Unusual Pathogen *Comamonas testosteroni* Sepsis Following Gastroenteritis in a 12 Months Old Child: Case Report and Literature Review

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Abstract  *Comamonas testosteroni* initially has been considered as a nonpathogenic microorganism until 1987; after which year, it has being recognized as a human pathogen with spectrum of infections both in adult and children. We report the first case of a healthy child who is 12 months old Omani girl presented with features of acute gastroenteritis with *Comamonas testosteroni* sepsis, that was treated successfully with two weeks course of intravenous ceftriaxone with excellent outcome. Most of the reported cases of *Comamonas testosteroni* infection were sensitive to antibiotics with favorable outcome.

Keywords: *Comamonas testosteroni*, gastroenteritis, sepsis, child


1. Introduction

*Comamonas testosteroni* is a gram-negative, motile, aerobic, Non-spore-forming bacillus. [1] Formerly known as *Pseudomonas testosteroni*. It is found in soil, plants, water saprophytes, and also may be found in humidifier reservoir water, even isolated from dromedary rumen fluid [2] It has became clinically important after 1987, when reports began accumulating on human infections such as cellulitis [4], peritonitis especially with a perforated appendix [5], bloodstream infection [6,7], infective endocarditis [8], purulent meningitis, [9] postoperative endophthalmitis [10] and hemodialysis catheter-related bacteremia [11]. However, cases of bloodstream infections caused by *Comamonas testosteroni* have been infrequently reported [12] and this is the first case reported in Oman in a 12 months old child.

In this report we presented a healthy child who is 12 months old girl presented with features of acute gastroenteritis with *Comamonas testosteroni* sepsis that was treated successfully with two weeks course of intravenous ceftriaxone with excellent outcome.

2. Case Report

A one year old girl previously well admitted with fever associated with lethargy and decreased oral intake. Fever started one week before her presentation, it was high grade, on and off, documented on admission to be 39.4.Fever responded to antipyretic medication. It was associated with watery loose stool, which was not mixed with mucus or blood about 5-8 times per day. No history of rash, no respiratory symptoms, no abnormal movement. No history of contact with sick persons, no history of travel and no history of eating from outside.

Systemic review was unremarkable. Antenatal history was not significant apart of mother had gestational diabetes mellitus (GDM) controlled with diet. Parents are second-degree relatives, has one sibling 6 years old who is healthy. No family history of similar illness. No previous medical or surgical admissions. Developmental history, she is corresponding to her age in all parameters. Not on any medications prior to admission and had no history of allergy. Her immunization history is up to date. She was eating normal family diet and thriving well.

Clinically, when the child was initially seen in the emergency room; she was sick looking, febrile 39.4 degree Celsius, moderately dehydrated, tachycardia with heart rate of 160 beat per minutes, Blood Pressure was maintained. Liver was palpable 2 cm below costal margin, other systemic examinations were unremarkable. The initial clinical impression was gastroenteritis with moderate dehydration. She received 3 boluses of intravenous fluid of 0.9% normal saline, and then shifted to pediatric ward with impression of acute gastroenteritis and to rule out sepsis in view of high-grade fever and tachycardia for further management.

Initial blood investigations showed no leukocytosis with total white blood cells 11.4, absolute neutrophils count 5.6, platelets 409, hemoglobin: 10.8.

During her first 3 days of admission, she was managed with intravenous fluid and oral rehydration solution for her dehydration, her gastroenteritis symptoms improved
but she continued to spike high grade fever that ranged between 38-39 degree Celsius. On the third day of admission blood culture showed gram-negative bacilli. Intravenous ceftriaxone started 80 mg per kg per dose once a day. Over the next 24 hours of starting antibiotics, her spike of fever started to improve and became less frequent while diarrhea gradually decreased significantly as well.

Final report of the blood culture showed *comamonas testosteroni* sensitive to ceftriaxone, cefazidime, cefipime, ciprofloxacin and gentamicin. Based on the sensitivity results; ceftriaxone was continued. Her symptoms improved after starting the antibiotics and the fever subsided. Blood culture was repeated 48 hours of starting antibiotics along with stool culture, which showed no growth. Child continued to improve clinically and she received ceftriaxone for total 14 days.

She was discharged in stable condition after finished ceftriaxone course for total 14 days. On subsequent follow up the child remained asymptomatic with normal activities.

