CASE REPORT

41-year-old man was admitted to our hospital with a 1-week history of febrile sense, chills, sweating, aggravation of dyspnea, and hypotension during hemodialysis. He had a complicated history, including liver cirrhosis caused by chronic hepatitis B infection and chronic kidney disease due to glomerulonephritis. He had received entecavir since 2009 and hemodialysis since 2000. In addition to these, he had undergone a mechanical mitral valve replacement due to infective endocarditis caused by methicillin-resistant Staphylococcus aureus more than 1 year ago. He denied having had dental treatment or drug abuse since mitral valve replacement.

On arrival at the emergency department, the patient’s vital signs were as follows: blood pressure, 86/52 mm Hg; respiratory rate, 22 breaths per min; and temperature, 37°C. Physical examination revealed metallic heart sounds without murmur and no abdominal tenderness with positive shifting dullness. A chest radiography showed cardiomegaly and pulmonary edema. Laboratory investigations revealed a C-reactive protein concentration of 10.0 mg/dl (normal [N], <0.3 mg/dl), an erythrocyte sedimentation rate of 37 mm/h (N, <22 mm/h), and a procalcitonin concentration of 152.2 ng/ml. The white blood cell (WBC) count was 9,850/mm³ with dominant segmented neutrophils (85%), hemoglobin (Hb) at 7.5 g/dl, platelet count of 57,000/mm³, blood urea nitrogen at 49.5 mg/dl, creatinine at 6.55 mg/dl (N, <1.3 mg/dl), and total bilirubin at 1.2 mg/dl (N, <1.5 mg/dl). He was coagulopathic with a prothrombin time of 23.1 s (N, 12.6 to 14.9), international normalized ratio (INR) of 2.0, activated partial thromboplastin time (APTT) of 72.7 s (N, 29.1 to 41.9), and D-dimer of 0.06 mg/liter. It was susceptible to ceftriaxone, piperacillin-tazobactam, 0.25 mg/liter; rifampin, 1 mg/liter; and ciprofloxacin, <0.06 mg/liter. It was susceptible to ceftriaxone, piperacillin/tazobactam, rifampin, and ciprofloxacin but showed intermediate resistance against penicillin. Interpretive criteria for susceptibility were those for Neisseria gonorrhoeae, because no breakpoints were provided by CLSI (2).

The patient was treated for prosthetic valve endocarditis with intravenous vancomycin at 1g every 3 days, piperacillin-tazobactam at 2.25 g four times daily, gentamicin at 100 mg daily, and oral rifampin at 900 mg daily. On hospital day four, the patient re-
Neisseria meningitidis

Neisseria meningitidis and Neisseria spp. are opportunistic pathogens, physicians should be aware of the possibility of endocarditis due to Neisseria species. More Neisseria species may cause human disease.
ACKNOWLEDGMENT
We have no conflict of interest to disclose.

REFERENCES

FIG 2 PFGE analysis of genomic DNA from N. skkuensis strains digested with NheI and SpeI. N. skkuensis strains digested with NheI (A) or SpeI (B) are shown. Two isolates showed <85% similarity. The isolates were considered to be unrelated to each other. N. skkuensis 1 is SMC-A9199 (7). N. skkuensis 2 is the isolate from this case patient.