baumannii isolate also being resistant to carbapenems. This resistance was likely acquired in vivo under imipenem treatment, but the susceptible strain was not available for strain comparison. This is also the first description of a PER-1 A. baumannii isolate from Russia, a country from which little epidemiologic data on antimicrobial drug resistance are available, except for the emergence of ESBLs of CTX-M type in Enterobacteriaceae (10).

This study highlights the importance of international patient transfer in the spread of antimicrobial drug resistance, thus emphasizing the need for hospitals to isolate and screen for multidrug-resistant pathogens in all patients admitted to hospitals from foreign countries. This is particularly critical when the foreign country is known for a high prevalence of multidrug-resistant bacteria or when no antimicrobial drug resistance data are available.

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Human Infection with Rickettsia sp. related to R. japonica, Thailand

To the Editor: Although rickettsioses caused by scrub typhus and typhus group rickettsiae are well recognized in Thailand, few spotted-fever group rickettsiae (SFGR), including Rickettsia honei TT118 and R. felis, have been documented to be associated with human illnesses (1,2). We report a case of human infection with an SFGR species closely related to R. japonica in Thailand.

In January 2005, a 36-year-old man with prolonged fever, pneumonia, and septic shock was transferred from a private hospital to Phramongkutkla Army Hospital in Bangkok. Two weeks before the onset of fever, the patient had camped at Khao Yai National Park, =175 km northeast of Bangkok. The park is a popular location for tourists and the largest national park declared as a natural wildlife reserve area. The patient reported the presence of wild deer around the camping area but did not recall being bitten by an arthropod. Ten days before hospitalization, he developed flulike symptoms, fever, and sore throat. Six days later, he noted petechiae on his lower extremities, and his condition worsened. At the time of hospital admission, the patient had fever of 38.6°C, tachycardia, dyspnea, hypotension, nausea, vomiting, generalized maculopapular rash, and subconjunctival hemorrhage. Laboratory investigation showed thrombocytopenia (platelets 64,000/mm³), leukocytosis (14,000/mm³), and elevated levels of serum hepatic enzymes (aspartate aminotransferase 287 IU/L [reference 5–50 IU/L]; alanine aminotransferase 186 IU/L [reference 5–40 IU/L]). Chest radiograph showed interstitial pneumonitis. Serum antibody test results were negative for leptospirosis and...
dengue virus; blood smear was negative for malaria.

Samples of the patient’s whole blood were collected in EDTA on days 10, 18, 20, and 25 after illness onset, and each sample was sent at the time of collection to the Armed Forces Research Institute of Medical Sciences, Bangkok, to be investigated for rickettsial infection. Plasma was separated and tested for scrub typhus, typhus group, and SFGR-specific immunoglobulin M (IgM) and IgG by immunofluorescence assay by using Orientia tsutsugamushi Karp-Kato-Gilliam strains and R. typhi Wilmington and R. honei TT118 whole cell antigens. No antibodies to rickettsiae were detected in the initial sample. On day 18, only antibodies against R. honei TT118 antigen were detected at a low titer, 50 for IgM and 200 for IgG, while antibodies to scrub typhus and typhus group rickettsiae remained negative (titers <50). Antibody level was unchanged on days 20 and 25.

At the time of admission, the patient began receiving 2 g of intravenous ceftriaxone and 200 mg of oral doxycycline daily. Three days later, treatment with doxycycline was stopped because the initial serologic results for rickettsia were negative. However, doxycycline was resumed on day 21, after antibodies to Thai tick typhus agent were detected in a second specimen. All amplicons were excised from agarose gels, purified by QIAEX II Gel Extraction Kit (QIAGEN), and then sequenced. BLAST analysis of 17-kDa antigen gene (GenBank accession no. DQ909071), gltA (DQ909073), and ompA (DQ909072) segments obtained from this patient showed 99% identity to corresponding genes of R. japonica. Phylogenetic analysis of these 3 genes indicates that the Rickettsia sp. from this patient is closely related and clustered within the same clade of R. japonica (Figure). Isolation of this rickettsial agent from the patient’s blood by animal inoculation and by cell culture methods is ongoing.

Persons visiting Khao Yai National Park are at risk for rickettsioses, particularly SFGR. Vectors for SFGR have been found in this area (5). The clinical and molecular findings in this case add to the accumulating data on the emerging rickettsial agents and their geographic distribution in Thailand.

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Figure. Phylogenetic relationships between Rickettsia sp. and rickettsial genes amplified from the patient (PMK 94) inferred from comparison with the rickettsial 17-kDa antigen gene, gltA, and ompA sequences by the neighbor-joining method. Bootstrap values of 1,000 replicates are indicated.
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