Methicillin-Susceptible Staphylococcus aureus ST398, New York and New Jersey, USA

To the Editor: Clinical infections with livestock-associated Staphylococcus aureus sequence type (ST) 398 have been reported in Europe, Canada, and the People’s Republic of China (1), as well as the Caribbean (2,3), and Colombia (4). Most reports describe infection with methicillin-resistant S. aureus; relatively few describe infection with methicillin-susceptible S. aureus (MSSA). In the United States, colonization of healthy adults by ST398 has been reported in Iowa (5) and in New York, New York (2); MSSA infections have been anecdotally reported in St. Louis, Missouri (6), and The Bronx, New York (7). We describe 8 infections with MSSA ST398 in the New York City area during a 7-year period (2004–2010). Five infections with a related ST (ST291) from clonal complex (CC) 398 also were identified. These findings highlight the emergence of clinical infections with 2 distinct CC398 sequence types in the New York City area.

Retrospective typing of 4,167 clinical S. aureus isolates from various studies involving inpatients and outpatients in the New York City area identified 13 meca-negative isolates with CC398-associated spa types (Table). Nine isolates were obtained from cultures of outpatients with skin and soft tissue infections; samples were submitted by physicians in the community. One isolate was associated with recurring skin and soft tissue infections in multiple body sites (BK21466); another was associated with genital infection (BK21732). Of the 4 ST398 isolates derived from bloodstream infections in hospitalized patients, 3 were recovered from intravenous drug users, 1 of whom died 1 day after admission for variceal bleeding (BK26722). Unlike the multidrug-resistant ST398 MSSA recently described in Colombia (4), most isolates in this study were susceptible to all antimicrobial drugs tested except penicillin, although several strains exhibited resistance to clindamycin and erythromycin. One isolate (BK23527) was submitted as oxacillin resistant (MIC ≈4 μg/mL) but lacked the meca gene, which suggested that another mechanism was contributing to the resistance phenotype.

Multilocus sequence typing confirmed 8 isolates as ST398 (3–35–19–2–20–26–39); 5 isolates were assigned to ST291 (3–37–19–2–20–26–32), a double-locus variant of ST398 (online Appendix Figure, panel A, wwwnc.cdc.gov/EID/article/18/4/11-1419-FA1.htm). Most of the ST398 strains were spa type 109 (t571), described in MSSA carriage isolates from New York City (2) and MSSA infections from China (1), France (8), Martineque (3), the Dominican Republic (2,3), and Colombia (4). BURP (based upon repeat pattern) analysis clustered all of the spa types into spa-CC t571 (online Appendix Figure, panel B). ST398 isolates clustered with spa type 109 (t571), whereas ST291 isolates clustered with spa type 865 (t2313). Pulsed-field gel electrophoresis was also performed on the 11 available isolates. Although the ST291 isolates were sensitive to digestion with SmaI, pulsed-field gel electrophoresis was performed with Cfr9I to compare

References

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all isolates simultaneously. As expected, the ST398 and ST291 isolates clustered separately (data not shown); 4 distinct patterns were observed within each cluster (Table). Only the ST398 isolates were positive for a CC398 lineage-specific PCR that targets the unique restriction for a CC398 lineage-specific system, further highlighting the differences between ST291 and ST398. None of the isolates harbored the genes coding for Panton-Valentine leukocidin.

Because of the retrospective nature of the findings, epidemiologic information for each isolate was limited. One patient (BK19382) reported travel to the Dominican Republic; Caribbean nationality was reported for BK27037 (Puerto Rico) and BK31274 (Trinidad). The cases described here occurred in urban and suburban settings, reflecting the likelihood that exposure to livestock was relatively low; however, travel history was unknown for most of the patients. Previous reports have linked ST398 transmission to other reservoirs, including companion animals, live animal food markets, and commercial meat products (1,2). However, data from a recent genome sequencing study suggest that MSSA ST398 is human in origin (10); other evidence suggests that certain lineages, particularly spa type 109 (t571), might circulate at low levels in humans in the absence of livestock exposure (8).

