

World Journal of *Clinical Cases*

World J Clin Cases 2017 July 16; 5(7): 258-306



MINIREVIEWS

- 258 New device to implement the adenoma detection rate
Zippi M, Hong W, Crispino P, Traversa G
- 264 Screening of celiac disease in Down syndrome - old and new dilemmas
Pavlovic M, Berenji K, Bukurov M
- 270 Practical approach to the patient with acute neuromuscular weakness
Nayak R

ORIGINAL ARTICLE

Retrospective Study

- 280 Feasibility of initial endoscopic common bile duct stone removal in patients with acute cholangitis
Yamamiya A, Kitamura K, Ishii Y, Mitsui Y, Nomoto T, Yoshida H

SYSTEMATIC REVIEWS

- 286 Diagnostic performance of high resolution computed tomography in otosclerosis
Kanzara T, Virk JS

CASE REPORT

- 292 Post traumatic dural sinus thrombosis following epidural hematoma: Literature review and case report
Pescatori L, Tropeano MP, Mancarella C, Prizio E, Santoro G, Domenicucci M
- 299 Rare case of cryptogenic brain abscess caused by *Raoultella ornithinolytica*
Luongo M
- 303 Is dengue emerging as important cause of acute liver failure in endemic regions?
Singh L, Singh A, Agarwal M, Mishra S

ABOUT COVER

Editorial Board Member of *World Journal of Clinical Cases*, Ashu Seith Bhalla, MD, Professor, Department of Radiodiagnosis, All India Institute of Medical Sciences, New Delhi 110029, India

AIM AND SCOPE

World Journal of Clinical Cases (*World J Clin Cases*, *WJCC*, online ISSN 2307-8960, DOI: 10.12998) is a peer-reviewed open access academic journal that aims to guide clinical practice and improve diagnostic and therapeutic skills of clinicians.

The primary task of *WJCC* is to rapidly publish high-quality Autobiography, Case Report, Clinical Case Conference (Clinicopathological Conference), Clinical Management, Diagnostic Advances, Editorial, Field of Vision, Frontier, Medical Ethics, Original Articles, Clinical Practice, Meta-Analysis, Minireviews, Review, Therapeutics Advances, and Topic Highlight, in the fields of allergy, anesthesiology, cardiac medicine, clinical genetics, clinical neurology, critical care, dentistry, dermatology, emergency medicine, endocrinology, family medicine, gastroenterology and hepatology, geriatrics and gerontology, hematology, immunology, infectious diseases, internal medicine, obstetrics and gynecology, oncology, ophthalmology, orthopedics, otolaryngology, pathology, pediatrics, peripheral vascular disease, psychiatry, radiology, rehabilitation, respiratory medicine, rheumatology, surgery, toxicology, transplantation, and urology and nephrology.

INDEXING/ABSTRACTING

World Journal of Clinical Cases is now indexed in PubMed, PubMed Central.

FLYLEAF

I-V Editorial Board

EDITORS FOR THIS ISSUE

Responsible Assistant Editor: *Xiang Li*
Responsible Electronic Editor: *Huan-Liang Wu*
Proofing Editor-in-Chief: *Lian-Sheng Ma*

Responsible Science Editor: *Fang-Fang Ji*
Proofing Editorial Office Director: *Ze-Mao Gong*

NAME OF JOURNAL

World Journal of Clinical Cases

ISSN

ISSN 2307-8960 (online)

LAUNCH DATE

April 16, 2013

FREQUENCY

Monthly

EDITORS-IN-CHIEF

Giuseppe Di Lorenzo, MD, PhD, Professor, Genitourinary Cancer Section and Rare-Cancer Center, University Federico II of Napoli, 80131, Naples, Italy

Jan Jacques Michiels, MD, PhD, Professor, Primary Care, Medical Diagnostic Center Rijnmond Rotterdam, Bloodcoagulation, Internal and Vascular Medicine, Erasmus University Medical Center, Rotterdam, Goodheart Institute and Foundation, 3069 AT, Erasmus City, Rotterdam, The Netherlands

Sandro Vento, MD, Department of Internal Medicine, University of Botswana, Private Bag 00713, Gaborone, Botswana

Shuhei Yoshida, MD, PhD, Division of Gastroenterology, Beth Israel Deaconess Medical Center, Dana 509, Harvard Medical School, Boston, MA 02215, United States

