Letter to the Editor

Spontaneous bacterial peritonitis due to *Corynebacterium* sp

Sir,

Spontaneous bacterial peritonitis is a common complication of alcoholic liver cirrhosis and is usually caused by Gram-negative bacilli.¹ We report such a case due to *Corynebacterium* sp.

An 80-year-old woman with a history of alcoholic liver cirrhosis and ascites was transferred to our hospital because of change in mental status and worsening ascites. Her medical history was significant for placement of a Denver shunt several months ago. On admission she was responsive only to painful stimuli. Her vital signs were: temperature 98°F, pulse 120 beats/min, blood pressure 135/85 mmHg. Examination of the neck showed a raised jugular venous pressure on the right and a palpable Denver shunt on the left. Her lungs were clear on auscultation and the heart examination was remarkable only for tachycardia. The abdomen was markedly distended with several dilated veins and there was no tenderness or rebound. Fluid thrill and shifting dullness were both present.

Laboratory data showed a white cell count of $11 \times 10^9/l$ with 80% neutrophils. An abdominal paracentesis was done which yielded 1500 ml of cloudy fluid with a white cell count of $4 \times 10^9/l$ with 84% neutrophils. The Gram staining showed +4 white cells and a few Gram-positive bacilli. She was started on ampicillin/sulbactam 3 g intravenously (iv) 6 hourly. Culture grew *Corynebacterium* sp sensitive to penicillin, cephalosporins and vancomycin; speciation was not done due to technical difficulties.

On the third day of antimicrobial therapy the patient improved markedly and became alert and oriented. Because of refractory ascites the old Denver shunt was removed and a new one inserted. Soon after the procedure the patient developed disseminated intravascular coagulation. On day 16 she developed another episode of spontaneous bacterial peritonitis due to highly resistant *Klebsiella pneumoniae* and was started on imipenem/cilastatin 500 mg iv 8 hourly. The same organism also grew from blood. Despite antibiotic and other supportive care she continued to deteriorate and died on the 23rd day of hospitalisation because of upper gastrointestinal haemorrhage.

Corynebacteria are Gram-positive, non-spore-forming rods and are considered commensals of human skin and nasopharynx. However, they have recently been reported as pathogens in a number of infections including erythrasma, pneumonia, endocardi-

tis, wound and urinary tract infection.^{2,3} The majority of these infections have been reported in immunocompromised patients.

Spontaneous bacterial peritonitis due to *Corynebacterium* sp has been reported previously only once in a 68-year-old man with a history of alcoholic cirrhosis and refractory ascites.⁴ The patient had a complete recovery on antibiotic therapy. Our case was similar in many respects. She was immunocompromised due to alcoholic cirrhosis and had refractory ascites. On paracentesis, the appearance and chemical analysis of the ascitic fluid was consistent with the diagnosis of spontaneous bacterial peritonitis, which was confirmed by a positive culture. This case again shows that, in immunocompromised patients, the isolation of corynebacteria should be considered significant and not dismissed as a mere contaminant.

ASHOK VAGHJIMAL

KEVIN SPERBER

Division of Infectious Diseases,
Maimonides Medical Center,
Brooklyn, NY 11219, USA

Summary points

- spontaneous bacterial peritonitis usually occurs in patients with cirrhosis of liver
- Gram-negative bacilli are the usual causative agents
- *Corynebacterium* sp is an extremely rare cause of spontaneous bacterial peritonitis
- prognosis of patients with spontaneous bacterial peritonitis and cirrhosis of liver is generally poor

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- 1 Maddrey WC. Approach to the patient with infections of liver. In: Gorbach, Bartlett, Blacklow, eds. *Infectious diseases*. WB Saunders, 1992; pp 699–703.
- 2 Brown AE. Other corynebacteria and rhodococcus. In: Mandell, Douglas, Bennett, eds. *Principles and practice of infectious diseases*. Churchill Livingstone, 1995; pp 1872–7.
- 3 Lipsky BA, Goldberg AC, Tompkins LS, Plorde JJ. Infections caused by nondiphtheria *Corynebacteria*. *Rev Infect Dis* 1982; 4: 12230–5.
- 4 Vettese TE, Craig CP. Spontaneous bacterial peritonitis due to *Corynebacterium xerosis*. *Clin Infect Dis* 1993; 17: 815–6.

Book review

Cardiology

Cardiological dilemmas, R Blackwood, B Daily. 87pp. Beaconsfield, Bucks, 1995. £10.95, paperback

Standard cardiac textbooks abound but are often unsuited to answering quickly and specifically questions raised by general practitioners (GPs) who have to cover the whole spectrum of medical knowledge. This slim paperback approaches the problem from a different angle by taking a problem-based approach in which questions likely to be asked by GPs are identified as isolated clinical scenarios to which answers are supplied.

Much good advice is given, eg, on home treatment of myocardial infarction, expressed in language and with comparisons which are easily understood. Practical insight is given into hospital treatments which GPs will rarely see, eg, cardiac catheterisation, and some cardiological myths are debunked, such as

headaches or dizziness being due to mild hypertension, or that a more expensive stethoscope equates to more accurate auscultation.

It is important that this type of problem-based approach be accompanied by an accurate and user-friendly index so that the reader can find information on even the more nebulous problems. In this aspect *Cardiological dilemmas* scores well; using the contents and the index allowed me to find the sections I was looking for fairly quickly.

The strength of this book lies in the brevity, clarity and realistic nature of these opinions. Unfortunately, these strengths become weaknesses when these opinions are too idiosyncratic and polarised. Is examination of jugular venous pressure really 'absolutely useless', does it truly belong 'to a bygone era'? Is it really possible to diagnose diastolic heart failure simply by the combination of breathlessness, absent physical signs and improvement with diuretics? Furthermore, perhaps not surprisingly, I found myself disagreeing

fairly strongly with some of the advice given. I am not at all sure that carrying out an exercise test in a woman with non-anginal chest pain for reassurance is a good idea – you will have achieved exactly the opposite effect in the 20–30% of tests which prove to be positive. Similarly, I don't believe that in atrial fibrillation controlled at rest but not on exertion, amiodarone is the 'best drug by miles'.

Nonetheless, this book is light, easy to read and cheap, if not always cheerful. Although of little value for hospital doctors, it may on occasions help the GP bridge the gap between formal standard textbooks and real life, particularly if the answers given are regarded as sensible individual opinions rather than accepted facts.

STEPHEN SALTISSE

Department of Cardiology
Royal Liverpool University Hospital
Liverpool L7 8XP, UK