Post-Operative Endophthalmitis Caused by the Nutritionally Variant Streptococcus *Granulicatella adiacens*

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**Abstract**

**Objective:** Bacterial endophthalmitis is among the most serious ocular infections. Nutritionally variant streptococci (NVS) are bacteria that are difficult to culture with standard media because of fastidious growth requirements. The cases of post-operative endophthalmitis caused by *Granulicatella adiacens*, one of the NVS were reported.

**Method:** Case report and review of literature

**Results:** In Case 1, a 77-year-old female, who had undergone repeated ocular surgeries including trabeculectomy in the left eye, had developed late-onset bleb-related endophthalmitis without bleb leakage. The best corrected visual acuity (BCVA) showed light perception. A vitrectomy was performed, following this procedure and topical, intravitreal and systemic antibiotics, the BCVA recovered to 18/20.

In Case 2, an 85-year-old male had developed acute postoperative endophthalmitis after cataract surgery in his left eye. The BCVA was light perception in the left eye. A vitrectomy and the removal of intraocular lens were performed. Inflammation was improved after the vitrectomy and administration of topical, intravitreal and systemic antibiotics.

Bacteria isolated from the vitreous samples of these patients were identified as *Granulicatella adiacens* by the 16S ribosomal RNA gene sequencing.

**Conclusion:** We report the first cases of post-operative endophthalmitis caused by *G. adiacens* identified by molecular genetic analysis. NVS should be considered in cases of post-operative endophthalmitis.

**Keywords** *Granulicatella adiacens*, Nutritionally variant streptococci (NVS); Endophthalmitis; Bleb-related infection; 16S ribosomal RNA gene; Vitrectomy

**Introduction**

Bacterial endophthalmitis is among the most serious infectious ocular diseases, and may result in severe visual disturbances, including blindness, enucleation, or evisceration. The causes of endophthalmitis include ocular surgery, penetrating ocular trauma, invasion from corneal or scleral abscess, and metastasis via bloodstream from systemic infectious diseases such as sepsis, catheter-related infection, liver abscess, infective endocarditis, and so on, a class of disease referred to as endogenous endophthalmitis. While most of the bacteria that cause post-operative endophthalmitis after cataract surgery are staphylococci derived from bacterial microflora of ocular surfaces [1], the bleb-related late-onset infection after glaucoma surgery is primarily the result of streptococci followed by coagulase-negative Staphylococcus, Haemophilus influenza, and Enterococcus species [2]. To detect the causative bacteria, intraocular samples are drawn for bacterial culturing, and empiric therapy then is started. However, the culture-positive rates of intraocular tapping from post-cataract surgery and bleb-related infection remain about 63-69% and 50% respectively, and the causative bacteria in the remaining cases are unknown [2-4]. Additionally, culture-positive results often include unidentified bacteria.

Nutritionally variant streptococci (NVS) are pleomorphic Gram-variable bacteria showing fastidious growth requirements; NVS are difficult to grow on standard sheep blood agar plates, because these bacteria require supplementation with pyridoxal for growth. It has been suggested that NVS is a common cause of infectious endocarditis in cases that are negative by blood culture [5,6]. To date, 4 bacterial species have been identified as NVS: *Abiotrophia defectiva*, *Granulicatella adiacens*, *Granulicatella elegans*, and *Granulicatella balaenopterae*. Although endophthalmitis by *Abiotrophia* species has
been reported previously [5,7,8], endophthalmitis by Granulicatella species has not been reported except outbreak cases of postinjection endophthalmitis after intravitreal bevacizumab [9]. In this manuscript, the first report of cases of Granulicatella adiacens postoperative endophthalmitis, which were successfully treated by early surgeries using vitrectomy were presented.

