new and previously positive), inmates who were HIV seropositive, and inmates and staff members with reported symptoms. Techniques used to evaluate TSTs were observed, and TSTs were repeated for persons who had positive TSTs from January to August 1996. Officials in other counties in which the lots of Tubersol (Connaught Laboratories, Swiftwater, PA) 2420, 2425, and 2423 that had been used in this prison were asked about unusual TST results. Samples of Tubersol from these lots were sent to the U.S. Food and Drug Administration (FDA) for testing of pH, phenol content, and sterility.

All persons with positive TSTs were evaluated medically, and among those for whom evaluations were negative for tuberculosis, isoniazid was instituted as preventative therapy. An investigation did not identify any cases of tuberculosis among current or former inmates or staff members, and there was no clustering of persons with positive TSTs. HIV testing is voluntary, and a 1992 blinded HIV serosurvey of blood discarded from routine prison-entry labo-

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