EDITORIAL BOARD MEMBERS

All editorial board members resources online at <http://www.wjgnet.com/2307-8960/editorialboard.htm>

EDITORIAL OFFICE

Xiu-Xia Song, Director
World Journal of Clinical Cases
 Baishideng Publishing Group Inc
 7901 Stoneridge Drive, Suite 501, Pleasanton, CA 94588, USA
 Telephone: +1-925-2238242
 Fax: +1-925-2238243
 E-mail: editorialoffice@wjgnet.com
 Help Desk: <http://www.wjgnet.com/helpdesk>
<http://www.wjgnet.com>

PUBLISHER

Baishideng Publishing Group Inc
 7901 Stoneridge Drive,
 Suite 501, Pleasanton, CA 94588, USA
 Telephone: +1-925-2238242
 Fax: +1-925-2238243
 E-mail: bpgoffice@wjgnet.com

Help Desk: <http://www.wjgnet.com/helpdesk>
<http://www.wjgnet.com>

PUBLICATION DATE

July 16, 2017

COPYRIGHT

© 2017 Baishideng Publishing Group Inc. Articles published by this Open Access journal are distributed under the terms of the Creative Commons Attribution Non-commercial License, which permits use, distribution, and reproduction in any medium, provided the original work is properly cited, the use is non commercial and is otherwise in compliance with the license.

SPECIAL STATEMENT

All articles published in journals owned by the Baishideng Publishing Group (BPG) represent the views and opinions of their authors, and not the views, opinions or policies of the BPG, except where otherwise explicitly indicated.

INSTRUCTIONS TO AUTHORS

<http://www.wjgnet.com/bpg/gerinfo/204>

ONLINE SUBMISSION

<http://www.wjgnet.com>

Rare case of cryptogenic brain abscess caused by *Raoultella ornithinolytica*

Marianna Luongo

Marianna Luongo, Department of Neurosurgery, San Carlo Hospital, 85100 Potenza, Italy

Author contributions: Luongo M finished this manuscript solely.

Institutional review board statement: This case report was exempt from the Institutional Review Board standards at San Carlo Hospital, Potenza.

Informed consent statement: The patient involved gave her verbal informed consent authorizing use and disclosure of her protected health information.

Conflict-of-interest statement: The author has no conflict of interests to declare.

Open-Access: This article is an open-access article which was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>

Manuscript source: Invited manuscript

Correspondence to: Marianna Luongo, MD, Department of Neurosurgery, San Carlo Hospital, via Potito Petrone, 85100 Potenza, Italy. marianna.luongo@gmail.com
Telephone: +39-338-9754505
Fax: +39-971-612535

Received: November 12, 2016

Peer-review started: November 13, 2016

First decision: February 17, 2017

Revised: March 2, 2017

Accepted: March 21, 2017

Article in press: March 22, 2017

Published online: July 16, 2017

Abstract

Cerebral abscess is a potentially fatal neurosurgical

condition, despite improvements in technology, new antimicrobial agents and modern neurosurgical instruments and techniques. I report the case of a 64-year-old woman, affected by a right frontobasal brain abscess, compressing the homolateral frontal horn of lateral ventricle, with a second mass partially occupying the right orbital cavity. She presented also with inflammatory sinusopathy involving the right maxillary, ethmoid and frontal sinuses. After 14 d of clinical observation and antimicrobial therapy, the patient received a computed tomography scan, which showed growth of the cerebral mass, with a ring of peripheral contrast enhancement and surrounding edema. She promptly underwent neurosurgical treatment and recovered well, except for the sight in her right eye, which remained compromised, as before the operation. This is believed to be the first case of cryptogenic cerebral abscess caused by *Raoultella ornithinolytica* isolated from the brain, with more than 1-year follow-up.

Key words: Brain abscess; Headache; *Raoultella ornithinolytica*; Visual loss

© **The Author(s) 2017.** Published by Baishideng Publishing Group Inc. All rights reserved.

Core tip: Brain abscess is a focal intracranial infection that evolves in a collection of pus. It could have cryptogenic origin in 10%-35% of cases. I present a 64-year-old woman affected by a frontal brain abscess that was surgically treated, from which *Raoultella ornithinolytica* (*R. ornithinolytica*) was isolated. The patient, after > 1 year, is doing well, except for her right eye that had already lost its visual power before surgery. This is believed to be the first case of cryptogenic cerebral abscess caused by *R. ornithinolytica*.

