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Contents

Thrice Monthly Volume 10 Number 15 May 26, 2022

EDITORIAL

- 4713 Diet and intestinal bacterial overgrowth: Is there evidence?
Souza C, Rocha R, Cotrim HP

MINIREVIEWS

- 4717 Definition and classification of acute-on-chronic liver diseases
Zhang YY, Meng ZJ
- 4726 Management of neurosurgical patients during coronavirus disease 2019 pandemics: The Ljubljana, Slovenia experience
Velmar T, Bosnjak R

ORIGINAL ARTICLE

Clinical and Translational Research

- 4737 Glycolytic and fatty acid oxidation genes affect the treatment and prognosis of liver cancer
Zou JY, Huang YJ, He J, Tang ZX, Qin L
- 4761 Detection of a novel panel of 24 genes with high frequencies of mutation in gastric cancer based on next-generation sequencing
Zeng HH, Yang Z, Qiu YB, Bashir S, Li Y, Xu M

Case Control Study

- 4776 Outcomes of cervical degenerative disc disease treated by anterior cervical discectomy and fusion with self-locking fusion cage
Zhang B, Jiang YZ, Song QP, An Y
- 4785 Impact of COVID-19 pandemic on clinicopathological features of transplant recipients with hepatocellular carcinoma: A case-control study
Akbulut S, Sahin TT, Ince V, Yilmaz S

Retrospective Study

- 4799 Risk factors and optimal predictive scoring system of mortality for children with acute paraquat poisoning
Song Y, Wang H, Tao YH
- 4810 Application effect of thoracoscopic tricuspid valvuloplasty in geriatric patients with tricuspid valve disease
Jiang W, Long XM, Wei KQ, Li SC, Zhang Z, He BF, Li H
- 4818 Endoscopic ultrasonography in the evaluation of condition and prognosis of ulcerative colitis
Jin RF, Chen YM, Chen RP, Ye HJ

- 4827** Dynamic interaction nursing intervention on functional rehabilitation and self-care ability of patients after aneurysm surgery

Xie YE, Huang WC, Li YP, Deng JH, Huang JT

Clinical Trials Study

- 4836** Validations of new cut-offs for surgical drains management and use of computerized tomography scan after pancreatoduodenectomy: The DALCUT trial

Caputo D, Coppola A, La Vaccara V, Passa R, Carbone L, Ciccozzi M, Angeletti S, Coppola R

Observational Study

- 4843** Psychosocial adaptation and influencing factors among patients with chemotherapy-induced peripheral neuropathy

Zhou X, Wang DY, Ding CY, Liu H, Sun ZQ

META-ANALYSIS

- 4856** Outcome of the efficacy of Chinese herbal medicine for functional constipation: A systematic review and meta-analysis

Lyu Z, Fan Y, Bai Y, Liu T, Zhong LL, Liang HF

CASE REPORT

- 4878** Familial gastrointestinal stromal tumors with *KIT* germline mutation in a Chinese family: A case report

Yuan W, Huang W, Ren L, Xu C, Luan LJ, Huang J, Xue AW, Fang Y, Gao XD, Shen KT, Lv JH, Hou YY

- 4886** Nonfunctional pancreatic neuroendocrine tumours misdiagnosed as autoimmune pancreatitis: A case report and review of literature

Lin ZQ, Li X, Yang Y, Wang Y, Zhang XY, Zhang XX, Guo J

- 4895** Sudden deafness as a prodrome of cerebellar artery infarction: Three case reports

Li BL, Xu JY, Lin S

- 4904** Importance of abdominal X-ray to confirm the position of levonorgestrel-releasing intrauterine system: A case report

Maebayashi A, Kato K, Hayashi N, Nagaishi M, Kawana K

- 4911** Bedside ultrasonic localization of the nasogastric tube in a patient with severe COVID-19: A case report

Zhu XJ, Liu SX, Li QT, Jiang YJ

- 4917** Paradoxical herniation after decompressive craniectomy provoked by mannitol: A case report

