Simón Pedro Lubián-López a,*, Fátima Galán-Sánchez b, Manuel Rodríguez-Iglesias b, Isabel Benavente-Fernández a,*

a Unidad de Neonatología, Hospital Puerta del Mar, Cádiz, Spain
b Servicio de Microbiología, Hospital Puerta del Mar, Cádiz, Spain

* Corresponding author.
E-mail address: slubian@yahoo.es (S.P. Lubián-López).

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Ruminococcus gnavus infection of a metal-on-metal hip arthroplasty resembling a pseudo-tumour in a 72 year-old woman with no intestinal symptoms

Infección por Ruminococcus gnavus de prótesis de cadera metal-metal asemejando un pseudotumor, en una mujer de 72 años sin síntomas intestinales

A 72-year-old woman was referred to the emergency department of a tertiary hospital under suspicion of left total hip infection and/or urinary infection. The patient complained of dysuria and left groin pain of several days duration, as well as temperature up to 39.5 °C, with no trauma. She had been implanted with a metal-on-metal big-head total hip arthroplasty five years ago. Physical exam revealed pain with groin palpation and with passive motion, and she had difficulty to walk. Blood analysis showed 18,980 g/l leukocytes, 87% neutrophils, C-reactive protein 180 mg/l and procalcitonin 4.12 ng/ml. Intravenous empiric antibiotic treatment was begun with cephalozolin 1 g/8 h, gentamicyn 240 mg/24 h and clindamycin 600 mg/8 h. After 3 days urine culture yielded 100,000 CFU of Klebsiella pneumoniae and treatment was changed to oral amoxicillin-clavulanate 875 mg for 10 days. The patient improved clinically and returned to walk without hip or groin pain. Along the following two months she suffered three episodes of left hip dislocation treated conservatively with closed reduction under general anaesthesia. The radiographic control after the last episode showed incomplete reduction (lack of full seating of head inside cup). The total hip was surgically revised to a conventional metal-on-polyethylene because of suspicion of pseudotumor interposition inside the joint.

One-stage uncemented exchange was performed, but only the acetabular cup and the femoral head were replaced. At the time of surgery, all biochemical parameters resulted normal. The removed periarticular tissue was examined histopathologically by microscopy to confirm the presence of a chronic inflammatory process with coagulation necrosis, hemosiderin and replacement of normal tissue with scar tissue. Five intraoperative specimens were obtained for microbiological purposes: three tissue samples of the periarticular and intraarticular granuloma/pseudotumour, the retired prosthetic components (big head and old acetabulum), and bone tissue from the reaming of acetabular bone.

Specimens were aseptically collected and sent for microbiological analysis and culture within 2 h. All samples were processed independently. Microscopic examination of the samples showed an absence of polymorphonuclear cells and/or microorganisms. Saline solution was added to the biopsies prior to homogenization. Ultrasonication of the removed prosthetic implants was performed. The resulting suspensions obtained were plated onto 5% sheep blood Columbia agar medium incubated at 36 °C under aerobic and anaerobic conditions; onto Chocolate agar incubated at 37 °C in a 5% CO2 atmosphere; and onto Schaedler agar +5% sheep blood, Phenyle-

DOI of refers to article: http://dx.doi.org/10.1016/j.eimc.2016.11.002
described in this case report had no intestinal history or symptoms at all, considering the case as a blood stream infection. The macroscopic perioperative findings were compatible with the presence of granuloma/pseudotumor tissue surrounding the pseudothymus.

An increased rate of pseudotumor formation has been described with metal-on-metal hip prosthesis. Pseudotumors can present variable granulomatous reactions. Pain is the strongest predictor for pseudotumor presence.6,7

Pseudotumors are often associated with subclinical infection, may destroy massively host bone and soft tissue, and usually require revision surgery for treatment.7

In the present case, the pseudotumor samples yielded positive for *R. granus*, the same microorganism as the prosthetic joint sample.

We conclude that the microorganism mentioned should be considered as a potential cause of joint prosthesis infection.

References


Belén Fernández-Caso a,b, Diego Domingo García a,b, Laura Cardénosoro Domingo a,b, José C Cordero Ampuero a,b,c

a Servicio de Microbiología, Hospital Universitario de La Princesa, Madrid, Spain

b Instituto de Investigación Sanitaria Princesa (IIS-IP), Madrid, Spain

c Servicio de Traumatología, Hospital Universitario de La Princesa, Madrid, Spain

* Corresponding author.

E-mail address: belenfernandezcaso@gmail.com (B. Fernández-Caso).

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Malaria in Europe: Follow-up of autochthonous malaria in Greece and new risks

Malaria en Europa: seguimiento de la malaria autóctona en Grecia y nuevos riesgos

Dear Editor:

Concerning the current Refugee crisis in Europe,1 we consider this moment opportune to comment upon the situation of the autochthonous malaria in Greece, focusing our thoughts on this newly raising concern.

As we commented upon in our previous paper,2 malaria remained a rare disease in the EU during the period 2009–2012 but few notorious cases of autochthonous malaria in Greece at that time, triggered an Action Plan for the Management of Malaria (2012–2015) which was introduced in Greece during the spring of 2012 and carried out by Greek Health Authorities (HDCP) in collaboration with the WHO (World Health Organization) and the European Center for Disease Prevention and Control (ECDC). The aim was to avoid its reintroduction and subsequent expansion in Greece. Surveillance results were successful on 2014 with none cases1 reported and, apparently very rapidly, the WHO has recently declared Malaria-free Europe4 area. However, cases of local-acquired malaria by *Plasmodium vivax* have been reported in Greece on 2015 and 2016.

In the light of these local-acquired transmissions occurred by vector-borne (Anopheles mosquitoes) from other humans who have been previously infected from a malaria endemic or epidemic area, the more imported malaria cases (*Plasmodium vivax* relapse cases with dormant hypnozoites), the more locally-acquired cases are to be expected when imported cases transit areas with confirmed or suspected circulation of the competent vector. Potential risks exist when migrants transit Greece within the current migration flow. Official number of current humanitarian crisis in Greece are 41,138 migrants arrived in 2014, 856,723 in 2015 and 157,396 in 2016 (by 15/6/2016).1

Table 1 shows the number of cases per year 2009–2015 and the average rate of autochthonous malaria cases during the study period (2013–2016) compared with previous one (2009–2012). Autochthonous cases and prevalence have both decreased with an average of 13 autochthonous cases and 0.0256 cases per million in the past 4 years compared with 19.25 autochthonous cases and 0.0382 on the previous study period but, the tendency from none on 2014 has round–turned to 6 cases and 4 cases occurred in 2015 and 2016 respectively.

Measures3 of the Action Plan (2012–2015) included active malaria case detection in the general and the migrant populations, screening of immigrants for malaria, administration of antimalarial drugs to immigrants with positive serology from malaria endemic countries (one course of prophylactic antimalarial treatment for *P. vivax* infection (Chloroquine + Primaquine)), closely monitor areas where sporadic malaria cases without travel history to a malaria country have occurred and vector control activities, among others.

According to the Health Authorities the risk in 20166 for malaria in Greece is very low so, as previously advised for travelers: chemoprophylaxis is not recommended for visitors to areas where locally-acquired malaria cases have been occurred until today nevertheless, personal protective measures against mosquitoes remain strongly encouraged.

In conclusion, it can be said that autochthonous malaria remains at lower risk after specific action plans started in 2012 by Health Authorities but, newly potential risks related to the numbers of