Cases and Methods

Case 1

A 77-year-old female had complained of decreased left vision for a week. This patient had undergone repeated ocular surgeries for primary angle closure glaucoma in both eyes and post-operative bullous keratopathy in the left eye; laser iridotomy had been performed in both eyes about 17 years previously. Additionally, the patient had received trabeculectomy 12 years previously, cataract surgery 9 years previously, and Descemet stripping automated endothelial keratoplasty (DSEAKe) twice (5 and 2 years previously) in her left eye. The subject had a history of hypertension and hypercholesterolemia but no immunosuppressive background. The best corrected visual acuity (BCVA) showed 20/20 in the right eye and light perception in the left eye. Intraocular pressure showed 18 mmHg in the right eye and 13 mmHg in the left eye. Slit-lamp examination revealed slight ciliary injection, corneal edema, inflammatory cells, flare, and fibrin in the anterior chamber of the left eye (Figure 1A). The corneal graft exhibited no signs of infection, including keratoprecipitate, infiltration, or endothelial plaque. An avascular filtration bleb at 11 o’clock of the left corneal limbus did not show bleb leakage or obvious blebitis (Figure 1B). The intraocular lens in the left eye was clear. The fundus of the left eye was not visible, and the B-scan ultrasonography revealed vitreous opacity. The right eye showed no signs of infection in the anterior or posterior segments. To differentiate endogenous endophthalmitis, thorough systemic examination was performed. The patient had no history of invasive procedures, including extraction of teeth, catheter insertion, intravenous drug abuse, or abdominal perforation. A blood sample was subjected to bacterial culturing. Computed tomography (CT) of the chest and abdomen detected no infectious origin, including liver abscess. Because endogenous endophthalmitis was suspected, and vitrectomy and the removal of the anterior chamber, and hypopyon (Figure 2A). The subject reported symptoms of blurred vision, including fever and pain in his left eye. On the following day, this individual visited an ophthalmologist because of a further decrease of vision and was immediately referred with the suspected acute postoperative endophthalmitis on the 6th postoperative day. The BCVA was 20/20 in the right eye and light perception in the left eye. Intraocular pressure was 5 mmHg in the right eye and 9 mmHg in the left eye. Slit-lamp examination of the left eye showed ciliary injection, cells and fibrin in the anterior chamber, and hypopyon (Figure 2A). The fundus of the left eye was improved due to vitreous opacity. B-scan ultrasonography showed dense vitreous opacity. Postoperative infectious endophthalmitis was suspected, and vitrectomy and the removal of intracocular lens was performed at the day of initial visit. Vitreous irrigation with VCM and CAZ as described above and topical LVFX and CMX (6 times per day each) and intravenous cefpirome was administered empirically. Inflammation of the left eye was improved

Figure 1: A) Photograph of slit-lamp examination of the left eye of Case 1 at the first visit. Observation revealed slight ciliary injection, corneal edema, inflammatory cells, flare, and fibrin in the anterior chamber. B) A downgaze-view of 1a. A filtration bleb at 11 o’clock of the left corneal limbus did not show bleb leakage. C) A micrograph of a Gram-stained specimen (x1,000) of colonies on a chocolate agar plate of the isolate from Case 1. Gram-variable pleomorphic bacteria were observed. D) The satellite phenomenon of the isolate from Case 1 growing on a sheep blood agar plate. Small colonies are observed around staphylococcal colonies.

Case 2

A 85-year-old male who had a history of hypertension and angina pectoris underwent cataract surgery and intraocular lens implantation in his left eye; no complications were reported during the operation. However, 5 days later, the subject reported symptoms of blurred vision and pain in his left eye. On the following day, this individual visited an ophthalmologist because of a further decrease of vision and was immediately referred with the suspected acute postoperative endophthalmitis on the 6th postoperative day. The BCVA was 20/20 in the right eye and light perception in the left eye. Intraocular pressure was 5 mmHg in the right eye and 9 mmHg in the left eye. Slit-lamp examination of the left eye showed ciliary injection, cells and fibrin in the anterior chamber, and hypopyon (Figure 2A). The fundus of the left eye was improved due to vitreous opacity. B-scan ultrasonography showed dense vitreous opacity. Postoperative infectious endophthalmitis was suspected, and vitrectomy and the removal of intracocular lens was performed at the day of initial visit. Vitreous irrigation with VCM and CAZ as described above and topical LVFX and CMX (6 times per day each) and intravenous cefpirome was administered empirically. Inflammation of the left eye was improved
immediately after the vitrectomy, and the retinal tissue was not injured. However, the final BCVA of the left eye remained 20/125 after 3 months because of the pre-existing foveal scar.

The vitreous sample collected at vitrectomy was cultured for bacteria as described in Case 1 section, which resulted in the growth of small bacterial colonies on a chocolate agar plate in 2 days. The bacteria were able to grow as satellite colonies around staphylococcal colonies when streaked onto a sheep blood agar plate containing staphylococci (Figure 2B). DNA sequence analysis of 16S rRNA using the primer pair 8UA (5'-AGAGTTTGATCCTGGCTCAG-3') and 1485B (5'-TACGGTTACCTTACGAC-3') [10] showed 99.7% identity with that of the type strain ATCC 49175, and the strain was designated *G. adiacens* GF02. Antibiotic susceptibility testing showed increased MIC of levofloxacin (LVFX) *in vitro* (Table 1).

