Carbapenemase-producing Bacteria in Patients Hospitalized Abroad, France

To the Editor: The emergence and rapid worldwide dissemination of carbapenemase-producing bacteria (CPB), especially carbapenemase-producing Enterobacteriaceae (CPE), have prompted public health authorities to reconsider prevention strategies to control the spread of these organisms (1–5). In France, national guidelines recommend systematic screening for commensal CPE and glycolipopeptide-resistant enterococci (GRE) in all patients admitted to hospitals who have been hospitalized in other countries during the preceding 12 months (6,7) (repatriated patients), independently of whether transfer was direct from hospital to hospital (DT) or not (NDT). These guidelines also recommend implementation of presumptive patient isolation and contact precautions on admission (6,7). We conducted a 33-month survey at Hôpital Européen Georges Pompidou (HEGP), a university teaching hospital in Paris, of CPE and GRE in repatriated patients; we also investigated incidence of extended-spectrum β-lactamase (ESBL) producers only (p = 0.67). Characteristics of the 33 patients carrying CPB and/or GRE are shown in the Table. Of all isolates, 191 produced ESBLs only.

Rates of resistance for ESBL-producing Enterobacteriaceae and CPE were, respectively, 53.1% and 57.1% to gentamicin, 16.7% and 32.1% to amikacin, 77.1% and 82.1% to nalidixic acid, 63% and 75% to levofloxacin, and 70.3% and 75% to ciprofloxacin. The Pseudomonas spp. and A. baumannii isolates were also multidrug resistant; all isolates were colistin susceptible.

Among the 33 colonized patients, 13 (39.4%) were not infected; 1 of the uninfected patients died. Seven patients were infected with ≥1 CPB (health care–related in 2 patients, 1 of whom died), 4 patients with ESBL-producing Enterobacteriaceae (health care–related in 1 patient, who died), and 9 patients with other bacteria (health care–related in 4 patients, 1 of whom died). No patients were infected with GRE. Overall, 60.6% of colonized patients were infected and 12.1% died; 35% (7/20) of the infections were health care–related (3 urinary tract device–related infections, 2 cases of ventilator-associated pneumonia, 1 infection at the site of a portacath, and 1 case of cellulitis).

Almost 25% of the repatriated patients carried ESBL-producing Enterobacteriaceae (mostly CTX-M-15 producers; online Technical Appendix, http://wwwnc.cdc.gov/EID/article/20/7/13-1638-Techapp1.pdf); 6.7% carried CPB and/or GRE. By comparison, during the study period, only 10.8% of 2,314 systematically screened patients in the medical and general surgery intensive care units at HEGP (repatriated patients excluded) carried ESBL-producing Enterobacteriaceae; 1 carried vanA Enterococcus faecium (data not shown). For patients with no record of hospitalization abroad, no CPE isolates were found; other bacterial isolates included 1 vanA E. faecalis, 13 vanA E. faecium (all known from previous outbreaks), 4 OXA-23–producing A. baumannii, and 4 VIM-1 IMP-producing P. aeruginosa.

Of the repatriated patients, 19.5% of DT patients (vs. 4.1% of NDT) and 23.9% (7 DT, 4 NDT) of those who were transferred to medical and general surgery intensive care units (ICUs) were CPB and/or GRE carriers. This finding highlights the role of severe underlying disease or injury and recent antimicrobial drug treatment. Among ICU patients, 3 died, most likely from underlying conditions, findings in line with the observation that carriage of or infection with multidrug-resistant bacteria is not the only predictor of death (8). Most of the 28 CPE isolates were resistant to fluoroquinolones and aminoglycosides except amikacin; 21 carried OXA-48–type genes, 7 of which were non-ESBL producers and were detected only around an etrampem disk on Drigalski agar (Bio-Rad, Marnes-la-Coquette, France). All CPB, irrespective of species, showed imipenem hydrolysis in a recently described test (9) that was shortened and simplified by incubating colonies directly in antibiotic solution.

Although time-consuming and certainly perfectible, implementation of strict control measures to limit CPB and GRE spread (6,7) seems justified, a conclusion supported by the occurrence, since November 2010, of just 1 cross-transmission–linked CPB outbreak in an ICU at HEGP (after urgent intervention for cardiac arrest). Of particular concern
is the high proportion of OXA-48–producing isolates in persons with no documented link to repatriation in France (10). This finding could be explained in part by the historical and demographic relationships between France and North Africa, where prevalence of OXA-48 is high, reflected in results from patients repatriated from that part of the continent.

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Zoonotic Filariasis Caused by Novel Brugia sp. Nematode, United States, 2011

To the Editor: Zoonotic brugian filariasis is an incidental infection of humans with Brugia spp. nematodes that primarily parasitize nonhuman vertebrates, rarely humans (1–3). In contrast to classical lymphatic filariasis caused by B. malayi and B. timori, which are found in Asia, most zoonotic Brugia infections have been reported from the northeastern United States (2,3) or South America (4). We report a case of symptomatic brugian infection in a New York City resident who had not traveled to the Eastern Hemisphere.

In 2011, a 53-year-old White man first noted tenderness and swelling behind his penis and in his right groin after having fallen 3 months earlier. The tenderness was relieved by nonsteroidal antiinflammatory drugs, but the swelling continued; an oral antimicrobial drug, prescribed for presumed cellulitis, produced no improvement. At the time of examination, the patient had no fever or other signs or symptoms. Only a 3.0-cm × 3.0-cm firm, nonfixed right inguinal nodule without warmth or tenderness was noted. Laboratory findings were remarkable for total leukocytes of 6.4 × 10^9, eosinophilia (12%, 600 cells/mm^3), decreased hemoglobin level (10.0 g/dL), and low hematocrit of 31.2%. An excisional biopsy sample revealed intralymphatic adult nematodes with viable-appearing microfilaria (online Technical Appendix Figure, wwwnc.cdc.gov/EID/article/20/7/13-1654-Techapp1.pdf).

The patient had been born and raised in Champlain, Illinois, and had resided in the Bronx, New York, since 1979; he had no history of travel to filariasis-endemic regions. Characteristics of the adult worms and microfilaria were most consistent with those of Brugia spp., which was surprising because classical brugian lymphatic filariasis seems to be limited to Asia (B. malayi) and Indonesia (B. timori) (4,5). However, the adult filariae were smaller than expected for B. malayi or B. timori nematodes, prompting consideration of zoonotic filariasis (1,6). The adult worms and microfilaria seemed to be viable, although zoonotic Brugia spp. in histologic...