Two Cases of Peritonitis Caused by *Kocuria marina* in Patients Undergoing Continuous Ambulatory Peritoneal Dialysis

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*Kocuria* spp. are members of the *Micrococcaceae* family that are frequently found in the environment and on human skin. Few human infections have been reported. We describe what appear to be the first two cases of *Kocuria marina* peritonitis in patients undergoing continuous ambulatory peritoneal dialysis.

**CASE REPORTS**

**Case 1.** A 57-year-old man was admitted to the emergency department because of turbid dialysis effluent for 1 day. He had end-stage renal disease as a result of diabetic nephropathy and had been undergoing continuous ambulatory peritoneal dialysis (CAPD) for 6 years. Upon physical examination, he was afebrile, with a normal-appearing catheter exit site. However, the peritoneal dialysate fluid was straw colored and cloudy, with a total leukocyte count of 0.78 × 10⁹ leukocytes/liter and a neutrophil count of 90%. No microorganisms were seen on a Gram stain. In the peripheral blood, the hemoglobin concentration was 11.7 g/dl, the WBC count was 7.40 × 10⁹ cells/liter, and the platelet count was 171 × 10⁹ platelets/liter. The C-reactive protein concentration was 2.76 mg/dl (reference concentration, <0.5 mg/dl), and the serum urea and creatinine concentrations were 53 mg/dl and 11.2 mg/dl, respectively. Intraperitoneal administration of netilmicin and narrow-spectrum cephalosporin (cefezole) was started for empirical treatment of CAPD peritonitis, which was changed to intraperitoneal ceftazidime and clindamycin when the placement of an arteriovenous shunt. The patient improved with antibiotic therapy for 7 days after catheter removal and was discharged.

We performed antimicrobial susceptibility testing on the isolate using the agar dilution method, according to the Clinical and Laboratory Standards Institute (CLSI) guidelines for *Staphylococcus* (4a). The isolate was susceptible to penicillin, ampicillin, ampicillin-sulbactam, gentamicin, cephalothin (cefalotin), ciprofloxacin, moxifloxacin, trimethoprim-sulfamethoxazole, erythromycin, clindamycin, vancomycin, chloramphenicol, tetracycline, and rifampin (rifampicin) (Table 1).

**Case 2.** A 73-year-old man visited the section for peritoneal dialysis of our hospital because of turbid dialysis effluent for 3 days. He had end-stage renal disease as a result of diabetic nephropathy and had been undergoing CAPD for 4 years. The peritoneal fluid was cloudy, with a total leukocyte count of 2.58 × 10⁹ leukocytes/liter and a neutrophil count of 90%. No microorganisms were seen on a Gram stain. In the peripheral blood, the hemoglobin concentration was 11.7 g/dl, the WBC count was 6.49 × 10⁹ cells/liter, and the platelet count was 314 × 10⁹ platelets/liter. The C-reactive protein concentration was 4.03 mg/dl, and the serum urea and creatinine concentrations were 34 mg/dl and 7.5 mg/dl, respectively. Intraperitoneal administration of netilmicin and narrow-spectrum cephalosporin (cefezole) was started.

Culture of the dialysate yielded a pure culture of gram-positive cocci in pairs or clusters (strain M07-0128). After 48 h of incubation at 35°C in 5% CO₂ on sheep blood agar, the organism grew as nonhemolytic orange colonies that were 1 to 2 mm in diameter. The isolate was identified as *Kocuria varians* by the Vitek 2 system (bioMérieux, St. Louis, MO) and as *K. marina* by an API Staph system (bioMérieux, Marcy l’Etoile, France). We performed 16S rRNA gene sequencing as previously described (5) and compared the obtained sequence with sequences similar to those of the type strains using BLAST and EzTaxon (4). The result showed 99.86% homology with *Kocuria marina*; the second closest match was *Kocuria campihila*, with 98.30% homology. This isolate was finally identified as *K. marina* by 16S rRNA gene sequence analysis. In spite of the start of administration of intravenous vancomycin on day 10, the response remained unsatisfactory. The Tenckhoff catheter in his abdomen was removed on day 17, and he was switched to hemodialysis with the placement of an arteriovenous shunt. The patient improved with antibiotic therapy for 7 days after catheter removal and was discharged.

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mm in diameter. We initially reported the isolate as *Staphylococcus hominis* according to the Vitek 2 system. However, upon reexamination, the isolate was identified as *K. kristinae* with a 94.3% probability by a Vitek 2 system. Sequencing of the 16S rRNA genes showed 99.7% homology with *K. marina* (GenBank accession no. AY211385) and 98.17% homology with *K. car- niphila* (GenBank accession no. A6122907). By day 5 of empirical treatment, the CAPD effluent had cleared, and the WBC count decreased. He was discharged with complete resolution of the peritonitis. This isolate was likewise susceptible to penicillin, ampicillin, ampicillin-sulbactam, gentamicin, cephalothin, ciprofloxacin, moxifloxacin, erythromycin, clindamycin, vancomycin, chloramphenicol, tetracycline, and rifampin but not to trimethoprim-sulfamethoxazole (Table 1).

