GII.6, GII.3/GII.17, GI.7/GII.17, and GI.7/GII.P7-GII.6). We did not perform dual typing on GI strains because they were less predominant than GII strains. However, future analysis of their recombination patterns will be useful for better characterizing these rare but potentially significant genotypes. This study was somewhat limited by lack of detailed clinical information accompanying the submitted samples and absence of surveillance from southern Thailand (≈14% of the country’s population). Molecular epidemiology and continued surveillance of norovirus strain diversity will increase awareness among clinicians and help epidemiologists determine global transmission patterns.

This work was supported by the Research Chair Grant from the National Science and Technology Development Agency (P-15-50004) and the Center of Excellence in Clinical Virology of Chulalongkorn University and Hospital (GCE 59-009-30-005). Support for W.C. was provided by the Tuition/Fee and Stipend Scholarship for Graduate Students (Faculty of Medicine of Chulalongkorn University) and a scholarship from Chulalongkorn University Graduate School to commemorate the Celebrations on the Auspicious Occasion of Her Royal Highness Princess Maha Chakri Sirindhorn’s 60th Birthday.

RESEARCH LETTERS

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References


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Sneathia amnii and Maternal Chorioamnionitis and Stillbirth, Mozambique

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We report a case of *Sneathia amnii* as the causative agent of maternal chorioamnionitis and congenital pneumonia resulting in a late fetal death in Mozambique, with strong supportive postmortem molecular and histopathologic confirmation. This rare, fastidious gram-negative coccobacillus has been reported to infrequently cause abortions, stillbirths, and neonatal infections.

*Sneathia amnii*, formerly designated *Leptotrichia amnionii*, is a rare, fastidious, gram-negative coccobacillus, first described in the amniotic fluid of a woman with a fetal demise (1). The inherent difficulties in conventionally culturing this pathogen led to its initial identification through analyzing the 16S rRNA gene; its genome was recently sequenced (1,2). *S. amnii* is an opportunistic agent of the female urogenital tract (3,4) associated with cases of spontaneous abortion (miscarriage) and neonatal meningitis (1,5,6). We describe a perinatal case of *S. amnii* infection in a mother–fetus dyad, which we documented and investigated with the minimally invasive tissue sampling (MITS) postmortem procedure (7).

An otherwise healthy multigravida 37-year-old woman, at an estimated gestational age of 39 weeks, was admitted to Manhiça District Hospital, southern Mozambique, in labor. During pregnancy, she had attended 2 antenatal consultations and received the standard of care for pregnant women in Mozambique; mild anemia was treated with ferrous sulfate and folic acid supplements. Serologic tests for syphilis and HIV were both negative. Upon arrival at the hospital, the mother was afebrile and hemodynamically stable; she had a fully effaced uterine cervix, thin and elastic, 2 cm dilation; intact amniotic membranes; and cephalic fetal presentation with heartbeat present. Physical examination did not provide additional information. Labor progressed with spontaneous rupture of membranes. No additional documentation of the fetal heartbeat was available before delivery. Two hours after arrival, a fresh stillborn female weighing 3.5 kg was born by spontaneous vaginal delivery. Size was normal, and no macroscopic congenital abnormalities were observed. The mother was discharged next day without complications.

As part of Mozambique’s Child Health and Mortality Prevention Surveillance (CHAMPS), after obtaining written, informed consent, we conducted MITS by biopsy needle of tissues and body fluids, in addition to placenta, to ascertain the cause of the stillbirth (7). Samples are subject to thorough histopathologic, molecular, and microbiological investigation, including universal screening for HIV-1, *Mycobacterium tuberculosis*, and malaria parasites. We performed conventional microbiological cultures of blood and cerebrospinal fluid (CSF); we inoculated ≈3 mL of blood into aerobic blood culture bottle (BACTEC system; Becton Dickinson, https://www.bd.com) and cultured CSF samples into blood, chocolate, and MacConkey agar plates. We performed multipathogen molecular screening using TaqMan Array Card (Applied Biosystems, https://www.thermofisher.com) in whole blood, CSF, lung, and rectal swab samples (8). We prepared and examined tissue samples using conventional pathologic methods and targeted immunohistochemical staining (9).

We isolated no microorganisms in CSF or blood, nor did we detect a likely pathogen in any of the unfixed

![Figure](https://www.cdc.gov/eid)
The Spanish Agency of Cooperation and International Development (AECID) funds the core activities of Centro de Investigação em Saúde de Manhiça. R.V. had a fellowship from the Rio Hortega program of the Instituto de Salud Carlos III (ISCIII) grant no. CD16/00024.

J.M.G. received grants from the Gates Foundation during the study period. The other authors declare that they have no competing interests.

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