putative N-glycosylation sequon was missing at positions 249–251 in hemagglutinin-esterase-fusion protein.

In summary, a cattle herd in Japan had influenza D virus infection. Although this study is a case report with a small number of samples, the observation shows a potential role for influenza D virus in the bovine respiratory disease complex.

References

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Fatal Septic Meningitis in Child Caused by Streptococcus suis Serotype 24

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To the Editor: Streptococcus suis is a zoonotic bacterium that causes invasive infections in humans and pigs (1). Of the 29 described serotypes, serotype 2 is the most prevalent in humans, almost exclusively affecting adults (1). Other serotypes occurring sporadically in humans have been reported (1). Here we report a rare case of S. suis serotype 24 infection in a child.

A 2-year-old girl with Down syndrome was admitted to a hospital in Rayong Province, eastern Thailand, in May 2015. She had a high fever of 3 days’ duration, vomiting, stiff neck, rash, and purpura on her right leg and hip. The initial diagnosis was cellulitis and suspected meningococcal meningitis. Physical examination revealed a temperature of 39.5°C, pulse rate of 160 beats/min, respiratory rate of 80 breaths/min, and blood pressure of 94/55 mm Hg. Oxygen saturation was 80%, which is indicative of severe respiratory failure. An analysis of the complete blood count showed a leukocyte count of 21,460 cells/mL (83% neutrophils, 13% lymphocytes, 1% eosinophils, 3% monocytes) and platelet count of 155,000 cells/μL. A comprehensive metabolic panel test was not performed.

Bacteria were isolated from the patient’s cerebrospinal fluid culture; however, hemoculture did not show any growth. Traditional biochemical tests and an API20Strep system assay (BioMérieux, Marcy l’Etoile, France) suggested that the organism was S. suis. The samples tested positive for S. suis serotype 24 by multiplex PCR and coagglutination testing (2,3). On the basis of these results, the condition was diagnosed as septic meningitis. Unfortunately, the patient died the day after admission, even though she had been treated with ceftriaxone on the day of admission.

The isolate from the child was susceptible to penicillin (MIC ≤0.12 μg/mL), ceftriaxone (MIC ≤1 μg/mL), erythromycin (MIC ≤0.25 μg/mL), levofloxacin (MIC ≤2.0 μg/mL), clindamycin (MIC ≤0.25 μg/mL), and vancomycin (MIC ≤1.0 μg/mL). Because breakpoints for S. suis are not
Infections caused by un

Given the emergence of treating patients with predisposing conditions is required strains remains low, increased awareness among clinicians reported (Table) (4). Previous case of could not be confirmed in this case. A previous case of S. suis was reported (2002 case (1)). Therefore, the presence of this CC should be monitored, and characterization of virulence factors of strains belonging to this CC should be further investigated.

The routes of S. suis infection include occupational exposure, recent contact with pigs or raw pork products, and recent consumption of raw pork products (1). This patient had no history of contact with pigs or pork products nor consumption of raw pig’s blood soup or any other source of undercooked meals before the onset of illness. S. suis may affect various other animal species (7), but the patient did not have any close contact with other animal species. Close family members of the patient did not report having consumed raw pork products, although they did report having close contact with pork meat for cooking. However, so far, no human cases have been confirmed to be the consequence of close contact with or consumption of undercooked meat from animal species other than pigs. In addition, human-to-human transmission of S. suis has not been reported (8).

As reported in other similar cases, the route of the infection could not be confirmed in this case. A previous case of S. suis infection in a child was reported in a 1-month-old girl with meningitis in Thailand; however, certain details of that case, including the causative bacterial serotype, were not reported (Table) (9).

Although the isolation rate for S. suis serotype 24 strains remains low, increased awareness among clinicians treating patients with predisposing conditions is required given the emergence of S. suis infections caused by uncommon serotypes. Such awareness will be important for development of enhanced surveillance, epidemiologic control, and prevention strategies for public health.

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**References**


**Table.** Demographic and clinical characteristics for the 2 known reported *Streptococcus suis* infections in children

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>2015 case (this study)</th>
<th>2002 case (9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>F</td>
<td>F</td>
</tr>
<tr>
<td>Age</td>
<td>2 y</td>
<td>1 mo</td>
</tr>
<tr>
<td>Temperature, °C</td>
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<td>38.0</td>
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<tr>
<td>Pulse rate, beats/min</td>
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<tr>
<td>Respiratory rate, breaths/min</td>
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<td>Blood pressure, mm Hg</td>
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<tr>
<td>Leukocyte count, cells/mL</td>
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<td>12,000</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Septic meningitis</td>
<td>Meningitis</td>
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<tr>
<td>Hearing loss</td>
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<td>No data</td>
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<tr>
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<td>Down syndrome</td>
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<td>Outcome</td>
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<td>Survived</td>
</tr>
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<tr>
<td>Sequence type</td>
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</tbody>
</table>

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