Pseudomonas mosselli: A Case Series on Its Potential as a Rare Opportunistic Pathogen in Immunocompromised Patients

Mitra Kar a*, Akanksha Dubey a#, Chinmoy Sahu æ and Sangram Singh Patel aø

a Department of Microbiology, Sanjay Gandhi Institute of Medical Sciences, Lucknow, India.

Authors’ contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

Article Information

DOI: 10.9734/SAJRM/2022/v12i130265

Open Peer Review History:

This journal follows the Advanced Open Peer Review policy. Identity of the Reviewers, Editor(s) and additional Reviewers, peer review comments, different versions of the manuscript, comments of the editors, etc are available here: https://www.sdiarticle5.com/review-history/84988

Received 10 November 2021
Accepted 29 January 2022
Published 31 January 2022

ABSTRACT

Background: Pseudomonas mosselli is a Gram negative, rod-shaped, aerobic, non-sporing and motile bacterium co-existing in the soil with plants, protecting them from fungal and bacterial infections by producing diverse molecules and causing rare opportunistic infections in immunocompromised hosts. Most common presentations of respiratory infection caused by this isolate include fever, respiratory distress and purulent cough. Satisfactory antibiotic coverage and early diagnosis mostly leads to complete recovery of the patient.

Cases: Three cases have been included in our case series of which case 1 had type 2 diabetes mellitus, chronic kidney disease and hypertension and was also diagnosed SARS-CoV-2 positive by RT-PCR (Real time polymerase chain reaction), case 2 had Takosubo cardiomyopathy, an immunological disorder with impending heart failure and case 3 suffered from advanced renal failure due to rapidly progressive glomerulonephritis on weekly dialysis and steroid therapy. Pseudomonas mosselli from the respiratory samples of the patients admitted to a tertiary care centre were identified by the culture characteristics, biochemical reactions and species identification, performed by Matrix assisted laser desorption / ionization- time of flight- mass spectrometry (MALDI-TOF-MS).
Introduction: Pseudomonas mosselii causes opportunistic infections in immunocompromised patients. Respiratory infections caused by it are highly drug susceptible and can be easily overcome by administration of appropriate antibiotic treatment followed by antibiotic susceptibility testing.

Keywords: Pseudomonas aeruginosa; pseudomonas putida; pseudomonas mosselii; matrix assisted laser desorption / ionization- time of flight- mass spectrometry (MALDI-TOF-MS).

1. Introduction

Pseudomonas genus forms a group of Gram-negative, rod shaped, aerobic, non-sporing and motile bacteria [1]. They can survive in varying environments, varying from aquatic to terrestrial ecosystem to eukaryotic tissues. Varying physiological and metabolic activities are displayed by members of this genus against pathogens [2,3]. Pseudomonas mosselii is a soil pathogen that protects plants from fungal and bacterial infections through production of varying metabolites and was first clinically isolated in France and deemed an opportunistic human pathogen [4,5]. It was placed in Pseudomonas putida group by virtue of 16S rRNA analysis [6]. Dabboussi et al. (2002) described P. mosselii as a novel specie in 2002 due to low level DNA–DNA relatedness to other Pseudomonas strains, they used polyphasic taxonomic approach including 16S rDNA phylogeny, numerical analysis, DNA–DNA hybridization, thermal stability of DNA–DNA hybrids and siderotyping methodology to examine strains of Pseudomonas fluorescens, Pseudomonas putida and other Pseudomonas species to confirm it [4]. We present three cases of immunocompromised patients with respiratory distress of which case 1 tested positive for COVID-19 and suffered from severe covid pneumonia followed by secondary bacterial infection, case 2 suffered from Takosubo cardiomyopathy and impending heart failure and case 3 was a known case of advanced renal failure due to glomerulonephritis. These patients’ sputum samples revealed growth of a rare Pseudomonas species that were confirmed as Pseudomonas mosselii by Matrix assisted laser desorption/ionization- Time of flight- Mass spectrometry (MALDI-TOF MS).

