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Septic arthritis caused by *Stenotrophomonas maltophilia* in a patient with acquired immunodeficiency syndrome

Sirs,

The Gram-negative bacillus *Stenotrophomonas maltophilia* is frequently isolated from clinical specimens in the absence of disease (1). Opportunistic infection occurs principally in individuals receiving immunosuppressive therapy, with underlying malignancy or with indwelling venous catheters (2, 3).

A 36-year-old man presented with fever and swelling and pain of 14 days duration in the right knee. He had been tested for human immunodeficiency virus infection (HIV) in 1985 with a positive result. He developed pulmonary tuberculosis in 1987, osteomyelitis of the right tibia due to *Salmonella* subgroup 1 in 1987, tuberculous osteomyelitis of the left tibia in 1990, cerebral toxoplasmosis in 1995, and HIV-associated encephalopathy in 1996. Both tibial osteomyelites were confirmed by bone biopsy.

On examination the patient was febrile and the right knee was enlarged. ESR was 120 mm/hr and haemoglobin 104 g/l. Blood and synovial fluid leukocyte counts were 11.1 10^9/l with 81% neutrophils and 35 10^9/l with 85% neutrophils, respectively. The number of CD4 positive lymphocytes was 0.11 10^9/l. Culture of the synovial fluid was negative. Simple x-rays and MRI showed findings compatible with osteomyelitis of the right femur and tibia and synovial fluid within the joint (Fig. 1).

Bacterial arthritis was suspected and the patient was empirically treated with intravenous (IV) gentamycin (180 mg/day for 2 weeks) and cloxacillin (2 g/day IV for 2 weeks followed by an oral regimen of 1 g/day for 4 weeks) with amelioriation of the pain and swelling. Two weeks after the cessation of antibiotics the patient once again became febrile and the knee was newly enlarged. Synovial fluid was aspirated and a bone biopsy of the right tibia was performed. Blood cultures and cultures of the bone biopsy were negative. Culture of the synovial fluid yielded *S. maltophilia*. The patient received oral trimethoprim (320 mg/12 hr) and sulfamethoxazole (1600 mg/12 hr) plus ciprofloxacin (750 mg/12 hr) for 6 weeks with resolution of the signs and symptoms.

HIV infection was present in 4 of 91 patients with *S. maltophilia* bacteraemia studied by Muder *et al.* (3). Manfredi *et al.* (4) described 54 episodes of *S. maltophilia* infection in 52 HIV-infected patients: bacteraemia in 44 cases, lower airway infection in 5 cases, urinary tract infection and pharyngitis in 2 cases each, and lymph node involvement in one case.

Fig. 1. MRI of the knee on T2-weighted images showing findings compatible with osteomyelitis of the femur and tibia.

Osteoarticular infections caused by *S. maltophilia* are rare. Osteomyelitis due to this organism has been reported in patients with wounds caused by corn-harvesting machines (5). Prepatellar bursitis due to *S. maltophilia* has been described in an elderly alcoholic man with heart disease, lung disease and adenocarcinoma of the stomach treated by gastrectomy (6).

In our patient diagnosis was difficult because he had received antibiotics for 6 weeks. Two weeks after the cessation of cloxacillin, an aetiologic diagnosis was made and a synergistic antimicrobial combination was administered with good results. Trimethoprim-sulfamethoxazole has traditionally been the most active agent used against this organism; the addition of another agent (in our case, ciprofloxacin) to which the isolate is susceptible should be considered in immuno-compromised patients (3).

We conclude that *S. maltophilia* should be included as a possible causative agent of septic arthritis in immunosuppressed patients.

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