in eradicating *U. urealyticum* from the genital tract. In the present case, however, azithromycin, at the dosage we report, was effective against a multidrug-resistant organism with a single 7-day course of treatment. If the expensive health outcomes of prematurity and chronic lung disease are factored into the analysis, the azithromycin treatment regimen described, although initially expensive (estimated cost, $75), may be cost-effective overall, as has been shown with treatment of infection due to *Chlamydia trachomatis* [10]. Although more experience is clearly needed before firm conclusions can be drawn, it would appear that azithromycin, when appropriately dosed, may represent an excellent alternative therapy for the eradication of genital *U. urealyticum*. Because of the drug’s superior acceptability among pregnant and preconceptual patients, it may eventually become a first-line therapy for this patient subset.

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**References**


**Septic Arthritis Due to Aeromonas veronii Biotype sobria**

*Aeromonas* species are gram-negative, asporogenic, facultatively anaerobic bacilli. They have been isolated from freshwater and tap water, soil, marine animals, and nonfecal organic materials. Thirteen species have been identified. Only the motile species (*A. hydrophila, A. caviae, A. veronii, A. jandaei, and A. schubertii*) are potentially pathogenic for humans [1]. The most frequent clinical presentations are infectious gastroenteritis and wound infections, generally due to *A. hydrophila* [2]. Sepsis, usually caused by *A. hydrophila*, is most frequently described in immunocompromised hosts [3]. Arthritis due to *Aeromonas* species is rare; only five cases have been reported in the English-language literature [4–7], all of which were due to *A. hydrophila*. We describe, to our knowledge, the first case of septic arthritis caused by *A. veronii* biotype *sobria*.

A 31-year-old male underwent orthotopic liver transplantation for end-stage cirrhosis. Immunosuppressive therapy consisted of cyclosporine and tapering doses of prednisolone. On posttransplantation day 10, he was treated with pulsed dosing of methylprednisolone because of acute severe rejection. On day 15, he presented with fever and pain in the left knee. The next day, findings on physical examination were normal except for a swollen, warm left knee. Significant laboratory findings included a WBC count of 3,800/mm³ with 77% neutrophils, and a C-reactive protein level of 27 mg/L. Arthrocentesis yielded purulent fluid containing 104,000 leukocytes/mm³ (89% neutrophils) without crystals. A gram stain did not show any bacteria. Three sets of aerobic and anaerobic blood cultures and one stool culture remained negative. After 24 hours, a synovial fluid culture yielded gram-negative bacilli further identified as *A. veronii* biotype *sobria* that was susceptible to all generations of cephalosporins and to ciprofloxacin but resistant to ampicillin. A radiograph of the left knee revealed enlargement of the articular space. An indium-111-labeled leukocyte scan did not demonstrate osteomyelitis. Ciprofloxacin (400 mg b.i.d.) was given intravenously for 4 days, than orally (750 mg b.i.d.) for 2 months. Local treatment included joint immobilization and daily tidal irrigation during the first 3 days. After 3 days, cultures of the synovial fluid remained negative and the patient had become afebrile. On discharge (day 28), the patient had recovered normal knee function and had no residual pain.

We did not find any series on septic arthritis in liver transplant recipients in the literature. Bomalaski et al. [8] reviewed septic arthritis in a renal transplant population and reported an incidence of 0.8%. To the best of our knowledge, only five cases of septic arthritis caused by *Aeromonas* species have been reported in the literature [4–7]. Pertinent clinical data on aeromonas septic arthritis are summarized in table 1. A patient’s immune status plays a major role in the development of aeromonas arthritis, which occurs most often in patients with cirrhosis and immunosuppressive conditions [3]. In our patient, arthritis was probably due to a septic graft secondary to a previous bacteremia. The possible bacteremia’s source may be areas of breakdown in the intestinal barriers. Indeed, during liver transplantation the portal vein is clamped, and intestinal edema may favor bacterial translocation [9].
Table 1. Summary of data from cases of aeromonas arthritis.