2. Case Reports

2.1 Case 1

A 74 year old male, case of type-2 diabetes mellitus, chronic kidney disease and hypertension, presented to a covid testing facility with chief complaints of fever, sore throat and myalgia for a week. He tested positive for SARS-CoV-2 and was admitted to a covid facility at a tertiary care center on 19th April 2021, where he was administered steroids, oxygen therapy and other broad spectrum antibiotics despite which he developed moderate COVID-19 pneumonia. Being a chronic kidney disease patient, he needed regular haemodialysis sessions and was referred to the haemodialysis unit dedicated for covid 19 patients after 12 days of admission. His cough and respiratory distress was not relieved so a sputum sample was sent to the bacteriology section of the department of microbiology and a Gram's stained smear and culture was put up for the same on MacConkey and blood agar. On Gram's stained smear, few epithelial cells, plenty pus cells and Gram negative bacilli were observed and the next day culture on MacConkey agar showed non-lactose fermenting colonies with a fruity odour and blood agar showed transparent to grey colonies with haemolysis and was oxidase positive, suggestive of Pseudomonas species. The colonies were subjected to species identification by Matrix assisted laser desorption / ionization- time of flight- mass spectrometry (MALDI-TOF-MS) and were identified as Pseudomonas mossellii. When antibiotic sensitivity testing was performed by Kirby- Bauer disc diffusion method after preparing a McFarland of 10^5 microorganisms, it showed sensitivity to Amikacin, Ceftazidime, Imipenem and Piperacillin-Tazobactam. The patient was started on Ceftazidime and his symptoms were relieved within 3 days.

2.2 Case 2

A 22 year old female, suffering from Takosubo cardiomyopathy with impending heart failure, presented to the department of emergency medicine on 22nd August 2021, with chief complaints of on and off fever for two weeks which subsided with administration of oral antipyretics, productive cough and respiratory distress for 10 days and generalised edema for a week. She was managed conservatively and Bi-level positive air pressure (BIPAP) was used for respiratory distress, cause of chest pain could not be ruled out, she also presented with lower...
gastrointestinal bleed, joint pains, rashes and one unit of blood was also transfused. On examination, she had pallor, cyanosis, clubbing and prominent edema. Her pulse rate was raised ranging from 120-130 per minute and respiratory rate was raised to 32 per minute with bilateral basal crepts. A COVID-19 Real Time-Polymerase Chain Reaction (RT-PCR) was performed owing to her symptoms but turned out to be negative. All other routine blood and radiological investigations were performed and a sputum sample was sent to the bacteriology section of the department of microbiology. Microscopic examination of the sample showed plenty pus cells and few long and thin gram negative bacilli; next day oxidase positive, translucent colonies were observed on blood agar surrounded by a zone of haemolysis, suggestive of Pseudomonas species. On MALDI-TOF-MS, the colonies were identified to be those of Pseudomonas mosselli. When antibiotic sensitivity testing was performed by Kirby- Bauer disc diffusion method, the microorganism showed sensitivity to Amikacin, Cefazidime, Cefoperazone- Sulbactum, Imipenem and Piperacillin-Tazobactam. Adequate antibiotics were administered after sensitivity and her fever subsided gradually over the course of 48 hours and respiratory symptoms where alleviated in 5 days of time.

2.3 Case 3

A 37 year old male, case of advanced renal failure presented to the department of Nephrology with chief complaints of edema, hypertension and active urinary sediments for a week and was admitted to the general ward on 8th October 2021. A kidney biopsy performed on admission, diagnosed him of having rapidly progressing glomerulonephritis (RPGN) and weekly dialysis was advised. Steroids were administered as histopathology reported IgA nephropathy. His total leucocyte count was around 22,000 cells/ cubic mm, suggestive of infection. He was advised to start Oseltamivir prophylaxis as a neighboring patient tested positive for H1N1 swine flu infection during course of hospital stay. After 10 days, he developed fever, respiratory distress and dry cough; but he tested negative for H1N1 swine flu. His sputum sample was sent for bacteriological culture and microscopy. Microscopic examination of the sputum sample showed moderate pus cells and few long and thin gram negative bacilli, next day oxidase positive, translucent colonies were observed on blood agar surrounded by a zone of haemolysis, suggestive of Pseudomonas species. On MALDI-TOF-MS, the colonies were identified as Pseudomonas mosselli. On antibiotic sensitivity testing by Kirby- Bauer disc diffusion method, it was sensitive to Amikacin, Cefazidime, Cefoperazone-Sulbactum, Imipenem, meropenem and Piperacillin-Tazobactam. After clinicians had started empirical antibiotics, his fever and respiratory symptoms were alleviated in 3 days of time. On discharge, he was advised to take oral Cefuroxime Axetil 500 mg tablets, twice a day for 5 days, steam inhalation and advised follow up in outpatient department after two weeks.