Du C, Tang HJ, Fan SM

- 4923** Targeted next-generation sequencing identifies a novel nonsense mutation in ANK1 for hereditary spherocytosis: A case report

Fu P, Jiao YY, Chen K, Shao JB, Liao XL, Yang JW, Jiang SY

- 4929** Nonfunctional bladder paraganglioma misdiagnosed as hemangioma: A case report

Chen J, Yang HF

- 4935** Special type of Wernekink syndrome in midbrain infarction: Four case reports
Yang YZ, Hu WX, Zhai HJ
- 4942** Primary extraskeletal Ewing's sarcoma of the lumbar nerve root: A case report
Lei LH, Li F, Wu T
- 4949** Yellow nail syndrome accompanied by minimal-change nephrotic syndrome: A case report
Zhang YN, Wang MH, Yu WC, Cheng W, Cong JP, Huang XP, Wang FF
- 4957** Total femur replacement with 18 years of follow-up: A case report
Yang YH, Chen JX, Chen QY, Wang Y, Zhou YB, Wang HW, Yuan T, Sun HP, Xie L, Yao ZH, Yang ZZ
- 4964** Male metaplastic breast cancer with poor prognosis: A case report
Kim HY, Lee S, Kim DI, Jung CS, Kim JY, Nam KJ, Choo KS, Jung YJ
- 4971** CD8-positive indolent T-Cell lymphoproliferative disorder of the gastrointestinal tract: A case report and review of literature
Weng CY, Ye C, Fan YH, Lv B, Zhang CL, Li M
- 4985** Bone flare after initiation of novel hormonal therapy in patients with metastatic hormone-sensitive prostate cancer: A case report
Li KH, Du YC, Yang DY, Yu XY, Zhang XP, Li YX, Qiao L
- 4991** Postoperative infection of the skull base surgical site due to suppurative parotitis: A case report
Zhao Y, Zhao Y, Zhang LQ, Feng GD
- 4998** Blunt aortic injury-traumatic aortic isthmus pseudoaneurysm with right iliac artery dissection aneurysm: A case report
Fang XX, Wu XH, Chen XF
- 5005** Extensive complex thoracoabdominal aortic aneurysm salvaged by surgical graft providing landing zone for endovascular graft: A case report
Jang AY, Oh PC, Kang JM, Park CH, Kang WC
- 5012** Gastric heterotopia of colon found cancer workup in liver abscess: A case report
Park JG, Suh JI, Kim YU
- 5018** Clinical manifestations and gene analysis of Hutchinson-Gilford progeria syndrome: A case report
Zhang SL, Lin SZ, Zhou YQ, Wang WQ, Li JY, Wang C, Pang QM
- 5025** Neurocutaneous melanosis with an intracranial cystic-solid meningeal melanoma in an adult: A case report and review of literature
Liu BC, Wang YB, Liu Z, Jiao Y, Zhang XF
- 5036** Metastasis of liver cancer to the thyroid after surgery: A case report
Zhong HC, Sun ZW, Cao GH, Zhao W, Ma K, Zhang BY, Feng YJ

