In this paper, we describe two cases of early multidrug-resistant (MDR) *Pseudomonas aeruginosa* endophthalmitis after penetrating keratoplasty as the result of transmission from the same donor. The cornea donor was a 38-year-old patient who died of cirrhosis 1 day before the surgeries. Donated corneas were collected with a death-to-preservation time of 2 h 45 min and were immersed in the preservative medium Optisol-GS (Bausch + Lomb, Irvine, CA). The donor was treated under conditions that included mechanical ventilation and was not septic. Before his death, previously collected blood and urine for cultures gave negative results. The recipients were (i) a 76-year-old man presenting with bullous keratopathy who underwent an uneventful penetrating keratoplasty on his right eye in August 2009, and (ii) a 14-year-old male with keratocornea who underwent an uneventful penetrating keratoplasty on the right eye in August 2009. On the first postoperative day, both recipients showed signs of infection in the donor corneal button. For both patients, treatment consisting of intravenous therapy with cefazolin (50 mg/ml), and gentamicin (14 mg/ml) administered every hour following an initial loading dose of 1 to 2 drops every 5 min for the first 30 min was initiated on the first postoperative day. Intravenous therapy with cefazolin (400 mg once a day) and topical therapy with moxifloxacin (0.5%), cefazolin (50 mg/ml), and gentamicin (14 mg/ml) were administered every hour following an initial loading dose of 1 to 2 drops every 5 min for the first 30 min. Afterward, Gram staining was done on the thioglycolate culture. In the presence of Gram-negative rods (grown also in MacConkey medium), *P. aeruginosa* was identified. The susceptibility profile was determined by the Kirby-Bauer disk-diffusion method. Both isolates were resistant to aminoglycosides, cephalosporins, fluoroquinolones, (extended-spectrum) penicillin, and monobactam and susceptible only to carbapenems and polymyxins. Multidrug-resistant *P. aeruginosa* was also isolated from the corneal scrapings of the recipients. Bacterial isolates recovered from both the corneoscleral rim and infected graft cornea were sent to the Laboratório Especial de Microbiologia Clínica of the Universidade Federal de São Paulo for further molecular characterization. Pulsed-field gel electrophoresis (PFGE) was performed using the CHEF-DR II system (Bio-Rad, Richmond, CA) with 0.5× TBE (50 mM Tris, 50 mM boric acid, 0.5 mM EDTA) and 1% agarose at 13°C and 200 V for 24 h, with a switch time of 5 to 90 s, as previously described by Pfaller et al. (7). Digestion of total DNA was achieved using SpeI. The PFGE patterns were analyzed using BioNumerics analysis software (Applied Maths, Kortrijk, Belgium), which revealed identical macrorestriction patterns obtained from the donor corneas in all samples, proving that the donor was the source of both recipient infections, as shown in the dendrogram in Fig. 1.

Donor-to-host transmission of *P. aeruginosa* is uncommon (6), and transmission of MDR *P. aeruginosa* to two recipients...
from a single donor after penetrating keratoplasty has not been previously described. The increasing frequency of infection by MDR \textit{P. aeruginosa} strains is alarming, since effective antimicrobial options are severely limited (5). Although donor-to-host transmission has been associated with cancer as a cause of long hospitalization time, mechanical ventilation, and death (3, 4, 6), culturing of this environment is not routinely done. Contamination during corneal harvesting, preparation, and preservation is unlikely, given that different harvesting sets were used and that strict sterile conditions were maintained for preparation (1, 3). Despite the aseptic precautions, the role of environmental contamination cannot be ruled out. Also, contamination during keratoplasty seems unlikely, because it was performed in different operating rooms with another set of instruments, other assistants, and a different surgeon. The solution of Optisol GS (Bausch + Lomb, Irvine, CA) contains 100 μg/ml gentamicin sulfate and 200 μg/ml streptomycin sulfate. The possibility of adding antibiotics with a broader spectrum of activity, such as vancomycin, fluoroquinolones, and penicillin, has been evaluated, although such therapy could be ineffective against MDR pathogens (2, 8). Studies aiming to evaluate the effects of antibiotics from the carbapenem or polymyxin class in preservation medium would be interesting and may represent an alternative method for treatment of multidrug-resistant \textit{P. aeruginosa}. The use of PFGE typing, as well as the routine culture of the corneoscleral rim, was important for confirming that the source of infection was the donor button in these cases. Besides all normal preventive measures, the judicious screening of donors, the use of antimicrobial agents of greater efficacy in preservation media, and the employment of better means of microorganism detection in preservation media before transplantation such as PCR using species-specific primers to identify potential posttransplantation keratitis pathogens, could minimize this type of transmission.

**REFERENCES**