3. DISCUSSION

P. mosselli can be detected in the rhizospheric soil deeming it an environmental species [7,8] and causes opportunistic infections in human. In our knowledge, only one case of P. mosselli has been reported to cause a prosthetic valve endocarditis [9]. Similarly rare Pseudomonad species from unknown natural sources act as opportunistic pathogens which mostly play a role as shuttles for acquired metallo-beta-lactamase (MBL) genes. Rarely Pseudomonad isolates like Pseudomonas mosselli are isolated from clinical samples other than Pseudomonas aeruginosa. Dabbousi et al described it as a novel species in 2002 due to low level of DNA–DNA relatedness to other Pseudomonas strains [4].

Before classifying Pseudomonas mosselli as a separate species, these strains have most likely been misidentified as Pseudomonas fluorescens; which has been reported to cause respiratory infections and has been identified in human bronchoalveolar lavage fluid (BALF), sputum specimens or throat swabs but its previously suspected role in pneumonia pathogenesis is unclear [10-13]. However, clinical characteristics and antibiotic susceptibility pattern of Pseudomonas fluorescens and P. mosselli pneumonia have rarely been reported [12]. In our case reports, the possible source of infection of the bacteria in the hospital setting could either be soil contaminated hands of the health care workers or through contaminated water supply. Among all our cases, empirical treatment had already been started by the clinician before sending the sputum samples for culture and antibiotic sensitivity testing. Among the cases discussed, case 1 was positive for SARS-COV-2, receiving steroid therapy due to severe COVID
Table 1. Cases of *Pseudomonas mosselli* isolated from respiratory samples of patients admitted to a tertiary care center in Northern India

| Case | Age /Sex | Underlying condition | Infecting organism | Culture specimen | Procalcitoni n assay | Treatment before antibiotic sensitivity testing | Outcome |
|------|----------|----------------------|--------------------|------------------|----------------------|-----------------------------------------------|---------|
| 1    | 74/M     | Type 2 Diabetes mellitus | *Pseudomonas mosselli* | Sputum          | 0.16                | Moxifloxacin and Ciprofloxacin               | Alive   |
| 2    | 22/F     | Takosubo cardiomyopathy  | *Pseudomonas mosselli* | Sputum          | 63.60               | Levofloxacin                                 | Alive   |
| 3    | 37/M     | Advanced renal failure on dialysis, Hypertension | *Pseudomonas mosselli* | Sputum          | 3.93                | Amoxicillin-clavulenic acid, Ceftriaxzone and Cotrimoxazole | Alive   |