- 5042** Spontaneous liver rupture following SARS-CoV-2 infection in late pregnancy: A case report
Ambrož R, Stašek M, Molnár J, Špička P, Klos D, Hambálek J, Skanderová D
- 5051** Carotid blowout syndrome caused by chronic infection: A case report
Xie TH, Zhao WJ, Li XL, Hou Y, Wang X, Zhang J, An XH, Liu LT
- 5057** Is repeat wide excision plus radiotherapy of localized rectal melanoma another choice before abdominoperineal resection? A case report
Chiu HT, Pu TW, Yen H, Liu T, Wen CC
- 5064** Metaplastic breast cancer with chondrosarcomatous differentiation combined with concurrent bilateral breast cancer: A case report
Yang SY, Li Y, Nie JY, Yang ST, Yang XJ, Wang MH, Zhang J
- 5072** Rare solitary splenic metastasis from a thymic carcinoma detected on fluorodeoxyglucose-positron emission tomography: A case report
Tsai YH, Lin KH, Huang TW
- 5077** Type A aortic dissection following heart transplantation: A case report
Zeng Z, Yang LJ, Zhang C, Xu F
- 5082** Catheter-related infections caused by *Mycobacterium abscessus* in a patient with motor neurone disease: A case report
Pan SF, Zhang YY, Wang XZ, Sun JJ, Song SL, Tang YR, Wang JL
- 5088** Clear aligner treatment for a four-year-old patient with anterior cross-bite and facial asymmetry: A case report
Zou YR, Gan ZQ, Zhao LX
- 5097** Knot impingement after arthroscopic rotator cuff repair mimicking infection: A case report
Kim DH, Jeon JH, Choi BC, Cho CH
- 5103** Solitary primary pulmonary synovial sarcoma: A case report
He WW, Huang ZX, Wang WJ, Li YL, Xia QY, Qiu YB, Shi Y, Sun HM
- 5111** Anesthetic management for intraoperative acute pulmonary embolism during inferior vena cava tumor thrombus surgery: A case report
Hsu PY, Wu EB
- 5119** Delayed diagnosis of arytenoid cartilage dislocation after tracheal intubation in the intensive care unit: A case report
Yan WQ, Li C, Chen Z

ABOUT COVER

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Catheter-related infections caused by *Mycobacterium abscessus* in a patient with motor neurone disease: A case report

Su-Fei Pan, Yuan-Yuan Zhang, Xiao-Zhen Wang, Jing-Jing Sun, Shao-Ling Song, Yu-Rong Tang, Ji-Liang Wang

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Abstract

BACKGROUND

Mycobacterium abscessus (*M. abscessus*) is a rapidly growing mycobacterium and ubiquitous in the environment, which infrequently causes disease in humans. However, it can cause cutaneous or respiratory infections among immunocompromised hosts. Due to the resistance to most antibiotics, the pathogen is formidable and difficult-to-treat.

CASE SUMMARY

Here, we present a case of catheter-related *M. abscessus* infections in a patient with motor neurone disease. Catheter and peripheral blood cultures of the patient showed positive results during Gram staining and acid-fast staining. The alarm time of catheter blood culture was 10.6 h earlier than that of peripheral blood. After removal of the peripherally inserted central catheter, secretion and catheter blood culture were positive. *M. abscessus* was identified by matrix-assisted laser desorption ionization-time of flight mass spectrometry and 16S rDNA sequencing.

CONCLUSION

For catheter-related *M. abscessus* infection, rapid diagnosis and timely and adequate antimicrobial therapy are crucial.

Key Words: Catheter-related infections; Diagnosis; Motor neurone disease; *Mycobacterium abscessus*; Case report

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Core Tip: *Mycobacterium abscessus* (*M. abscessus*) is a rapidly growing mycobacterium and ubiquitous in the environment, which infrequently causes disease in humans. However, it can cause cutaneous or respiratory infections among immunocompromised hosts. Due to the resistance to most antibiotics, the pathogen is formidable and difficult-to-treat. Here, we present a case of catheter-related *M. abscessus* infections in a patient with motor neurone disease. *M. abscessus* was identified by matrix-assisted laser desorption ionization-time of flight mass spectrometry and 16S rDNA sequencing. For catheter-related *M. abscessus* infection, rapid diagnosis and timely and adequate antimicrobial therapy are crucial.