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Reference</th>
<th>Age (y)/sex</th>
<th>Predisposing factor(s)</th>
<th>Extraarticular infection</th>
<th>Blood culture</th>
<th>Portal of entry</th>
<th>Involved joint</th>
<th>Synovial fluid WBC count in mm³</th>
<th>(%) neutrophils</th>
<th>Organism</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>[4]</td>
<td>45/M</td>
<td>Alcoholic liver disease</td>
<td>Peritonitis</td>
<td>+</td>
<td>HS</td>
<td>Bilateral glenohumeral</td>
<td>259,000 (NA)</td>
<td>85,000 (NA)</td>
<td>A. hydrophila</td>
</tr>
<tr>
<td>2</td>
<td>[5]</td>
<td>15/M</td>
<td>None</td>
<td>None</td>
<td>–</td>
<td>Penetrating wound</td>
<td>Knee</td>
<td>NA</td>
<td>NA</td>
<td>A. hydrophila</td>
</tr>
<tr>
<td>3</td>
<td>[6]</td>
<td>65/F</td>
<td>Acute myeloblastic leukemia</td>
<td>Cellulitis</td>
<td>+</td>
<td>HS</td>
<td>Left knee</td>
<td>9,800 (45)</td>
<td>A. hydrophila</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>[6]</td>
<td>36/M</td>
<td>Chronic myelogenous leukemia</td>
<td>None</td>
<td>+</td>
<td>HS</td>
<td>Right knee</td>
<td>90,000 (97)</td>
<td>A. hydrophila</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>[7]</td>
<td>16/M</td>
<td>Acute myelogenous leukemia</td>
<td>Cellulitis</td>
<td>+</td>
<td>HS</td>
<td>Second right metacarpal phalangeal left knee</td>
<td>104,000 (89)</td>
<td>A. veronii (sobria)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>31/M</td>
<td>Cirrhosis, OLT</td>
<td>None</td>
<td>–</td>
<td>HS</td>
<td>Left knee</td>
<td>OS, NA</td>
<td>A. veronii (sobria)</td>
<td></td>
</tr>
</tbody>
</table>

NOTE. HS = hematogenous spread; NA = data not available; OLT = orthotopic liver transplantation; + = positive; – = negative.

Intestinal permeability is also elevated in cirrhotic patients and has contributed to bacterial infections [10]. A. veronii biotype sobria differs from the other pathogenic Aeromonas species in that it remains susceptible to first- and second-generation cephalosporins [5]. Co-trimoxazole and ciprofloxacin are good choices for oral therapy [2]. Septic arthritis due to Aeromonas species is rare. This infection usually occurs in immunocompromised patients.

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References

Acute Prostatitis with Prostatic Abscess Caused by Group B Streptococcus

Group B Streptococcus (GBS), or Streptococcus agalactiae, causes puerperal sepsis and neonatal infections [1]. The occurrence of invasive infections due to GBS in nonpregnant adults is now well recognized [2]. Numerous cases of upper and lower urinary-tract infections in nonpregnant adults have been reported, but we have found only two cases in the literature (MEDLINE search) of probable prostatitis due to GBS [3] and none of prostatic abscess. We describe a case of prostatic abscess due to GBS.

A 45-year-old male with diabetes mellitus type II controlled by diet was evaluated for complaints of dysuria and perineal discomfort. He started receiving therapy with ofloxacin as an outpatient. Two days later he presented to the emergency room of University Hospital of Geneva (Geneva) for evaluation of suprapubic pain. An urethral bladder catheter was inserted because of acute urinary retention, and a urine culture yielded pure GBS, >10⁵ cfu/mL. This result was neglected for unknown reasons. Four days later, the patient complained of progressive, unbearable perineal pain as well as fever and chills. He was febrile (temperature, 39°C). The prostate was soft and extremely tender on digital examination. Ultrasonography did not reveal signs of abscess. The urethral catheter was replaced by a suprapubic catheter. Two pairs of blood cultures (BACTEC, Becton Dickinson Europe, Meylan, France)