**Ralstonia Pickettii Bacteremia**

Renuka Pandey, Purabi Barman and Sharmila Sengupta  
Department of Clinical Microbiology, BLK Super Speciality Hospital, India

Corresponding author: Purabi Barman, Department of Clinical Microbiology, BLK Super Speciality Hospital, New Delhi, India, Tel: 91-9899094295; E-mail: purabi.barman@gmail.com

Case Report 1

A forty year old foreign national was admitted for evaluation of refractory Diffuse Large-B cell lymphoma. He was suffering from fever and weight loss for past 1 month and had deep mucosal ulcers. Blood parameters indicated hemoglobin 10.3 gm/dl, red blood cell count 3.3x10^6/µl, total leucocyte count 3000 cells/µl, platelets 6000/µl, urea 78 mg/dl and creatinine 1.7 mg/dl. The patient was shifted on Mini BEAM chemotherapy. On day 2, he developed sudden hypotension and was shifted to the intensive care unit and was ventilated. A central line was inserted and he was put on vasopressor support. Intravenous meropenem 1 gm i.v 8 hourly was started empirically. Gradually his parameters stabilized though the neutrophilic blood picture continued to persist. Patient deteriorated significantly on day 20. Fresh nodular opacities were visualized radiologically and endotracheal (ET) secretion and paired blood samples were sent for culture. Serum procalcitonin level was 12.7 ng/ml. Endotracheal and blood culture samples both grew nonlactose fermenting colonies on Macconkey agar, ET secretion growing with a colony count of 10^6 CFU/ml. Direct Time to Positivity (DTP) for the paired blood samples was more than 2 hours. The colonies were catalase and oxidase positive. The isolate was identified as *R. pickettii*. Identification and antibiotic susceptibility was done on VITEK 2 compact. The patient was put on ciprofloxacin i.v 400 mg 8 hourly as per susceptibility report. The patient responded to the treatment and was discharged on Day 21.

Case Report 2

A 30 year old case of acute lymphoblastic leukemia was admitted for allogenic stem cell transplant. On admission hemoglobin was 4 gm/dl, total leucocyte count 800 cells/µl and platelets 32000/µl. The patient was started on a conditioning regimen of Melphalan and Fludarabine through a hickmann catheter. Stem cell transplant was performed on Day 11 with patient receiving GVHD prophylaxis of Cyclosporine and Methotrexate. On day 14, the patient developed high grade fever with diarrhea and vomiting. i.v metronidazole 7.5 mg/kg and i.v meropenem 1 gm 8 hourly along with supportive fluid therapy were initiated. Paired blood samples, taken from catheter and peripheral site flagged positive on BD BACTECTM.system was more than two hours. Identification of the isolate as *R. pickettii* was carried on the VITEK 2 system. Our isolate was sensitive only to cefepime and ciprofloxacin according to the Vitek report. Treatment was changed accordingly. However the condition of the patient worsened due to severe hypokalemia. Inspite of all the rehydration and supportive measures, the patient succumbed to multi organ failure.

Case Report 3

A 19 year old thalassemic patient was admitted for evaluation of skin rashes and severe diarrhea. Two months earlier, she had undergone an allogenic stem cell transplant. Rashes were present on her back, trunk and arms. A Hickmann catheter was in situ. Hematological investigations revealed hemoglobin 13 gm/dl, total leucocyte count 13.9x10^3 cells/µl and platelets 13.2x10^3 cells/µl. Gastric biopsy revealed mucosal edema with fibrinous exudates consistent with the diagnosis of gut GVHD. The patient was put on immunosuppressive drugs cyclosporine and solumedrol. Antibiotics given empirically were i.v meropenem 1 gm i.v 8 hourly and metronidazole i.v 7.5 mg/kg. On day 10, the patient had spike of fever measured to be 102°C. His total leucocyte count was 16x10^3 cells/µl and platelets dipped to 84000 cell/µl. Paired blood samples flagged positive on BD BACTECTM.system grew non lactose fermenting, nonpigmented smooth colonies. These were identified as *R. pickettii* by Vitek 2 compact. The patient was put on ciprofloxacin i.v 400 mg 8 hourly as per susceptibility report. The patient responded to the treatment and was discharged on Day 21.

Discussion

The classification of *R. pickettii* has undergone many taxonomic changes. Previously identified as Burkholderia, it now has an independent status [2]. Emerging as an important pathogen in health care facilities, its causative role in patient morbidity cannot be ignored.

*R. pickettii* has been described to cause pulmonary infections especially in cystic fibrosis patients [1]. In one study, *R. pickettii* was isolated from 38 sputum samples [2]. As described in our first case, *Ralstonia* was isolated from the endotracheal secretions and subsequently from blood. Persistant colonization of the airways in this immunocompromised individual by this organism seems to be a plausible hypothesis which may have led to secondary bacteremia.
In our second and third cases, *R. pickettii* was isolated from twin sets of blood culture in absence of any identifiable infective foci. Heparin flush was cultured to look for the source but was found to be sterile. There was a Hickmann catheter in situ which could not be sent for culture. DTP was positive suggesting central line associated infection. *R. pickettii* sepsis has been reported in literature where contaminated intravenous solutions, medical devices like port-a-cath and central lines [4,7] were incriminating foci (Table 1).

### Table 1: *Ralstonia pickettii* Bacteremia – Brief Review of Literature

Antibiotics which have activity against *R. pickettii* are piperacillin-tazobactam, ceftazidime, cefepime, levofloxacin, ciprofloxacin, cotrimaxazole and meropenem [12]. Also it has been researched that this bacteria produces many beta-lactamases. An imipenem hydrolyzing enzyme OXA-60 has been isolated from *Ralstonia* [1]. Recently, Khajuria et al. have reported VIM-2 metallo beta lactamase enzyme from a *R. pickettii* isolate in blood [6].

Table 2 gives the MIC breakpoints of all the isolates in our report which have been interpreted according to CLSI guidelines.
Table 2: Comparison of MIC† breakpoints of antibiotics for three isolates of Ralstonia pickettii, (µg/ml)

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>MIC†</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colistin</td>
<td>≥16</td>
<td>R</td>
</tr>
</tbody>
</table>

†MIC–minimum inhibitory concentration
R–resistant, S–sensitive, I–intermediate

Also, it is worthwhile mentioning that isolation of *R. pickettii* from blood in three patients cannot be termed as an outbreak. All the patients were admitted in different time periods. Moreover the antimicrobial susceptibility of all these isolates were variable [13-15].

Novel gram negative bacilli like *Ralstonia* are increasingly being isolated from intensive care and oncology units. All our cases could be line associated. An attempt to look into the probable cause of these isolates was not diagnostic and was inconclusive. However infection control protocols have been reinitiated and we are vigilant for any new cases. The limitation of our study is the inability to sequence the three strains. This would have shed light on the existing hospital ward epidemiology. Previously being reported as *Burkholderia* species and recently as *Ralstonia* emphasizes the observation that identification is not easy and misdiagnosis is an issue. In developing countries, where sophisticated Microbiology laboratories are far from reality, it is immensely difficult to correctly identify these non fermenters. We have used Vitek GN card for identification and ASTN281 panel for antimicrobial susceptibility. Reproducibility of the Vitek 2 compact system is well established now. Knowledge about local epidemiology and these novel bacteria has immense significance in designing infection control policies and antibiotic stewardship programmes.

Studies like ours can create awareness and help in reducing antibiotic resistance, hospital associated infections and improve patient outcome.

References