### 3. Discussion

There are few cases of *Comamonas testosteroni* bacteremia reported in the literature. *Comamonas testosteroni* initially has been considered as a nonpathogenic microorganism until 1987; after which year, it has being recognized as a human pathogen with spectrum of infections both in adult and children [4-11].

Most reported cases have immune suppression such as malignancy [13], on hemodialysis patients, [14] alcoholic patient, patient with hepatitis B infection with liver cirrhosis and hepatocellular carcinoma [15], and cholesteatoma [16]. Our patient was absolutely healthy and has no comorbid conditions, with no evidence of immunodeficiency.

Gastrointestinal pathologies are usually accompanied by intra-abdominal infections such as this organism, and so it is considered as a risk factor for *comamonas testosteroni* infection [17]. Our patient presented initially with viral gastroenteritis, which we believe it was the risk factor to the development of *comamonas testosteroni* sepsis.

There are 15 reported cases of *C. testosteroni* infections in pediatrics age including our patient shown in Table 1.

<table>
<thead>
<tr>
<th>Patients no</th>
<th>Gender/Age years</th>
<th>Diagnosis</th>
<th>Sample</th>
<th>Antibiotic treatment</th>
<th>Result</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M/11</td>
<td>Appendicitis</td>
<td>Peritoneal fluid</td>
<td>Ampicillin/clindamycin and tobramycin</td>
<td>Recovered</td>
<td>Barbaro et al [5]</td>
</tr>
<tr>
<td>2</td>
<td>F/12</td>
<td>Appendicitis</td>
<td>Peritoneal fluid</td>
<td>Cefoxitin</td>
<td>Recovered</td>
<td>Barbaro et al [5]</td>
</tr>
<tr>
<td>5</td>
<td>F/newborn</td>
<td>Maternal Intravenous drug abuse</td>
<td>Blood</td>
<td>Aminicillin and amikacin</td>
<td>Dead</td>
<td>Barbaro et al [5]</td>
</tr>
<tr>
<td>6</td>
<td>M/10</td>
<td>Bacteremia</td>
<td>Blood</td>
<td>Ciprofloxacin/Amikacin</td>
<td>Recovered</td>
<td>Frashad et al [6]</td>
</tr>
<tr>
<td>7</td>
<td>M/16</td>
<td>Appendicitis</td>
<td>Peritoneal fluid</td>
<td>Amikacin, ampicillin, and clindamycin</td>
<td>Recovered</td>
<td>Gülsüm Iclal Bayhan [7]</td>
</tr>
<tr>
<td>8</td>
<td>F/17</td>
<td>Appendicitis</td>
<td>Peritoneal fluid</td>
<td>NR</td>
<td>Recovered</td>
<td>Barbaro et al [5]</td>
</tr>
<tr>
<td>9</td>
<td>M/14</td>
<td>Appendicitis</td>
<td>Appendix</td>
<td>NR</td>
<td>Recovered</td>
<td>Barbaro et al [5]</td>
</tr>
<tr>
<td>10</td>
<td>M/15</td>
<td>Appendicitis</td>
<td>Appendix</td>
<td>NR</td>
<td>Recovered</td>
<td>Barbaro et al [5]</td>
</tr>
<tr>
<td>12</td>
<td>M/10</td>
<td>Medulloblastoma, chemotherapy</td>
<td>blood</td>
<td>Ciprofloxacin, amikacin</td>
<td>Recovered</td>
<td>Frashad et al [6]</td>
</tr>
<tr>
<td>13</td>
<td>F/1</td>
<td>Acute gastroenteritis/ sepsis</td>
<td>Blood</td>
<td>Ceftriaxone</td>
<td>Recovered</td>
<td>(Present patient)</td>
</tr>
</tbody>
</table>

* M, male; F, female
NR, Not reported.

Table 1. Summary of pediatric reported cases of *Comamonas testosteroni* infection
4. Conclusion

*Comamonas testosteroni* is a gram-negative, motile, aerobic, Non-spore-forming bacillus. It has became clinically important after 1987, when Reports began accumulating on human infections. This is the first case report of *Comamonas testosteroni* sepsis in a healthy Omani child following acute gastroenteritis. It represents the potential virulence of this organism that should be considered as real pathogen rather than contaminant when isolated from a sterile body site.

References