Luongo M. Rare case of cryptogenic brain abscess caused by *Raoultella ornithinolytica*. *World J Clin Cases* 2017; 5(7): 299-302 Available from: URL: <http://www.wjgnet.com/2307-8960/full/v5/i7/299.htm> DOI: <http://dx.doi.org/10.12998/wjcc.v5.i7.299>

INTRODUCTION

Brain abscess is a focal intracranial infection characterized as an area of cerebritis that evolves in a collection of pus surrounded by a vascularized capsule. Organisms can reach the central nervous system by spreading from a contiguous source of infection, hematogenous dissemination, or trauma, but there are cryptogenic brain abscesses in 10%-35% of cases. The frontal lobe is the predominant site of cerebral abscess in patients with paranasal sinusitis. *Raoultella ornithinolytica* (*R. ornithinolytica*) is an encapsulated Gram-negative bacterium and member of the Enterobacteriaceae. Human infections caused by *Raoultella* are rare. I describe a case of cryptogenic cerebral abscess caused by *R. ornithinolytica*, with good recovery after > 1 year after surgery.

CASE REPORT

A 64-year-old woman was admitted to our hospital for fever and headache. She was hospitalized in the Infectious Disease Department for observation and study. Chest X-ray and abdominal ultrasound examination were normal. Magnetic resonance imaging (MRI) with gadolinium revealed a right frontobasal brain abscess, compressing the homolateral frontal horn of the lateral ventricle, with a second mass partially occupying the right orbital cavity (Figure 1A). She presented also with inflammatory sinusopathy involving the right frontal, ethmoid and maxillary sinuses. After 14 d of clinical observation and intravenous broad-spectrum antibiotic therapy, nasal culture was performed on day 14 of hospitalization, which showed evidence of low levels of *Candida albicans*. Ophthalmological consultation revealed visual loss from her right eye, and contrast computed tomography (CT) showed an increase in abscess size, so the patient underwent prompt surgery with right frontobasal craniotomy (Figure 1B). Thanks to neuronavigation and under operative microscopy, the abscessual capsule was opened widely, in order to drain its content, and it was coagulated to avoid damage to nervous structures, given that the cerebral parenchyma in the right orbit appeared to be involved in an inflammatory reaction. Some of the mass content was sent for microbiological examination in Bactec broth and, 8 d after surgery, *R. ornithinolytica* was isolated by conventional microbiological tests. On the basis of an antibiogram, determined according to the European Committee on Antimicrobial Susceptibility Testing, and after consulting an infectious diseases specialist, the patient started intravenous therapy with metronidazole and ceftriaxone, four times and twice daily, respectively (Table 1). She received a basal CT scan that showed no residual or recurrent brain abscess.

Her general clinical conditions were improved but, on day 30 in hospital (approximately 2 wk after

surgery) she developed right-side pneumonia with pleural effusion, caused by *Klebsiella pneumoniae*, which was treated by intravenous ceftriaxone and ciprofloxacin twice daily, together with amphotericin B and amikacin once daily (Table 1). During the last month she was free from antimicrobial therapy, without infectious problems, but it was necessary to correct persistent hypokalemia, presented by the patient from the first time. The patient was discharged after approximately 3 mo of hospitalization and she is currently well.

DISCUSSION

R. ornithinolytica is an encapsulated, aerobic, non-motile, blood-borne Gram-negative bacterium belonging to the Enterobacteriaceae, which is frequently misidentified as *Klebsiella* spp. It was first described by Sakazaki *et al*^[1] in 1989 and it can be isolated from aquatic environments, insects, fish and brackish water. It can cause fish poisoning because of its capacity to produce histamine and it can cause headache, flushing, abdominal cramps, pruritus, and rarely, bradycardia, bronchospasm and hypotension. Over the years, *R. ornithinolytica* has emerged as an infrequent cause of human infections, with about 10 cases reported linking the bacterium to bacteremia, sepsis, and soft tissue and other infections, as described by Nakasone *et al*^[2] in their article about a case of community-acquired urinary infection.

