Case Report

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Received 14 August 2006
Accepted 29 December 2006

Introduction

Raoultella planticola was first described as Klebsiella planticola in 1981 (Bagley et al., 1981) and as Klebsiella trevisanii in 1983 (Ferragut et al., 1983). In 1986, the two organisms were placed in the same species because of their extensive DNA sequence similarity (Gavini et al., 1986). In 2001, based on 16S rRNA gene and rpoB sequence analysis, the new genus Raoultella was created, and the name R. planticola was proposed to accommodate K. planticola (Drancourt et al., 2001).

R. planticola was initially seen as an aquatic, botanic and soil bacterium. However, in 1984, a human infection caused by this organism was reported: a patient with sepsis, admitted to an intensive care unit in France (Freney et al., 1984). Two other cases were later described: a bloodstream infection after a mitral valve replacement for infective endocarditis and a bacteremic pneumonia after coronary artery graft surgery (Freney et al., 1986). No other case reports or case series of infections caused by R. planticola have been published, and the clinical spectrum of diseases caused by this organism is unknown. The correct identification of Raoultella is not easily accomplished in most clinical microbiology laboratories, and isolates can be easily misidentified as Klebsiella pneumoniae or Klebsiella oxytoca (Monnet & Freney, 1994). In the present report, we describe a patient with pancreatitis with a primary infection by R. planticola.

A 45-year-old male presented with severe pancreatitis. Two bacterial isolates obtained from peritoneal fluid and abdominal purulent secretion were identified to the species level by 15 biochemical tests and four supplementary tests as Raoultella planticola. Identification was confirmed by rpoB gene sequencing. R. planticola is difficult to identify in the clinical laboratory, and the clinical significance of this isolation remains uncharacterized. This is the first report of pancreatitis with a primary infection by R. planticola.

Case report

On 2 September 2003, a 45-year-old male patient was admitted to a small (80 beds) public general hospital in Juiz de Fora, Minas Gerais state, Brazil, with abdominal pain, diarrhea and a 30-year history of alcoholism. After 10 days of treatment for a suspect pneumonia and no invasive procedures, abdominal symptoms persisted and the patient was transferred to Hospital Universitário of Universidade Federal de Juiz de Fora on 12 September 2003. On admission, he had abdominal pain, vomiting, diarrhea and fever. Chest X-ray and an abdominal CT scan revealed a small left pleural effusion and two abdominal fluid collections. Ciprofloxacin and metronidazole were started. On September 16, the patient underwent an exploratory laparotomy. Pancreatitis with a retroperitoneal abscess was diagnosed, with inflammation of pancreatic body and tail. A Gram-negative bacterial isolate was obtained as pure culture from the peritoneal fluid collected before surgery (isolate K111) and from abdominal pyogenic secretion (isolate K112). Other clinical specimens (urine, catheter tip and three blood samples) sent for culture were negative. The patient made a full recovery after 15 days on imipenem and amikacin and placement of a new abdominal drainage. He was discharged on October 21.

Bacterial isolates K111 and K112 were part of a surveillance study for characterization of klebsiellae infections. Both bacterial isolates were identified as K. oxytoca in the original clinical laboratory by non-automated biochemical tests. Isolates were re-evaluated in 15 biochemical tests for members of the Enterobacteriaceae (Farmer et al., 1985), and four supplementary tests (Drancourt et al., 2001;
Monnet & Freney, 1994). Both isolates formed typical red colonies indicating fermentation of lactose and acid production on MacConkey agar; were oxidase- and Voges–Proskauer-negative, did not produce H₂S, and did not utilize arginine or phenylalanine; fermented glucose; utilized citrate, lysine, malonate and l-sorbose, and were urease- and methyl red-positive; and were non-motile. Isolates were positive for indole production, histamine assimilation and growth at 10 °C, and did not utilize ornithine or d-melezitose, and were identified as R. planticola. Biochemical identification was confirmed by rpoB gene sequencing as described by Drancourt et al. (2001). The two R. planticola isolates exhibited 98% rpoB gene sequence similarity to known R. planticola strains, including the type strain R. planticola ATCC 33531T. By disc diffusion (Clinical and Laboratory Standards Institute, 2005), isolates were resistant to ampicillin and susceptible to amikacin, amoxicillin–clavulanate, aztreonam, cefepime, cefotaxime, cefoxitin, ceftazidime, cephalothin, ciprofloxacin, gentamicin, imipenem and trimethoprim–sulfamethoxazole, and did not exhibit extended-spectrum β-lactamase production. A dendrogram of ERIC-PCR profiles (Pellegrino et al., 2002) obtained with GelComparII, version 3.5 (Applied Maths), compared by the Dice index and the unweighted pair group method with arithmetic averages (UPGMA) is shown in Fig. 1. The two isolates had identical banding profiles.

**Discussion**

The genus *Klebsiella* has been recently re-analysed regarding its phylogenetic structure. All studies performed to date have shown the taxonomic heterogeneity of this organism, and the new genus *Raoultella* has been proposed for some of these isolates. The isolation of *R. planticola* from human specimens has been reported as part of studies on various collections of isolates (Freney et al., 1984, 1986; Monnet & Freney, 1994). However, the clinical significance of this isolation remains uncharacterized. To date, only three case reports have described invasive diseases caused by this organism (Freney et al., 1984, 1986). In the present report, *R. planticola* was repeatedly isolated in pure culture from intra-abdominal pyogenic specimens. The patient had pancreatitis with an infection that occurred without any abdominal manipulation. However, it is likely that previous antimicrobial exposure for the treatment of a questionable pneumonia selected for this agent. *R. planticola*, like other *Raoultella* species, carries a chromosomal β-lactamase that makes this agent naturally resistant to several antimicrobial agents.

*R. planticola* is difficult to identify in the clinical laboratory. Nevertheless, the correct identification of bacterial species is the most important measure to guide antimicrobial treatment and detect outbreaks.

**Acknowledgements**

This study was supported by Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq), Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES), Fundação de Amparo à Pesquisa do Estado do Rio de Janeiro (FAPERJ) of Brazil and Fogarty International Program in Global Infectious Diseases (TW006563) of the National Institute of Health. We are grateful to Maria de Lourdes Junqueira for storage of isolates.

**References**


