

Kocuria varians infective endocarditis

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Citation

S Shashikala, R Kavitha, K Prakash, J Chithra, T Shailaja, P Shamsul Karim. *Kocuria varians infective endocarditis*. The Internet Journal of Microbiology. 2007 Volume 5 Number 2.

Abstract

Kocuria varians belongs to genus *Micrococcus*. Members of the genus *Micrococcus* are generally believed to be temporary residents on humans, most frequently found on the exposed skin. We report a case of prosthetic valve endocarditis caused by *K. varians* in a patient who had undergone aortic valve replacement 8yrs ago. He presented with fever of two weeks duration. Investigations revealed infective endocarditis of prosthetic valve. Blood culture samples grew *K. varians*. The patient was empirically started on ampicillin and gentamicin intravenously and later with vancomycin and rifampicin. But the patient died due to neurological complications.

INTRODUCTION

Kocuria is a member of the *Micrococcaceae* family. ¹ Their role as pathogens, when isolated from clinical specimens, can be difficult to determine. Since early reports of endocarditis caused by gram-positive cocci did not reliably differentiate between micrococci and coagulase-negative staphylococci, the frequency of micrococcal endocarditis and related genera is difficult to ascertain and might be underestimated. ² Though several cases of endocarditis due to *M. lylae*, *M. luteus*, *K. sedentarius* and unspecified micrococci have been reported, documented cases of infections due to *Kocuria* species are limited. ^{2,3} Hence, we report, *K. varians* infection causing prosthetic valve endocarditis.

CASE REPORT

A 39 year old man was admitted with history of fever for two weeks duration. His past history revealed that he had undergone aortic valve replacement with Starr Edwards prosthesis 8yrs ago. On physical examination he was conscious, well oriented, febrile 102 F, pulse rate 90/min, blood pressure 120/80mmHg, clubbing was present, there was palpable spleen. Laboratory investigations revealed neutrophil 85.4%(37-80%), lymphocytes 9.32%(10-50%), RBC count 4.93 M/uL (4.04-6.13), platelet count 416K/uL(150-450), ESR 30mm/hr (8-20mm/hr). Blood glucose 95 mg/dl, B.urea 24mg/dl, S.creatinine 1.3 mg/dl. Liver function tests were within normal limits. Echocardiogram showed a large vegetation on prosthetic valve and valve dehiscence. Patient was started on parenteral

ampicillin 2gm, fourth hourly and gentamicin 60mg, eighth hourly. On third day of admission, he complained of headache and vomiting and the next day he developed tremors of right hand and imbalance of gait. CT scan brain done on tenth day of admission revealed subacute/old infarct in right middle cerebral artery territory and small lesion at right cerebellar hemisphere. He was started on conservative treatment by the neurologist. Repeat echocardiogram done on 11th day of admission revealed multiple small vegetations on prosthesis and he was started on parenteral vancomycin 1gm 12th hrly and oral rifampicin 600mg once a day. On 16th day of admission he developed sudden respiratory arrest and remained unresponsive. He was intubated and ventilated. He was reviewed by neurologists and neurosurgeons. He had no elicitable brain stem response with normal cardiac activity. Repeat CT scan brain showed a large haematoma in the cerebellar hemisphere with intraventricular extension and obstructive hydrocephalus. On 19th day of admission he developed asystole with no recordable blood pressure and succumbed to death.

A total of six blood cultures (BACTEC), three aerobic and three anaerobic bottles were collected at an interval of 1hour from different sites, prior to start of antibiotics. After 48hours one aerobic bottle flagged positive and smear revealed gram positive cocci in tetrads, pairs and small groups. Subsequently the other two aerobic bottles also grew gram positive cocci. All three anaerobic bottles did not grow any organism. Subculture was done on MacConkey agar, blood agar and chocolate agar plates. After 72hrs of

incubation, small, lemon yellow, wrinkled colonies appeared on blood agar. MacConkey agar showed no growth. Colony gram smear showed gram positive cocci arranged in tetrads and small groups. The isolate was catalase positive, oxidase positive, coagulase negative, Bacitracin (0.04U) sensitive, reduced nitrates, indole negative, urease negative, VP negative and arginine negative. Based on colony morphology, biochemical reactions the organism was identified as *K. varians*.⁵

Antibiotic susceptibility was performed by disc diffusion method recommended for Staphylococci by Clinical Laboratory Standards Institute (CLSI).⁶ The isolate was sensitive to oxacillin, gentamicin, vancomycin, rifampicin, linezolid, co-trimoxazole and resistant to penicillin. It was β -lactamase negative. MIC value of Penicillin was 4 µg/ml.

