Pediococci are homofermentative, gram-positive, nonmotile, catalase-negative facultative anaerobes of the family 
Streptococcaceae and are used in the biotechnology and food industries (1,2,7). The ecological niche of pediococci in humans appears to be the enteral tract (7). Although pediococci have been described as harmless bacteria (5), they have been infrequently recovered from the human respiratory tract and saliva and also from other clinical specimens, viz., stool, urine, wounds, abscesses, peritoneal fluid, and blood from immunocompromised patients with various underlying conditions including burns, malignancies, cardiovascular disease, chronic lung disease, and diabetes mellitus (1–3, 5–8). They have not, however, previously been recovered from pregnant women.

Of the eight species of the genus Pediococcus currently recognized (1), only Pediococcus acidilactici and P. pentosaceus have been described as human pathogens causing septicemia, hepatic abscesses, and bacteremia (2,3,5,8). Pediococci appear on Gram’s stains to be arranged in tetrads (1,2,5,7) and clusters and are universally resistant to vancomycin and teicoplanin (1,2,6,7).

We report a case of pneumonitis and bacteremia caused by P. acidilactici in a pregnant woman. A 26-year-old primigravida with a history of chronic bronchitis was admitted to Jawaharlal Nehru Hospital, Madhya Pradesh, India, at 14 weeks of pregnancy after 6 days of fever and purulent expectoration. She had received oral amoxicillin at 250 mg three times a day for 7 days and was febrile (40°C), tachypneic, and normotensive and had mild hepatic abscesses, splenomegaly, patchy bilateral pneumonitis, and a single viable fetus as assessed by physical examination and guarded-skialariniography. She was well, with a normal fetus of 24 weeks’ gestation. There were underlying predisposing factors for septicemia, lung disease, and diabetes mellitus (1–3, 5–8). They have not, however, previously been recovered from pregnant women.

The isolate did not exhibit intermediate susceptibility (zone diameters of 10 to 16 mm) to the antibiotics tested. While Tankovic et al. (9) and Gollelge et al. (3) have reported susceptibility to penicillin, other reports have noted pediococci to be mostly moderately susceptible to penicillin and resistant to quinolones (2,5–8). Treatment with ceftaxone was discontinued. Treatment with benzyl penicillin at 2 million U intravenously every 6 h was started. Defervescence occurred promptly, within 48 h. Therapy was continued for a total of 10 days. Subsequent cultures of blood and sputum remained sterile. The patient was discharged on the 15th hospital day. At follow-up 2 months later, she was well, with a normal fetus of 24 weeks’ gestation. There appears to be little doubt that P. acidilactici is a rare clinical isolate and an opportunistic pathogen (7). This report underlines the importance of accurate identification of organisms found to be vancomycin-resistant; shows that pregnancy, with depressed humoral and polymorphonuclear functions beginning with the second trimester (4), is one of the underlying predisposing factors for P. acidilactici infection; and reveals the benefits of initiation of prompt and specific antibiotic therapy.

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REFERENCES


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