as criteria for accurate identification of bacterial organisms at the species level (8). In this patient, 2 A. rimae isolates were recovered from 2 different blood-culture bottles drawn 48 h apart, suggesting that A. rimae was not just a bypassing organism but indeed responsible for septicemia. In these specimens, S. gordonii was also isolated. Both species have been described as belonging to the oral flora, suggesting that these flora probably were the source for mixed septicemia in the patient. A. rimae was isolated as the patient was presenting with clinical features of septic shock, suggesting that A. rimae may have contributed to the shock. Antimicrobial drug treatment based on in vitro A. rimae susceptibility profile, along with reanimation measures, allowed for the patient’s recovery.

This case report illustrates the usefulness of 16S rDNA sequencing for accurate identification of anaerobic organisms and suggests that A. rimae should be added to the list of organisms responsible for bacteremia in patients.

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References

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Systemic Infection with Enteric Adenovirus in Immunocompetent Child with Haemophilus influenzae Disease

To the Editor: Recent articles have reported enteric human adenoviruses (HAdVs) types 40 and 41, previously thought to be restricted to the gastrointestinal tract (1), in multiple organ systems of a deceased immunodeficient child (2) and in respiratory specimens of children with acute respiratory illnesses (3). Here we present a case in which enteric HAdV-40 was found in the cerebrospinal fluid (CSF) and blood of an apparently immunocompetent child with Haemophilus influenzae invasive disease.

The patient, a 10-month-old previously healthy Thai boy, met the criteria for a clinical case of encephalitis (4) and, after informed consent was obtained, was enrolled in the study of causes of encephalitis in Thailand (collaboration between the US Cen-
Adenovirus and Haemophilus influenzae disease, Thailand, 2003–2004*  

<table>
<thead>
<tr>
<th>Date, 2003</th>
<th>Events</th>
</tr>
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<tbody>
<tr>
<td>Dec 7</td>
<td>Patient hospitalized with 6-day history of fever &gt;38°C and somnolence; blood culture positive for <em>Haemophilus influenzae</em>; isolate not typed (unavailable for further characterization)</td>
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<tr>
<td>Dec 9</td>
<td>CSF results: pleocytosis (2,710 leukocytes/mm³, 94% neutrophils); protein 178 mg/dL; glucose 11 mg/dL; CSF culture positive for <em>H. influenzae</em>; CSF Gram stain positive for gram-negative coccobacilli; antimicrobial drug treatment (ceftriaxone) started</td>
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<tr>
<td>Dec 11</td>
<td>New onset seizures, ataxia, and maculopapular rash on entire trunk and all extremities; no diarrhea or respiratory symptoms; brain ultrasound scan results within normal limits; anticonvulsant therapy (phenobarbital) started</td>
</tr>
<tr>
<td>Dec 12</td>
<td>CSF results: pleocytosis (100 leukocytes/mm³, 60% neutrophils, 40% monocytes); protein 131.6 mg/dL; glucose 31 mg/dL; CSF bacterial culture, results negative; CSF Gram stain results negative; patient enrolled in the encephalitis study; initial specimens for the study collected</td>
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<tr>
<td>Dec 22</td>
<td>Brain ultrasound scan results within normal limits; antimicrobial drug treatment (ceftriaxone) discontinued</td>
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<tr>
<td>Dec 23</td>
<td>CSF bacterial culture results negative; CSF Gram stain results negative; anticonvulsant therapy (phenobarbital) discontinued</td>
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<tr>
<td>Dec 27</td>
<td>Patient discharged in improved condition; discharge diagnosis: <em>H. influenzae</em> meningitis and sepsicaemia</td>
</tr>
<tr>
<td>Jan 7†</td>
<td>Follow-up visit: full recovery without sequelae; convalescent-phase serum specimen obtained</td>
</tr>
</tbody>
</table>

*CSF, cerebrospinal fluid.  
†2004.
CSF was negative for 16S bacterial RNA by PCR and culture-negative for H. influenzae, and the CSF pleocytosis had decreased substantially. These circumstances make it less likely that these signs were associated with the underlying H. influenzae disease and raise the possibility that superimposed HAdV-40 infection played a role. Because the patient had no diarrhea or respiratory symptoms, no evidence of immunodeficiency, no stool specimen available for testing, and no evidence of HAdV in throat swab specimen, the pathogenesis of HAdV-40 infection in this case is unknown. The origin of the maculopapular rash concurrent with neurologic symptoms in this patient is also unclear. Rash is not typical for H. influenzae infection and, although reported for some HAdV infections (7), has not been previously described for HAdV-40/41.

In conclusion, this case demonstrates the possibility of nongastroenteric, systemic infection involving CNS with enteric HAdV in immunocompetent hosts. Broad-specificity AdV PCR assay followed by amplicon sequencing enabled detection of this pathogen in an unexpected context and can be useful in defining the nongastroenteric disease effects associated with the enteric HAdVs.

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Mesotherapy-associated Outbreak Caused by Mycobacterium immunogenenum

To the Editor: Mesotherapy, a procedure for medical and cosmetic treatment, involves use of microinjections of different biologically active substances into the dermis or subcutaneous adipose tissue. This controversial practice is used for spot contouring and anti-aging therapy. Concerns have been raised about mesotherapy complications, such as asptic subcutaneous necrosis and cutaneous nontuberculous mycobacterial infections. Several rapidly growing mycobacterial species, primarily Mycobacterium fortuitum, M. peregrinum, M. chelonae, M. abscessus, M. simiae, and the newly described M. massiliense, M. bolletii, and M. simiae (1–5), have been reported to cause infections and outbreaks originating from use of contaminated injectable solutions or skin antiseptics during mesotherapy and other invasive cosmetic procedures. We describe a mesotherapy-