Acinetobacter infection, and received a second course of colistin–rifampicin; two of these patients died (one from carbapenem-resistant A. baumannii ventilator-associated pneumonia and candidae-mia, and the other from Pseudomonas ventila-tor-associated pneumonia). Thus, therapy with colistin–rifampicin, and with ampicillin–sulbacter in case of susceptibility to this combination, resulted in microbiological clearance of carbapenem-resistant A. baumannii infection in nine (64%) of 14 critically-ill patients, with limited side-effects. Although the limited number of patients, and the lack of a control group, in this series does not allow a definite conclusion, it seems that the combination of colistin and rifampicin may be an innovative therapeutic option for consideration in the treatment of severe infections caused by carbapenem-resistant A. baumannii.

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Occurrence of chlamydial cervicitis in Upper Silesia, Poland

The recent article in Clinical Microbiology and Infection by Kese et al. [1] described a prevalence of Chlamydia trachomatis infection of 19.5% in male partners and of 10.7% in female partners attending two sexually transmitted disease clinics in Slovenia. The study used two diagnostic methods for the detection of C. trachomatis, namely the MicroTrak direct fluorescent antibody test, followed by the Amplicor PCR assay if the direct fluorescent antibody results were inconclusive. The results of the study supported the implementation of routine screening for C. trachomatis genital infection among male and female patients aged <30 years who attend sexually transmitted disease clinics in Slovenia.

It is well-known that the level of chlamydial cervicitis decreases quickly in countries where routine screening for C. trachomatis is mandatory [2,3]. In Poland, routine screening for C. trachomatis is not yet provided. Our own experience in Upper Silesia (south Poland; population c. 5 million) demonstrated a chlamydial aetiology for cervicitis in 173 (49.3%) of 351 sexually active women (mean age 31.7 ± 6.82 years) attending the Department and Clinic of Gynaecology and Endocrinology at the Medical University of Silesia, Katowice, between 2001 and 2004. All 351 women had symptoms of cervicitis, i.e., mucopurulent endocervical discharge and/or ≥30 neutrophils in a ×1000 field on the cervical Gram stain, and/or bleeding. C. trachomatis was detected by the direct immunofluorescence assay (bioMérieux, Marcy l’Etoile, France), performed according to the manufacturer’s instructions.

There was a significant difference between the prevalence of C. trachomatis in Katowice (49.3%) and the study of Kese et al. (10.7%) [1]. However, Kese et al. [1] studied patients without clinical symptoms of cervicitis attending sexually transmitted disease clinics, while the Katowice study only included patients with clinical symptoms of cervicitis. In addition, there were differences in the methods used for the detection of C. trachomatis. The direct immunofluorescence assay is a rapid assay, but is less sensitive than the nucleic acid amplification techniques, which are accepted currently as the standard for diagnosis of C. trachomatis infection and which were used by Kese et al. [1] when inconclusive results were obtained with the direct fluorescent antibody test. Nucleic acid amplification techniques demonstrate a sensitivity and specificity of 56–100% and >99%, respectively, in comparison with cell culture [4]; in contrast, the reported sensitivity
and specificity of the direct immunofluorescence method are 50–90% and > 95%, respectively.

The direct immunofluorescence method is still often used for detection of C. trachomatis in Poland. In a separate study using this method in northern Poland [5], a similar relatively high percentage (39.2%) of chlamydial cervicitis was demonstrated, although another Polish study [6] demonstrated a somewhat lower percentage of chlamydial cervicitis (18.4%) using the same method. In Katowice, cervical ectopia was confirmed in 26.5% (93/351) of the women examined, and ectopia was associated with cervical chlamydial infection in 42 cases, although the prevalence of ectopia among women with chlamydial and non-chlamydial cervicitis was similar (24.3% vs. 28.7%, respectively; p < 0.05). The possible interdependence of cervical ectopia and C. trachomatis must be analysed carefully because of the difficulty in deciding whether ectopia is a predisposing factor for C. trachomatis infection, or whether the infection process started by chlamydia leads to cervical ectopia [5,7,8]. However, the results obtained suggest that the presence of cervical ectopia indicates the importance of looking for C. trachomatis.

The results from Upper Silesia demonstrate the importance of C. trachomatis screening, especially in the group aged < 30 years. We agree with Kese et al. [1] that early diagnosis and appropriate treatment of chlamydial cervicitis among the younger population will help to prevent eventual severe complications emerging in older age groups. There appears to be a high frequency of C. trachomatis infection among women with cervicitis in Upper Silesia, thereby indicating a requirement to implement routine screening for these organisms.

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