Our findings seem to support the hypothesis of low-level ST398 MSSA prevalence, and further surveillance might uncover additional cases of colonization or infection with ST398- and ST291-related strains in the New York City area. For example, active surveillance cultures performed at one of the 3 hospitals during January–March 2009 detected 7 additional ST398 and 3 additional ST291 isolates among 260 MSSA carriage strains (data not shown). In addition to the intrinsic virulence exhibited by ST398 MSSA in previous studies, the potential to acquire resistance to multiple classes of antimicrobial drugs (1,4,10), as well as virulence factors such as Panton-Valentine leukocidin (8), warrants continued surveillance in light of recent ST398 methicillin-resistant S. aureus outbreaks in health care settings (1).

**Acknowledgments**

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Table. Characteristics of *Staphylococcus aureus* clonal complex 398 isolates, New York and New Jersey, USA, 2004–2010

<table>
<thead>
<tr>
<th>Isolate† Year</th>
<th>Geographic location‡</th>
<th>Submitting institution§</th>
<th>Isolate source</th>
<th>Antimicrobial resistance</th>
<th>PFGE spa repeat type</th>
<th>spa pattern</th>
<th>RIdom type</th>
<th>ST</th>
</tr>
</thead>
<tbody>
<tr>
<td>BK13684 2004</td>
<td>Monmouth County, NJ</td>
<td>Laboratory A</td>
<td>Wound</td>
<td>PEN</td>
<td>–</td>
<td>109</td>
<td>XKAOAOBO</td>
<td>398</td>
</tr>
<tr>
<td>BK18505 2006</td>
<td>Manhattan</td>
<td>Laboratory A</td>
<td>Wound</td>
<td>–</td>
<td>A1</td>
<td>109</td>
<td>XKAOAOBO</td>
<td>398</td>
</tr>
<tr>
<td>BK21466 2007</td>
<td>Staten Island</td>
<td>Laboratory A</td>
<td>Arm, face, leg, buttocks</td>
<td>PEN, CLI, ERY</td>
<td>A3</td>
<td>109</td>
<td>XKAOAOBO</td>
<td>398</td>
</tr>
<tr>
<td>BK21732 2007</td>
<td>Manhattan</td>
<td>Laboratory A</td>
<td>Genital</td>
<td>PEN, ERY, OXA</td>
<td>–</td>
<td>109</td>
<td>XKAOAOBO</td>
<td>398</td>
</tr>
<tr>
<td>BK27037 2007</td>
<td>The Bronx</td>
<td>Hospital A</td>
<td>Blood, lung abscess, Blood, buttocks</td>
<td>PEN, CLI, ERY</td>
<td>B1</td>
<td>856</td>
<td>XKBBM</td>
<td>1321</td>
</tr>
<tr>
<td>BK23527 2008</td>
<td>Manhattan</td>
<td>Hospital B</td>
<td>Blood, sternum</td>
<td>PEN, ERY, OXA</td>
<td>–</td>
<td>109</td>
<td>XKAOAOBO</td>
<td>398</td>
</tr>
<tr>
<td>BK26722 2009</td>
<td>Nassau County, NY</td>
<td>Hospital B</td>
<td>Blood</td>
<td>PEN, CLI, ERY</td>
<td>A1</td>
<td>109</td>
<td>XKAOAOBO</td>
<td>398</td>
</tr>
<tr>
<td>BK31274 2010</td>
<td>Somerset County, NJ</td>
<td>Hospital C</td>
<td>Blood</td>
<td>PEN, CLI, ERY</td>
<td>A1</td>
<td>109</td>
<td>XKAOAOBO</td>
<td>398</td>
</tr>
<tr>
<td>BK13771 2004</td>
<td>Union County, NJ</td>
<td>Laboratory A</td>
<td>Wound</td>
<td>PEN</td>
<td>B4</td>
<td>716</td>
<td>XKBQBM</td>
<td>291</td>
</tr>
<tr>
<td>BK13451 2004</td>
<td>Union County, NJ</td>
<td>Laboratory A</td>
<td>Wound</td>
<td>PEN</td>
<td>B2</td>
<td>718</td>
<td>XKBQBM</td>
<td>291</td>
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<tr>
<td>BK19382 2004</td>
<td>Staten Island</td>
<td>Laboratory A</td>
<td>Right ear</td>
<td>PEN</td>
<td>B1</td>
<td>856</td>
<td>XKBQBM</td>
<td>1321</td>
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<td>BK21746 2007</td>
<td>Manhattan</td>
<td>Laboratory A</td>
<td>Torso</td>
<td>PEN, ERY, OXA</td>
<td>B1</td>
<td>208</td>
<td>XKBQBM</td>
<td>1327</td>
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<tr>
<td>BK22183 2007</td>
<td>Manhattan</td>
<td>Laboratory A</td>
<td>Axilla</td>
<td>PEN</td>
<td>B3</td>
<td>208</td>
<td>XKBQBM</td>
<td>1327</td>
</tr>
<tr>
<td>BK13684 2004</td>
<td>Somerset County, NJ</td>
<td>Laboratory A</td>
<td>Wound</td>
<td>PEN</td>
<td>B3</td>
<td>208</td>
<td>XKBQBM</td>
<td>1327</td>
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</tbody>
</table>