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INTRODUCTION

Mycobacterium abscessus (*M. abscessus*) is a rapidly growing non-tuberculous mycobacterium and is ubiquitous in the environment[1]. Recent gene sequence analysis has shown that *M. abscessus* can be divided into three different subspecies (*M. abscessus* subsp. *bolletii*, *M. abscessus* subsp. *abscessus*, and *M. abscessus* subsp. *massiliense*)[2]. *M. abscessus* can cause a variety of clinical manifestations including cutaneous infections, catheter-related infections, post-surgical soft tissue infections, and respiratory diseases[3]. Besides, the incidence of pulmonary non-tuberculous mycobacteria infection has been increasing[4]. Of all the rapidly growing mycobacteria, *M. abscessus* is the most common cause of pulmonary infections. *M. abscessus* is also one of the mycobacteria that are most often isolated from patients with cystic fibrosis[5]. However, *M. abscessus* is resistant to most antibiotics in vitro, and thus is a formidable and difficult-to-treat pathogen[6]. At present, little is known regarding the diagnosis and management of catheter-related *M. abscessus* infections due to only a limited number of cases that have been reported[7,8]. Here, we present a case of catheter-related *M. abscessus* infections in a patient with motor neurone disease.

CASE PRESENTATION

Chief complaints

On February 6, 2019, a 62-year-old Chinese man presented with mild skin edema at the site of the peripherally inserted central venous catheter (PICC, median cubital vein) which had been inserted for 30 d, without skin redness and inflammatory exudation.

History of present illness

He presented with a two-day history of dyspnea and was admitted to our emergency intensive care unit with a diagnosis of motor neurone disease on January 7, 2019. The patient received comprehensive symptomatic treatment including invasive ventilator-assisted ventilation, pulse oxygen saturation measurement, expectorant, and nutritional supplement.

History of past illness

There was no history of past illness.

Personal and family history

There was no personal and family history.

Physical examination

Physical examination revealed that he was stuporous with a Glasgow coma scale of E1VTM1. His body temperature was 35.0 °C, heart rate 66 beats per minute, blood pressure 90/54 mmHg, and respiratory rate 23 breaths per minute.

Laboratory examinations

Routine blood tests revealed 3.7×10^9 cells/L white blood cells (reference range, 4.0 - 10.0×10^9 cells/L) and 67.2% neutrophils (reference range, 40%-75%). Catheter and peripheral blood cultures were performed on February 10, 2019. On February 11, 2019, he presented with elevated body temperature

(37.1 °C), white blood cells (10.2×10^9 cells/L), and neutrophils (86.7%). The serum procalcitonin and C-reactive protein levels were 0.99 ng/mL (reference range, 0–0.05 ng/mL) and 184.9 mg/L (reference range, 0–5 mg/L), respectively. The patient began to receive anti-infective treatment with vancomycin. On February 19, 2019, the blood culture showed positive results during Gram staining (Figure 1A) and acid-fast staining (Figure 1B). The alarm time of catheter blood culture was 10.6 h earlier than that of peripheral blood culture. The treatment regimen of the patient was changed to combination therapy with vancomycin and amikacin.

On February 23, 2019, repeat blood cultures showed positive acid-fast bacilli, and the treatment regimen was adjusted to amikacin plus clarithromycin. On the second day, his body temperature was 35.3 °C, his heart rate was 74 beats per minute, white blood cells 7.4×10^9 cells/L, and neutrophils 77.6%. After removal of the PICC on March 11, 2019, secretion culture and catheter blood culture were all positive. The blood culture isolate was identified as *M. abscessus* by matrix-assisted laser desorption/ionization-time of flight mass spectrometry (MALDI-TOF MS) (Figure 2A) and 16S rDNA sequencing (Figure 2B).

FINAL DIAGNOSIS

The patient was finally diagnosed with catheter-related infections caused by *M. abscessus*.

TREATMENT

He continued to receive anti-infective treatment with amikacin plus clarithromycin.

OUTCOME AND FOLLOW-UP

His body temperature was maintained at a basic level (35–36.3 °C). Unfortunately, the patient gave up treatment due to an unsatisfactory response to respiratory failure and shock and was discharged on April 13, 2019.