![Figure 2: A) Photograph of slit-lamp examination of the left eye of Case 2 at the first visit. Ciliary injection, inflammatory cells and fibrin in the anterior chamber, and hypopyon are observed. B) The satellite phenomenon of the isolate from Case 2 growing on a sheep blood agar plate. Small colonies are observed around a streak of staphylococci.](image)

<table>
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<th>Antibiotics <em>a</em></th>
<th>MIC (µg/mL)</th>
<th>Case 1</th>
<th>Case 2</th>
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<td>≤ 0.06</td>
<td>≤ 0.06</td>
<td>≤ 0.06</td>
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<tr>
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<td>CFPM</td>
<td>NA</td>
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<tr>
<td>IPM/CS</td>
<td>≤ 0.06</td>
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*Abbreviations: PCG: Penicillin G; ABPC: Ampicillin; CVA/AMPC: Clavulanate/Amoxicillin; CTRX: Ceftriaxone; CCL: Cefaclor; CFPM: Cefepime; IPM/CS: Imipenem/Cilastatin; EM: Erythromycin; MINO: Minocycline; LVFX: Levofloxacin; CLDM: Clindamycin; ST: Sulfamethoxazole-Trimethoprim; VCM: Vancomycin*

Table 1: Antibiotic susceptibilities of *Granulicatella adiacens* strains isolated in this study based on the CLSI M45-A2 method.

**Discussion**

Nutritionally variant streptococci (NVS) originally were described by Frenkel and Hirsch as streptococci that were able to grow as small satellite colonies when placed near other bacterial colonies [11]. Notably, NVS cannot grow on standard trypticase soy agar with 5% sheep blood because of their fastidious growth requirements. However, helper organisms like staphylococci, streptococci (excepting *Streptococcus pyogenes*), Enterobacteriaceae, and yeasts support the growth of NVS by producing pyridoxal or L-cysteine [11]. NVS usually
grow on chocolate agar, Brucella agar with 5% horse blood, media supplemented with pyridoxal hydrochloride 0.001%, and in thioglycolate broth [6,12,13]. In the cases described here, vitreous samples were first cultivated in thioglycolate broth and then subcultured onto chocolate agar, a method that facilitated the effective isolation of NVS from vitreous samples.

To date, NVS have been classified as strains of one of 4 bacterial species: Abiotrophia defectiva, Granulicatella adiacens, Granulicatella elegans, or Granulicatella balanenopterae [14]. The first three of these species are normal residents of the oral cavity or upper respiratory tract, but G. balanenopterae is not a human commensal [15]. NVS are important human pathogens of infectious endocarditis [16-19], especially in cases that test negative by blood culture [13]. In addition, NVS have also (rarely) been identified as the causative agent of ocular infections, including conjunctivitis [20], keratitis and corneal ulcers [21], infectious crystalline keratopathy [22,23], post-traumatic orbital abscess [24], chronic dacryocystitis [25], and postoperative endophthalmitis after cataract or glaucoma surgery [5-8,26]. NVS that have previously been reported as causative agents of bacterial endophthalmitis have been limited to Abiotrophia adiacens (the former name of Granulicatella adiacens) as identified by API 20 Strep (bio-Merieux) [5], Granulicatella adiacens (not detailed to the methodology of species identification) [9] and Abiotrophia defectiva [5-8, 26]. The cases described here are the first two examples in which the causative organism was assigned as G. adiacens based on molecular evidence (16S rRNA gene sequencing) since the reclassification of A. adiacens into the genus Granulicatella [14].

Case 1 developed endophthalmitis long after the last intraocular surgery; 2 possible routes of the entry of the microbe were considered, either via filtration bleb or via bloodstream metastasis (derived from other infectious foci). Despite thorough examination, no evidence of endogenous endophthalmitis was detected, and this patient exhibited no history of immunodeficiency, no general infectious signs in blood test including blood culture, and no infection focus. Thus, a diagnosis of late-onset endophthalmitis without bleb leakage after a filtration surgery for glaucoma was made by exclusion. In contrast, Case 2 presented as a case of acute postoperative endophthalmitis after cataract surgery.

As described above, postoperative endophthalmitis, especially late-onset cases, frequently yield negative results on culturing. Bleb-related infections often are caused by oral bacteria like viridans-group streptococci. This case report implies the possibility that some cases of culture-negative endophthalmitis are caused by NVS. To improve the culture-positive rate, it is suggested that vitreous samples should be cultured on media (such as thioglycolate broth or chocolate agar) enriched for the growth of NVS.

Conclusion

The first case of post-operative endophthalmitis caused by G. adiacens in which the identity of the infecting bacteria was demonstrated by molecular genetic analysis was reported. These cases show that post-operative endophthalmitis can be caused by NVS. Therefore, it is proposed that that cultural media (such as thioglycolate broth or chocolate agar plates) that can enrich for NVS should be incorporated into screens for causative agents of endophthalmitis. NVS should be considered in cases of post-operative endophthalmitis.

Nucleotide sequence accession numbers

The nucleotide sequences of the 16S ribosomal RNA genes of the strains GM01 and GF02 are available in the DDBJ/EMBL/GenBank databases under accession nos. LC125190 and LC125191, respectively.

Patient consent

The patients described in the manuscript provided consent for publication of this case report.

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Conflict of Interests

None of the authors have any competing interests to declare.

References


