

CAMPYLOBACTER FETUS BACTEREMIA IN AN IMMUNOCOMPROMISED PATIENT: CASE REPORT AND REVIEW OF THE LITERATURE

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SUMMARY

A 33-year-old woman underwent a liver transplantation and splenectomy in 1985 and had followed immunosuppressive therapy until 1995. Afterwards a non-Hodgkin lymphoma was diagnosed and chemotherapy was started. In January 2000, because of suspect transplantation rejection she was treated with steroid and immunosuppressive therapy. Fever occurred after two months and Cytomegalovirus (CMV) infection was diagnosed. Ganciclovir was started with clinical remission. In November 2000 fever recurred without clinical symptoms. Lymphoma recurrence was excluded and CMV was detected by PCR in several biological fluids. Blood cultures were positive for a bacterium that was identified as *Campylobacter fetus*. The patient was successfully treated with intravenous ciprofloxacin. For persistent CMV viremia therapy with ganciclovir was stopped and foscarnet was used (60mg/Kg/tid i.v. for two weeks). Bacteremia due to *C. fetus* is rare, occurring mainly in immunocompromised patients.

In our patient the immunosuppressive therapy, chemotherapy for lymphoma and CMV infection had made the patient susceptible to bacteremia with this infrequently found bacterium. The clinical microbiologist should be aware of this infection in immunocompromised hosts.

KEY WORDS: *C. fetus*, bacteremia, immunocompromised host, CMV infection

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INTRODUCTION

Campylobacters are small, curved microaerophilic Gram-negative bacteria motile by single polar flagella. Campylobacteriosis is considered to be a zoonotic disease. Contaminated food is the usual source of human *Campylobacter* infection (Shallow *et al.*, 1996). The most common disease is enterocolitis, and *Campylobacter jejuni* and *Campylobacter coli* are the species most commonly recognized. Extraintestinal infections such as bacteremia occur more rarely, mainly in immunocompromised patients (De Mol, 1994).

We report a case of *C. fetus* bacteremia in an immunocompromised patient.

A 33-year-old woman was admitted to the Gastroenterology Unit of the University of Bari, Italy, for recurrent fever. Clinical history revealed that the patient had undergone a liver transplantation and splenectomy in 1985 for hepatitis-related cirrhosis of unknown origin. She had taken immunosuppressive therapy with prednisone and azathioprine until 1995 when tacrolimus was added for chronic rejection. In 1999 due to epigastric pain not responsive to symptomatic therapy she underwent esophagogastroduodenoscopy which showed multiple mucosal elevations and ulcerations suggestive of a post-transplantation lymphoproliferative disease (PTLD). Histology confirmed this suspicion