An important study on clinical characteristics of *R. ornithinolytica* bacteremia focused on its unfavorable outcomes, compared to bacteremia caused by other *Raoultella* spp. The study analyzed 16 patients (11 male and 5 female) over 10 years, with a mean age of 55.7 years; all but one had an underlying malignant condition and seven had infections associated with the biliary tract. They found that the overall mortality of *R. ornithinolytica* bacteremia could be compared to that of *Klebsiella* spp., and it was reported to be 20%-25%. In addition, suggested an increased risk of *R. ornithinolytica* bacteremia in patients affected by underlying malignant conditions extending to the biliary tract^[3]. Even though some cases of biliary tract infection, urinary infection and bacteremia have been reported, there is not much information about clinical features and outcomes of *R. ornithinolytica*. A recent review by Seng and colleagues discusses the largest series reported to date of 86 cases from four French universities over 12 years (with half of cases in 2015), and emphasizes different important characteristics such as a high rate of hospital-acquired infection (49%). Besides comorbidity and risk factors previously reported such as solid tumor, post-urethra trauma, and post invasive procedures, Seng *et al*^[4] found that half of the patients had diabetes or immunodeficiency, and they described infections not previously reported, including pleural effusion, meningitis and cerebral

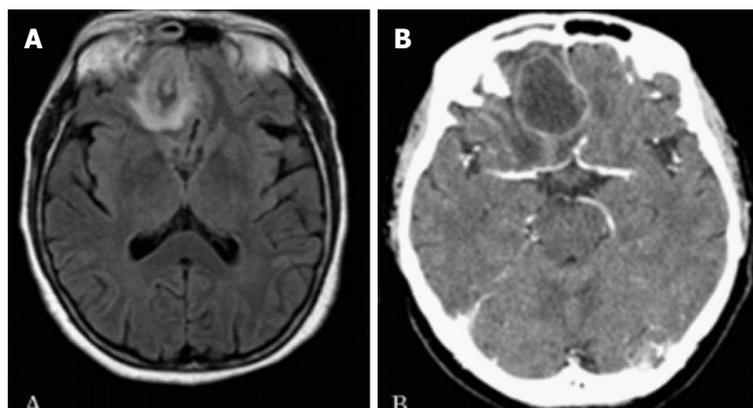


Figure 1 Preoperative images. A: Magnetic resonance imaging with gadolinium showing right frontobasal brain abscess and a second mass occupying the right orbit; B: Contrast-enhanced computed tomography scan.

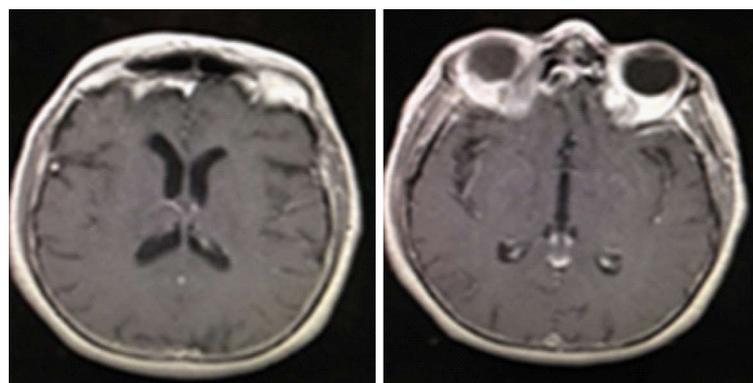


Figure 2 Magnetic resonance imaging performed 14 mo after surgery.

Table 1 Scheme summarizing the antimicrobial drugs assumed by the patient during the hospitalization

Drug	Dosage	Administration route	Duration of therapy, d	Frequency of administration, d
Ceftriaxone	2 g	Intravenous	50	2
Amphotericin b	50 mg	Intravenous	20	1
Amikacin	500 mg	Intravenous	12	1
Ciprofloxacin	200 mg	Intravenous	11	2

abscess. The cerebral abscess described by Seng *et al*^[4] was secondary to a craniotomy for head trauma and not spontaneous as in the present case^[4].

The frontal lobe is the predominant site in patients with brain abscess secondary to paranasal sinusitis, so I thought that the cerebral abscess in my patient was secondary to sinusopathy, but nasal culture only isolated a low number of *C. albicans*. The patient has diabetes and experienced pleural effusion caused by *K. pneumoniae* during hospitalization, > 2 wk after surgery, so this case was not related to any condition previously described.