†Antimicrobial drug susceptibilities were obtained from submitting institutions (unavailable for BK18505 and BK21466). PFGE was performed by using Cfr91, with patterns assigned on the basis of 80% similarity cutoffs (BioNumerics version 6.5, Applied Maths, Austin, TX, USA); BK13684 and BK23527 were unavailable for PFGE analysis. spa typing was performed by using eGenomics software (www.egenomics.com), and RIdom spa types were assigned by using the SpaServer Web site (www.spaserver.ridom.de). Multilocus sequence typing was performed as described (http://saureus.mlst.net).

‡Manhattan, Staten Island, and the Bronx are boroughs of New York, New York.

§Laboratory A is a large outpatient commercial laboratory serving the metropolitan New York, New York, area.

1BK27037 has been described (7).

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Rickettsia monacensis as Cause of Mediterranean Spotted Fever–like Illness, Italy

To the Editor: Rickettsia conorii, the etiologic agent of Mediterranean spotted fever (MSF), is transmitted to humans by the brown dog tick (Rhipicephalus sanguineus). MSF is endemic to Italy; incidence is highest in the south and on the islands of Sardinia and Sicily (1). Recently, the use of molecular methods has enabled identification of other rickettsiae of the spotted fever group (SFG) from *Ixodes ricinus* ticks in northeastern Italy and in other areas of Europe (2–6). *R. monacensis* was identified as an etiologic agent of MSF-like illness in Spain (7).

We report a case of MSF-like illness in a 28-year-old man from Sassari in northwestern Sardinia who was admitted to the Infectious Disease Unit of the University of Sassari Hospital in April 2011. At admission, he reported fever (38.2°C) and headache of 2 days’ duration. At physical examination, he had a crusted skin lesion surrounded by edema and erythema, which was compatible with inoculation eschar, on the left calf. He had no rash. Laboratory results showed a slight leukocyte increase, hypocromic and microcytic anemia (hemoglobin 10.6 g/dL [reference range 13.1–17.1 g/dL]), mean corpuscular volume 70.8 fL [reference range 81–88 fL], mean corpuscular hemoglobin concentration 29.6 g/dL [reference range 30–35 g/dL]), hyperbilirubinemia (total bilirubin 1.36 mg/dL [reference range 0.2–1.3 mg/dL], direct bilirubin 0.49 mg/dL [reference range 0.0–0.6 mg/dL]), and erythrocyte sedimentation rate 37 mm/h (reference range 0–25 mm/h). The remaining parameters

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