The opinions expressed by authors contributing to this journal do not necessarily reflect the opinions of the Centers for Disease Control and Prevention or the institutions with which the authors are affiliated.
The patient was successfully extubated. He was transferred to a pulmonary ward on day 9 and discharged on day 15. Antimicrobial treatment was stopped on day 10.

Most nonhuman strains of *V. metschnikovii* are usually found in aquatic habitats (e.g., lakes and marine waters). Human clinical infections with this bacterium are rare; however, cases of epidemic diarrhea caused by *V. metschnikovii* have been reported (5,6). Contamination by water or fish was not always demonstrated in these cases, but an orofecal source is possible. In coproculture, this microorganism is probably not diagnosed: it was initially identified as normal aerobic flora because it was oxidase negative.

The first case of septicemia with *V. metschnikovii* was reported in 1981 in a patient with peritonitis and an inflamed gallbladder (1). Three other patients with similar septicemia, all >70 years of age, were described (7,8); 2 had polymicrobial results in blood cultures. *V. metschnikovii* was also found in a mucocutaneous site (wound infection) after saphenectomy in swab samples of the wound site (9).

The patient in our study denied contact with lake or sea water, and he had not eaten any seafood. He was a retired carpenter without contact with domestic or wild animals and did not recall an episode of diarrhea before his hospitalization. The source of contamination that caused his acute respiratory failure was not identified.

Miyake et al. showed that *V. metschnikovii* produces a cytolysin with hemolytic properties (10). This finding might explain the invasive process of this bacterium, which resulted in pulmonary lesions in a patient with respiratory deficiency. As far as we know, this is the first case of pneumonia caused by *V. metschnikovii*.

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**References**


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**To the Editor:** Suspected outbreaks of Lassa fever have been reported in the northern part of Edo, Nigeria, including Ekpoma, Igarra, and Ibilo, in 2001 and between November 2003 and March 2004 (1,2). To confirm Lassa fever activity in this area, serum samples were collected at the Specialist Teaching Hospital in Irrua (ISTH) from September 2003 to January 2004. Approximately 16,000 patients are seen each year at ISTH, and ≈80% of them have febrile illness. Serum specimens were taken from patients with febrile illness (n = 31), healthy contact persons (n = 17), and healthy hospital staff (n = 12). The samples were analyzed by Lassa virus–specific reverse-transcriptase polymerase chain reaction (RT-PCR) at the University of Lagos. Aliquots of specimens were sent to the Bernhard-Nacht Institute (BNI in Hamburg, Germany) for confirmatory PCR analysis, serologic testing, and virus isolation. The PCR used at both facilities was based on primers 80F2 and 36E2 that targeted the glycoprotein precursor (GPC) gene (3), although the protocols were slightly different. At BNI, virus RNA was purified by QIAamp viral RNA kit (Qiagen, Hilden, Germany), and RT-PCR was performed with Superscript II RT/Platinum Taq polymerase 1-step reagents (Invitrogen, Karlsruhe, Germany). This PCR assay has a 95% detection limit of 2,500 copies/mL (4). At the University of Lagos, virus RNA purification and RT-PCR were performed with diatomaceous silica and Brilliant single-step RT-PCR kit (Stratagene, Heidelberg, Germany), respectively. Serologic testing for Lassa virus–specific immunoglobulin G (IgG) and IgM was performed by indirect immunofluorescence assay.

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**Lassa Fever, Nigeria, 2003 and 2004**