**Kocuria** spp. are aerobic, gram-positive cocci occurring in tetrads. They are members of the *Micrococccacea* family. More than 11 species of *Kocuria* are recognized. The organism is widespread in nature, frequently being found as normal skin flora in humans and other mammals (7, 13). However, we do not know the source of the organisms in these two infections. There are only a few reports of human infection caused by *Kocuria*. Specifically, we found a single case of acute cholecystitis caused by *Kocuria* (9) and three cases of catheter-related bacteremia, attributing one each to *K. kristinae* (10) and *K. car- niphila* (1–3). Most patients with catheter-related bacteremia were immunocompromised by malignancy or a metabolic disorder. Strain KMM 3905T, isolated from a high-salt environment, was recently given the name *K. marina* biovar 3 (6). There are only a few reports of human infection caused by *Kocuria* spp., as follows: it was positive for urease and nitrate reduction, negative for oxidase and alkaline phosphatase, and negative for acid production from glucose, lactose, or sucrose (6). How- ever, it was doubtful that we could identify *K. marina* to the species level with these biochemical tests, as our two *K. marina* strains differed from those reported by Kim et al. (6). Moreover, the two isolates showed different pigmentation on sheep blood agar; one strain was orange and the other was yellow. At present, correct identification of *Kocuria* spp. by commercial systems is problematic because systems such as Vitek 2 GP card and API Staph do not include all *Kocuria* spp. in their database. To describe the common phenotypic properties of *K. marina*, further investigation should be conducted on many strains.

Empirical therapy for CAPD peritonitis is an intraperitoneal narrow-spectrum cephalosporin such as cefazolin for gram-positive cocci and a fluoroquinolone or an expanded-spectrum cephalosporin for gram-negative bacilli (8). Our patients were treated empirically with a narrow-spectrum cephalosporin and netilmicin by intraperitoneal infusion before culture results were available, and one was cured. However, the other patient did not respond in spite of the addition of intravenous vancomycin, and catheter removal was necessary. This is similar to

### TABLE 1. Antimicrobial susceptibility profiles of two *K. marina* strains

<table>
<thead>
<tr>
<th>Strain</th>
<th>PC</th>
<th>AM</th>
<th>SAM</th>
<th>GM</th>
<th>CF</th>
<th>CIP</th>
<th>MXF</th>
<th>SXT</th>
<th>E</th>
<th>CC</th>
<th>VA</th>
<th>CM</th>
<th>TET</th>
<th>RIF</th>
</tr>
</thead>
<tbody>
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<td>M07-0128</td>
<td>0.06</td>
<td>≤0.03</td>
<td>0.06/0.03</td>
<td>0.06</td>
<td>0.06</td>
<td>0.5</td>
<td>0.25</td>
<td>2/38</td>
<td>0.06</td>
<td>0.06</td>
<td>0.5</td>
<td>4</td>
<td>0.06</td>
<td>≤0.03</td>
</tr>
<tr>
<td>M07-1356</td>
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<td>≤0.03</td>
<td>0.06/0.03</td>
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<td>0.06</td>
<td>0.5</td>
<td>0.25</td>
<td>4/76</td>
<td>0.06</td>
<td>0.06</td>
<td>0.5</td>
<td>2</td>
<td>0.06</td>
<td>≤0.03</td>
</tr>
</tbody>
</table>

* Abbreviations: PC, penicillin; AM, ampicillin; SAM, ampicillin-sulbactam; GM, gentamicin; CF, cephalothin; CIP, ciprofloxacin; MXF, moxifloxacin; SXT, trimethoprim-sulfamethoxazole; E, erythromycin; CC, clindamycin; VA, vancomycin; CM, chloramphenicol; TET, tetracycline; RIF, rifampin.
the situation with catheter-related bacteremia. In those cases, therapy with a glycopeptide failed, but the patients were cured after removal of the catheter (1–3). Our case 1 patient likewise recovered with the removal of the catheter and continuous antibiotic therapy.

Our two strains were isolated with a 9-month interval between them, and there was no relationship between these two patients. The source could not be identified. Because there are no interpretative guidelines for antimicrobial susceptibility testing for Kocuria spp., we did not test any antimicrobial agents at the time the organisms were isolated. Later, however, we performed susceptibility testing using an agar dilution method according to the CLSI recommendations for Staphylococcus lugdunensis. Korean J. Lab. Med. 28:196–200.

We describe two cases of K. marina peritonitis in patients undergoing CAPD; this is, to our knowledge, the first report of Kocuria marina as a pathogen, and there are no data on MICs for Kocuria spp.

Nucleotide sequence accession numbers. The GenBank accession numbers for the 16S rRNA gene sequences of the two strains of K. marina identified in the present study are FJ789660 and FJ789661.

REFERENCES