pneumonia; type-2 diabetes mellitus, chronic kidney disease and hypertension, owing to severe immunosuppression may be a cause for succumbing to an opportunistic infection by *Pseudomonas mosselli* after two weeks of hospitalization, the patient was empirically started on moxifloxacin and levofloxacin, as mentioned in Table 1, without sending a sample for culture or referring to the antibiogram which showed susceptibility to Ceftazidime, imipenem, meropenem and amikacin, thus an inappropriate drug regimen could not contain the infection and further starting ceftazidime led to relief of symptoms. However, case 2 was a Takosubo cardiomyopathy patient with impending heart failure having a presentation similar to that of an infectious disease in a young female who developed respiratory distress with pulmonary edema and purulent cough, sputum culture revealed growth of *Pseudomonas mosselli* after four days of hospitalization. He was already started on Levofloxacin (Table 1) on admission but due to timely communication with the clinicians our case was discharged after starting ceftazidime according to antibiotic susceptibility testing and was advised for follow up after two weeks. Case 3 was a patient of rapid progressive glomerulonephritis on weekly dialysis and steroid therapy, who developed respiratory distress during the course of hospital stay, the sputum culture revealed growth of *Pseudomonas mosselli* after two weeks of hospitalization. The clinicians had started amoxicillin-clavulenic acid, ceftazidime and cotrimoxazole prophylaxis (Table 1) not waiting for antibiotic sensitivity testing which further showed susceptibility to ceftazidime, suspecting an opportunistic infection.

4. CONCLUSION

*Pseudomonas mosselli* causes opportunistic infections in immunocompromised patients. Although, the infection caused by this isolate is less virulent in comparison to *Pseudomonas aeruginosa*, it causes enough morbidity to already immunocompromised patients. The respiratory infection can thus be easily overcome by administration of appropriate antibiotic treatment followed by antibiotic susceptibility testing.

CONSENT

As per international standard or university standard, patients’ written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Holloway BW, Krishnapillai V, Morgan AF. Chromosomal genetics of Pseudomonas. Microbiol Rev. 1979;43:73-102. PMid:111024
2. Silby MW, Winstanley C, Godfrey SAC, Levy SB, Jackson RW. Pseudomonas
3. Poblete-Castro I, Becker J, Dohnt K, dos Santos VM, Wittmann C. Industrial biotechnology of Pseudomonas putida and related species. Appl Microbiol Biot. 2012;93:2279-2290. PMid:22350258
4. Dabboussi, Hamze M, Singer E, Geoffroy V, Meyer JM, Izard D, et al. Pseudomonas mosselii sp. nov., a novel species isolated from clinical specimens. Int J Syst Evol Microbiol. 2002;52(Pt 2):363–76.
5. Deora A, Hatano E, Tahara S, Hashidoko Y. Inhibitory effects of furanone metabolites of a rhizobacterium, Pseudomonas jessenii, on phytopathogenic Aphanomyces cocklioides and Pythium aphanidermatum. Plant Pathol. 2010;59:84–99.
6. Anzai; Kim H, Park JY, Wakabayashi H, Oyaizu H, et al. Phylogenetic affiliation of the pseudomonads based on 16S rRNA sequence. Int J Syst Evol Microbiol. 2000;50(4):1563–89.
7. Naik P, Raman G, Narayanan K, and Sakhivel N. Assessment of genetic and functional diversity of phosphate solubilizing fluorescent pseudomonads isolated from rhizospheric soil. BMC Microbiol. 2008;8:230.
8. Naik P, Sahoo N, Goswami D, Ayyadurai N, and Sakhivel N. Genetic and functional diversity among fluorescent pseudomonads isolated from the rhizosphere of banana. Microb. Ecol. 2008;56:492–504.
9. Mclellan E and Partridge D. Prosthetic valve endocarditis caused by Pseudomonas mosselii. J. Med. Microbiol. 2009;58:144–145.
10. Bahrani-Mougeot FK, Paster BJ, Coleman S, Barbuto S, Brennan MT, Noll J, et al. Molecular analysis of oral and respiratory bacterial species associated with ventilator-associated pneumonia. J Clin Microbiol. 2007;45(5):1588–93
11. Redding PJ, McWalter PW. Pseudomonas fluorescens cross-infection due to contaminated humidifier water. Br Med J. 1980;281(6235):275.
12. Thangkhiew I. Successful treatment with ceftazidime of a Pseudomonas fluorescens chest infection in a myasthenic patient. J Antimicrob Chemother. 1986;18(3):428–9.
13. Zervos M, Nelson M. Cefepime versus ceftriaxone for empiric treatment of hospitalized patients with community-acquired pneumonia. The Cefepime Study Group. Antimicrob Agents Chemotherapy. 1998;42(4):729–33.