Dear Editor,

As you are aware that leptospirosis has become a globally important zoonotic disease, and is commonly seen in tropical and subtropical regions, probably because of poor hygiene and favourable climate. It is transmitted by direct contact with urine, blood or tissue of infected animals; with water being an important medium. Abrasions or cuts in skin, and mucous membranes especially conjunctiva and oral mucosa are the doors of entry. Clinically, leptospirosis has a biphasic nature - a leptospiremic phase characterized by 3 to 10 days of fever and an immune phase characterized by resolution of symptoms and appearance of antibodies. The common symptoms include fever, headache, nausea, vomiting and conjunctival suffusion, along with calf and back muscle tenderness. Hepatomegaly, splenomegaly and meningism may be present clinically. Hemorrhagic spots, macuopapular rashes, jaundice and lung crepitations are other findings. Weil’s syndrome is a severe form of leptospirosis characterized by haemorrhage, jaundice and acute kidney injury. The diagnosis is based on Modified Faine’s criteria (Figure 1). Penicillin, ceftriaxone, amoxicillin and doxycycline form the mainstay of treatment. 1

Coagulase-negative staphylococcus (CoNS) are less virulent than staphylococcus aureus and are often associated with prosthetic device infections. Staphylococcus epidermidis is the most common among human pathogens and is a component of normal human skin flora. 2

The case being reported is of a 32 year old lady, hailing from a rural area in Kerala, India, who had history of fever and myalgia for 6 days. She went to nearby hospital and was diagnosed to have leptospirosis. She was started on intravenous Penicillin 1.5 million units. Following 2 days of therapy, she continued to have fever and was referred to our hospital for further management. On admission, she was conscious, oriented and febrile with temperature of 101°F. She had mild dyspnoea but saturation was 96% in room air. She was not icteric. Her vitals and systemic examinations were normal. Her complete blood count showed mild thrombocytopenia of 122,000/cmm (150,000-450,000). She had elevated SGOT 96 U/L (12-38) and SGPT 72 U/L (7-41) but normal bilirubin, proteins and albumin. Prothrombin time, INR and activated partial thromboplastin time were within normal range. Her renal parameters and electrolytes were normal. Her urine microscopy showed only 2-3 pus cells and chest Xray was normal. Ultrasound abdomen showed mild hepatomegaly. Malarial card test and Dengue serology were negative and leptospira IgM (ELISA) was positive. She also satisfied the Modified Faine’s criteria with a score of 31. Intravenous Penicillin was continued with addition of ceftriaxone. She continued to have fever spikes (101-102°F). Her blood culture grew CoNS. She was started on linezolid as per culture sensitivity reports; and within 24 hours she became afebrile. She was given the full course of Penicillin and 7 days of linezolid and was discharged after being afebrile for 48 hours.

Only a handful of cases of coinfections with leptospirosis have been reported. Of these, majority were with dengue. 3,4 There are reports of coinfection with scrub typhus and melioidosis. 5,6 This might be the first reporting of a coinfection between leptospirosis and CoNS. This case

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1. Coagulase-negative staphylococcal coinfection with leptospirosis

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Figure 1: Modified Faine’s criteria

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Access this article online
Website: http://nepjol.info/index.php/AJMS
DOI: 10.3126/ajms.v7i6.15786
E-ISSN: 2091-0576
P-ISSN: 2467-9100

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LETTER TO THE EDITOR
ASIAN JOURNAL OF MEDICAL SCIENCES

Coagulate negative staphylococcal coinfection with leptospirosis

Submitted: 24-09-2016
Revised: 27-09-2016
Published: 01-11-2016

Asian Journal of Medical Sciences | Nov-Dec 2016 | Vol 7 | Issue 6

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also highlights the need to rule out other coinfections in patients diagnosed to have leptospirosis.

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