DISCUSSION

M. abscessus was a terrible and difficult-to-treat mycobacterial pathogen, which is resistant to most antibiotics *in vitro*[9]. It was ubiquitous in the environment including soil, water, and dust, and survived extreme temperatures and nutritional deprivation[10]. It can cause soft tissue and skin infections after surgical procedures or trauma, pulmonary infections, and disseminated diseases among immunocompromised hosts[11]. Infections in immunocompetent patients tend to be more localized, and usually due to contamination of wounds or abrasions with soil, water, dust, or other materials[12]. While, infections in immunosuppressed patients are often deeper and more diffuse, involving subcutaneous tissue, and leading to the formation of an abscess. Catheter-related infections often occurred in the setting of central venous access devices[13]. In the present study, we present a case of catheter-related *M. abscessus* infections in a patient with motor neurone disease.

Catheter-related bloodstream infection (CRBSI) is the most common complication associated with the use of intravascular catheters[14]. Our patient was a 62-year-old man with motor neurone disease. He had been treated in our hospital many times due to respiratory failure, shock, and electrolyte disorder. During the hospitalization, the patient used PICC for blood controls, which was a high-risk factor for CRBSI. No other obvious source of bloodstream infection was found, except for PICC. He presented with fever and mild skin edema at the site of PICC. Routine blood tests revealed elevated white blood cells and neutrophils, procalcitonin, and C-reactive protein. Catheter and peripheral blood cultures of the patient showed positive results during Gram staining and acid-fast staining. The alarm time of catheter blood culture was 10.6 h earlier than that of peripheral blood. He was diagnosed with catheter-related infections. Gram positive cocci (such as *Staphylococcus epidermidis*, *Staphylococcus aureus*, and *Enterococcus*) have been historically the leading cause of CRBSI[15]. Catheter-related *M. abscessus* infection is relatively rare, with limited literature reports[7,8]. In the present study, *M. abscessus* was identified by matrix-assisted laser desorption/ionization-time of flight mass spectrometry and 16S rDNA sequencing. The patient was finally diagnosed with catheter-related infections caused by *M. abscessus*.

The main threat of *M. abscessus* is its antibiotic resistance. *M. abscessus* may be the most resistant species among pathogenic rapidly growing mycobacteria, and its antimicrobial therapy is still a challenge[8]. A previous study showed that the treatment strategy of *M. abscessus* infections was the combination of multiple antibiotics, including amikacin, ofloxacin, ciprofloxacin, clarithromycin, and doxycycline[16]. *In vitro* studies showed that clarithromycin was the most effective of these antibiotics

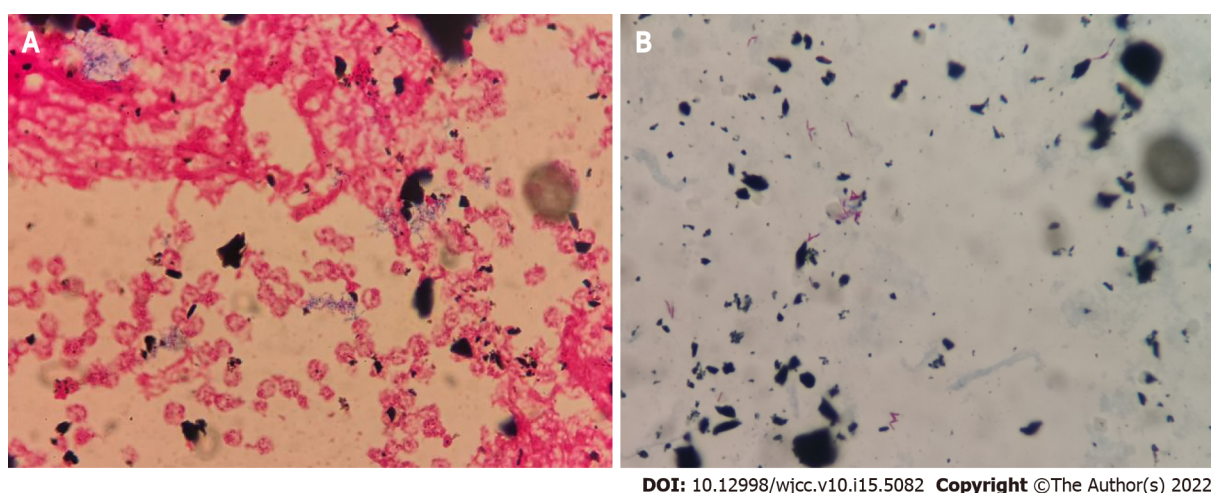


Figure 1 Blood culture findings of the patient. A: Gram staining of the strain isolated from catheter blood culture; B: Acid-fast staining of the strain isolated from catheter blood culture.

