Correspondence

Clostridium difficile Infection in a Health Care Worker

To the Editor—With great interest, we read the article about laboratory-acquired infection with Clostridium difficile ribotype 027 in the 1 December 2008 issue of Clinical Infectious Diseases [1]. An elevated risk of acquiring C. difficile infection in the laboratory seems plausible because of possible exposure to a high inoculum of C. difficile while working with cultures [1]. Currently, C. difficile is not recognized as a pathogen that also presents significant risk for health care workers on wards and in outpatient clinics. Present safety precautions are mainly aimed at protecting other patients from C. difficile infection [2].

We report a case of patient care–associated C. difficile infection in a nurse. A 24-year-old female nurse from the oncology ward developed severe, nonbloody diarrhea at the end of November 2007, 3 days after she had consulted a dentist for root canal treatment of 1 of her molars. She had been receiving oral clindamycin (600 mg 3 times per day) for 3 days. A stool specimen obtained 3 days after she had consulted a dentist for root canal treatment of 1 of her molars. She had been receiving oral clindamycin (600 mg 3 times per day) for 3 days. A stool specimen obtained 3 days after commencement of oral clindamycin treatment (125 mg 4 times per day for 10 days). She remained on sick leave for a total of 2 weeks.

PCR ribotyping demonstrated that the strain was PCR ribotype 053. Determination of the ribotype was performed as described elsewhere [3, 4]. The isolate demonstrated in vitro resistance to clindamycin (MIC, >256 mg/L) and moxifloxacin (MIC, >32 mg/L). The nurse had experienced contact with at least 3 persons who had symptomatic infection due to C. difficile PCR ribotype 053 on the oncology ward during the 4 weeks before the onset of diarrhea. Two of the 3 C. difficile ribotype 053 isolates from these 3 persons with symptomatic infection were indistinguishable also by multilocus variant analysis of the loci A29, B21, C29, E6, F5, G9, and H2.

In our opinion, this case demonstrates that not only laboratory staff but all health care workers are at increased risk of acquiring C. difficile infection. C. difficile infection in health care workers should be documented by the employee health service and—in the event of clusters—reported to public health authorities. Stool specimens should be obtained from health care workers with diarrhea and tested for toxigenic C. difficile. C. difficile infection control guidelines should include health care worker protection, because C. difficile can cause health care–associated infections even outside of the laboratory. The case report also underlines the considerable potential for molecular typing methods to elucidate chains of C. difficile transmission.

Acknowledgments

We thank A. Wojna and M. Maass from the local microbiology laboratories for their support.

Potential conflicts of interest. All authors: no conflicts.

References


Epidemics of Poliomyelitis in Africa since 1993

To the Editor—Chumakov and Ehrenfeld [1] have described how cases of vaccine-associated paralytic poliomyelitis and the discovery of circulating vaccine-derived poliovirus have implicated efforts to eliminate poliovirus by vaccination. They do not, however, mention that serious epidemics of poliomyelitis have occurred in Africa since 1993, after the