DISCUSSION

The genus *Micrococcus* has been dissected into six genera *Micrococcus* (containing the species *M. luteus*, *M. lylae* and newly described *M. antarcticus*), *Kocuria* (containing the former species *M. roseus*, *M. varians* and *M. kristinae*), *Kytococcus* (the former *M. sedentarius*), *Nesterenkonia* (the former *M. halobius*), *Dermococcus* (the former *M. rishinomiyensis*), and *Arthrobacter* (the former *M. agilis*). Members of the genus *Micrococcus* are gram-positive cocci (1-1.8 µm in diameter), occurring mostly in pairs, tetrads and irregular clusters. They are obligate aerobes. Micrococci and staphylococci have been confused with one another for more than a century on the basis of their similar morphologies, gram staining results and positive catalase activities. By the mid 1960's, a clear distinction could be made between staphylococci and micrococci on the basis of their DNA base composition. Members of the genus staphylococcus have a G+C content of 30-39 mol%, whereas member of the micrococcus and related genera have a G+C content within the range of 66-75 mol%.¹

Members of the genus micrococcus and related coccal genera *Kocuria* and *Kytococcus* are generally considered to be harmless saprophytes that inhabit or contaminate the skin, mucosa and perhaps the oropharynx. They can be opportunistic pathogens in certain immunocompromised patients.¹ Despite their low virulence, these organisms may become pathogenic, colonizing the surface of heart valves.² The reported infections in literature are endocarditis, arthritis, central nervous system infection, pneumonia, peritonitis, hepatic abscess and nosocomial blood stream infections.⁶ In addition, strains identified as *Micrococcus*

spp. have been reported recently in infections associated with indwelling intravenous lines, continuous ambulatory peritoneal dialysis fluids, ventricular shunts and prosthetic valves.^{3,7}

The genus *Kocuria* accommodates *Kocuria rosea* (the type species), *Kocuria kristinae* and *Kocuria varians*. Reported infections caused by *Kocuria* species is limited. *K. rosea* and *K. varians* have been reported to cause catheter-related bacteremia.⁷ Our patient had no recent history of dental manipulation or intravenous drug administration. Endocarditis in this case was probably caused by haematogenous spread. The most common organisms responsible for prosthetic valve endocarditis are *S. epidermidis*, *S. aureus*, Viridans streptococci and enterococci.⁷ Medline search did not reveal endocarditis caused by *Kocuria varians* and other *Kocuria* species. This is because earlier reports did not differentiate these different species. Recently, Edmond et al have reported a case of *Kocuria kristinae* causing acute cholecystitis and Fevzi et al have reported a case of *K. rosea* causing catheter related bacteremia.^{3,4}

At present there are no recommended standard methods by CLSI, for antibiotic susceptibility testing and interpretive criteria for organisms belonging to *Micrococcus* and related genera.^{8,9} There is a need to develop standard guidelines for such less frequently encountered organisms. A report in the literature on 219 strains of *Kocuria* and *Micrococcus* shows that most strains are sensitive to doxycycline, ceftriaxone, cefuroxime, amikacin, and amoxicillin with clavulanic acid, but most are resistant to ampicillin and erythromycin.³ This isolate was also resistant to penicillin. The duration of therapy in general depends on site and severity of infection. However, this patient died before completion of treatment due to neurological complications. Common neurological complications from endocarditis are stroke, encephalopathy and retinal emboli.

Attempts should be made for complete identification of such unusual pathogens and reporting of such infections serve to increase our awareness about these organisms causing infections.

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