In summary this is the report of a rare case of brain abscess caused by *R. ornithinolytica* that was successfully treated by intravenous antibiotics and prompt surgical intervention. This is believed to be the first cryptogenic brain abscess caused by *R. ornithinolytica*, with MRI showing complete surgical removal and no recurrence after > 1 year (Figure 2). It could be important to focus attention on this bacterium in order to understand better and eventually prevent occurrence of this potentially fatal condition.

ACKNOWLEDGMENTS

The author thanks Dr. Luigi Armignacco, Department of Infectious Diseases, San Carlo Hospital, Potenza (Italy), for his help, willingness and expertise in treating the patient. Special thank goes to Noreen Turyn for her support.

COMMENTS

Case characteristics

A 64-year-old woman with inflammatory sinusopathy and, a few days later, visual loss in the right eye.

Clinical diagnosis

Fever and headache with visual disturbance.

Differential diagnosis

Central nervous system inflammatory conditions, cerebral abscess, meningitis, and brain tumor.

Laboratory diagnosis

Nasal culture and microbiological examination of the surgically removed cerebral

mass.

Imaging diagnosis

Magnetic resonance imaging with gadolinium revealing the presence of a right frontobasal brain abscess and a second mass partially occupying the right orbital cavity.

Pathological diagnosis

Some of the mass content was sent for microbiological examination and *Raoultella ornithinolytica* was isolated by conventional microbiological tests.

Treatment

Right frontobasal craniotomy was performed and the abscessual capsule was opened widely and coagulated. On the basis of an antibiogram and after consulting an infectious diseases specialist, the patient started intravenous therapy with antibiotics.

Related reports

R. ornithinolytica is a Gram-negative bacterium belonging to the family Enterobacteriaceae that is frequently misidentified as *Klebsiella* spp.. It has potent virulence and is rare in clinical situations but results in a high risk of bacteremia in patients affected by underlying malignant conditions extending to the biliary tract.

Term explanation

R. ornithinolytica brain abscess is a rare condition because, over the years, the bacterium has mainly been responsible for infrequent but important human urinary tract infections.

Experience and lessons

Brain abscess caused by *R. ornithinolytica* is a rare condition to be aware of in daily clinical practice in order to understand, prevent and treat it, through a combination of prompt surgical intervention and intravenous antibiotics.

Peer-review

This is a very interesting presentation about a rare etiology for brain abscess. It is a case that reminds us to be aware of this condition in the daily practice. The paper is well structured and written.

REFERENCES

- 1 **Sakazaki R**, Tamura K, Kosako Y, Yoshizaki E. *Klebsiella ornithinolytica* sp. nov., formerly known as ornithine-positive *Klebsiella oxytoca*. *Curr Microbiol* 1989; **18**: 201-206 [DOI: 10.1007/BF01570291]
- 2 **Nakasone ES**, Kaneshiro R, Min K, Tokeshi J. Emergence of *Raoultella ornithinolytica* on O'ahu: a case of community-acquired *R. ornithinolytica* urinary tract infection. *Hawaii J Med Public Health* 2015; **74**: 174-175 [PMID: 26019987]
- 3 **Chun S**, Yun JW, Huh HJ, Lee NY. Clinical characteristics of *Raoultella ornithinolytica* bacteremia. *Infection* 2015; **43**: 59-64 [PMID: 25367410 DOI: 10.1007/s15010-014-0696-z]
- 4 **Seng P**, Boushab BM, Romain F, Gouriet F, Bruder N, Martin C, Paganelli F, Bernit E, Le Treut YP, Thomas P, Papazian L, Raoult D, Stein A. Emerging role of *Raoultella ornithinolytica* in human infections: a series of cases and review of the literature. *Int J Infect Dis* 2016; **45**: 65-71 [PMID: 26921549 DOI: 10.1016/j.ijid.2016.02.014]

P- Reviewer: Grigoriadis S, Hall WA, Nagashima G, Nedelcuta RM
S- Editor: Kong JX **L- Editor:** A **E- Editor:** Wu HL





Published by **Baishideng Publishing Group Inc**
7901 Stoneridge Drive, Suite 501, Pleasanton, CA 94588, USA
Telephone: +1-925-223-8242
Fax: +1-925-223-8243
E-mail: bpgoffice@wjgnet.com
Help Desk: <http://www.f6publishing.com/helpdesk>
<http://www.wjgnet.com>

