Possible Avian Influenza (H5N1) from Migratory Bird, Egypt

To the Editor: Wild migratory birds are reservoirs for low pathogenic avian influenza (LPAI) viruses (1), but their role in transmitting highly pathogenic avian influenza (HPAI) viruses is hotly debated and unclear (2–4). Beginning in July 2005, a clade of HPAI (H5N1) viruses rapidly expanded from an apparent focus in western People’s Republic of China and spread to the Middle East, Africa, and Europe (5). Genetic analysis of HPAI virus isolates from dead wild birds along major flyways indicated that the strains were closely related to the Qinghai H5N1 A/bar-headed goose/Qinghai/65/2005 virus (clade II) (GenBank accession no. DQ095622). In addition to transmission to domestic poultry, HPAI (H5N1)–infected mute swans have been implicated in direct transmission to humans in Azerbaijan (6).

The US Naval Medical Research Unit No. 3 and the Ministry of Environment of Egypt have collaborated since 2003 in obtaining samples from migratory birds to detect circulating influenza viruses. During the 2005–06 migratory birds season, 1,304 migratory birds were sampled from either live bird markets or cage birds trapped by fishermen in Port Said, Damietta, Fayoum, Arish, and Sharm el Sheikh (online Appendix Figure, panel A). All HPAI (H5N1) strains were positive for the neuraminidase 1 (N1) gene by real-time PCR.

Phylogenetic analysis showed clustering of the HPAI (H5N1) strains collected from 1 geographic region (country) (online Appendix Figure, panel B). All HPAI (H5N1) strains from Egypt or humans or chickens analyzed clustered with a bootstrap support value of 98%. Furthermore, the A/Teal/Egypt/14051-NAMRU3/2006 virus was an LPAI most closely related to strain A/mallard/Bavaria/1/2005(H5N2) (GenBank accession no. DQ387854 (2).
(H5N1) strain (collected in December 2005; online Appendix Figure, panel A) is an HPAI and is closely related to the parent of the group of viruses isolated in the early 2006 Egypt outbreak, with an average identity of 99.4% with all other strains from Egypt and a bootstrap support value of 96% (online Appendix Figure, panel B). Despite the rapid spread of this clade (Qinghai-like strain) to many countries, since late 2005, strains analyzed in this study showed low-level genetic variation (<2%).

Brown et al. reported that species can vary greatly in their response to HPAI (9). At least in ducks, it appears that viral shedding is highest in birds with clinical signs of infection, and lowest, as seen in the common teal infected with the HPAI strain in this study, in birds with subclinical infections. These subclinical infections may be due to flock immunity from previous exposure to LPAI H5 virus or genetic factors. This suggestion is conceivable in light of the LPAI H5 virus detected in the other teal a few months earlier.

Such naturally resistant wild birds might serve as vectors for introduction of HPAI viruses into new locations. Data presented herein suggest that an HPAI virus may have been introduced into new locations.

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Community-acquired Extended-Spectrum β-Lactamase Producers, United States

To the Editor: Extended-spectrum β-lactamase (ESBL)-producing organisms have become a common problem for patients in hospitals and other healthcare facilities (1). Community-onset ESBL infections have recently been described in Spain, the United Kingdom, Israel, and Canada (2,3). Typically, the infections are urinary tract infections (UTIs) with CTX-M–producing Escherichia coli. These organisms may be resistant to most or all antimicrobial agents commonly used to treat UTIs, such as ciprofloxacin, trimethoprim-sulfamethoxazole, gentamicin, and ceftriaxone.

Although CTX-M–producing E. coli have previously been found in the United States (4), clinical descriptions of community-acquired ESBL-producing E. coli infections have not been reported in this country. We describe 2 healthy young women in Pennsylvania in whom UTI with CTX-M-15–producing E. coli developed.

A 25-year-old woman was seen in October 2006 at the emergency department of a hospital in Pittsburgh reporting frequent urination, chills, and bilateral back pain. She had no relevant past medical history except for previous UTIs. Results of a physical examination were unremarkable.

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