Letters to the Editor

Catheter-Related Bloodstream Infection Caused by *Mycobacterium mageritense*[▽]

Mycobacterium mageritense is an uncommon cause of catheter-related bacteremia (1, 4).

We report a 26-year-old pregnant woman who presented with fever for 3 weeks. A tunneled central venous catheter (CVC) had been placed due to hyperemesis. The patient did not have any immunocompromised conditions. Blood cultures were performed by use of BACTEC Aerobic Plus and Anaerobic Lytic. Anaerobic cultures from both the central line and a peripheral site showed beaded gram-positive rods. The time to detection was 103 h. A modified acid-fast stain was highly suggestive of a nontuberculous mycobacterium (NTM) which was identified as *Mycobacterium mageritense* by DNA sequencing. Susceptibility studies performed by a broth dilution MIC method showed the organism to be susceptible to ciprofloxacin (MIC, 0.5 µg/ml) and trimethoprim-sulfamethoxazole (TMP-SXT) (MIC, 0.5 and 9.5 µg/ml, respectively) and resistant to amikacin (MIC, 128 µg/ml) and clarithromycin (MIC, >64 µg/ml). The breakpoints were determined according to standards of the Clinical and Laboratory Standards Institute (CLSI).

Intravenous TMP-SXT was initiated. The catheter was removed 1 week later, and the tip was cultured using the roll plate technique on sheep blood agar. No growth was observed after 5 days of incubation. The patient was treated for 2 weeks with intravenous TMP-SXT, with complete resolution of her symptoms.

To our knowledge, this is the second reported case in the literature of a CVC-related bloodstream infection due to *Mycobacterium mageritense*. The first reported case occurred in a 32-year-old immunocompromised woman who was treated with linezolid and amikacin.

Clinical disease produced by *M. mageritense* is uncommon and ranges from skin and soft tissue infection to health care-associated infections (4). It is a nonpigmented, rapidly growing mycobacterium, closely resembling the *M. fortuitum* third biovariant complex (2, 4). The source of *M. mageritense* in our case remains unclear.

Although bloodstream infection with NTM usually occurs in immunocompromised patients with CVC, our case occurred in a patient with no immunocompromised state. The catheter tip did not grow the organism, which may be due to the patient's prior antimicrobial therapy. Also, since this catheter was cultured using the roll plate technique (which detects only extraluminal colonization), intraluminal colonization, frequently seen with long-term catheters, was not detected. CVC infection is documented with a positive catheter tip in only 15 to 25% of cases with presumptive CVC-related infection. There are no treatment guidelines for NTM bloodstream infections.

The decision to remove the catheter from our patient was based on previously reported cases of *M. fortuitum* bacteremia in which a high relapse rate was seen if catheters were not removed (3).

The susceptibility pattern of this isolate of *M. mageritense* resembles that of the *M. fortuitum* group. Given that isolates of *M. mageritense* have growth, biochemical, and drug susceptibility patterns of the *M. fortuitum* third biovariant complex, it has been postulated that *M. mageritense* might actually be a new taxon within the *M. fortuitum* third biovariant complex (2). Even though *M. mageritense* is a low-virulence organism usually not associated with clinical disease, this case illustrates the pathogenic potential of this organism in patients with long-term indwelling catheters.

We declare no conflicts of interest.

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