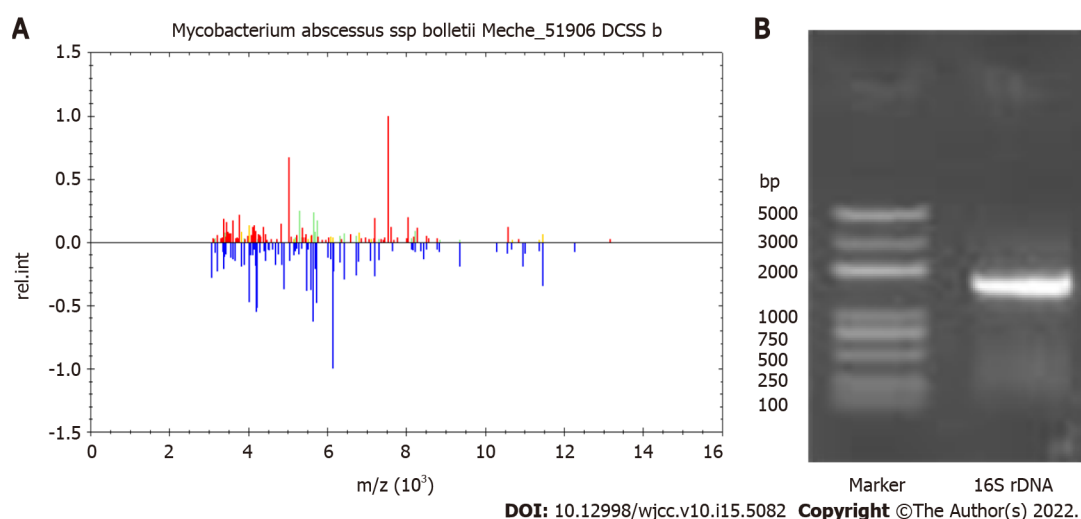


Figure 2 Identification of *Mycobacterium abscessus*. A: Mass spectrometry identification results of *Mycobacterium abscessus* (*M. abscessus*); B: Gel electrophoresis of the 16S rDNA. The nucleotide sequences were analyzed with the National Center for Biotechnology Information BLAST. The almost full-length 16S rDNA gene sequence of the blood culture isolate shared 100% identity with that of *M. abscessus* subsp. massiliense.

[17]. In the present study, the patient received anti-infective treatment with amikacin plus clarithromycin. In addition, in the case of catheter-related *M. abscessus* infections, removal of the catheter is necessary due to the high incidence of relapsing or uncontrolled bacteremia[8]. After the removal of the PICC of our patient, he continued to receive anti-infective treatment with amikacin plus clarithromycin, and his body temperature was maintained at a basic level (35-36.3 °C). Unfortunately, the patient gave up treatment due to an unsatisfactory response to respiratory failure and shock, so the long-term treatment results were not obtained.

CONCLUSION

In conclusion, we reported a case of catheter-related *M. abscessus* infections in a patient with motor neurone disease. For catheter-related *M. abscessus* infection, rapid diagnosis, and timely and adequate antimicrobial therapy are crucial.

FOOTNOTES

Author contributions: Pan SF, Zhang YY, and Wang JL designed the research and wrote the paper; Pan SF, Zhang YY,

Wang XZ, Sun JJ, Song SL, and Tang YR collected all the data related to the case report; Wang JL supervised the report; all authors have read and approved the final manuscript.

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