antimicrobianas empíricas en infecciones producidas por este patógeno.

No podemos obviar la posibilidad de colonización de reservorios, pero tampoco podemos descartar la implicación de este microorganismo en bacteriemias descritas[5], dado que algunos patógenos desencadenantes de sepsis, pueden colonizar reservorios cutáneos (port-a-cath) y generar biofilms.

Concluimos, que la secuenciación para la identificación de microorganismos no habituales en pacientes oncológicos es importante; que su uso puede ayudar a la caracterización de especies poco conocidas en muestras humanas y que el estudio de su etiopatogenia en este tipo de infecciones, con o sin inmunodepresión es interesante, aunque no estén al alcance de todos los laboratorios de microbiología clínica.

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First cases of *Neisseria gonorrhoeae* resistant to ceftriaxone in Catalonia, Spain, May 2011

Primeros casos de Neisseria gonorrhoeae *resistente a ceftriaxona en Cataluña, España, mayo 2011*

Dear Editor,

We report the first 2 cases of *Neisseria gonorrhoeae (NG)* infection with a high minimal inhibitory concentration (MIC = 1.5 and 1 mg/L) to ceftriaxone in Catalonia, and to our knowledge in Spain, and the second in Europe.[1] Isolates were obtained from the rectum and urethra, respectively. The strain that triggered the alert came from a 21 year old man (case A) who attended the emergency department (ED) of a regional hospital on 20th April 2011 (day 15). He had received a phone call from his most recent sexual partner who had recently been diagnosed with gonococcal urethritis. On the date of arrival at the ED he was asymptomatic and the physical examination did not reveal signs of proctitis or urethritis. A rectal swab was performed and antimicrobial treatment with levofloxacin 500 mg/day for 7 days was prescribed. On 9th of May, (day 34) the microbiology laboratory reported the isolation of a strain of *NG* resistant to ceftriaxone and cefixime that was confirmed by a University Reference Laboratory. Susceptibility to penicillin, cefixime, ceftriaxone and ciprofloxacin was determined using E-test (bioMerieux) on a GC agar base supplemented by 1% defined growth supplement (Isovilalex, BD). Susceptibility to doxycycline and ciprofloxacin was tested by the disk diffusion method using the same medium. The interpretation was based on EUCAST breakpoints.[2] The MIC to penicillin was 0.094 mg/L, cefixime 1.5 mg/L and ceftriaxone 1.5 mg/L. The beta-lactamase test using the nitrocefin method (Cefinase, BD) was negative. The strain was also resistant to doxycycline and ciprofloxacin (MIC > 32 mg/L), but susceptible to azithromycin and spectinomycin. The patient was contacted on day 34, and despite being asymptomatic, based on the results of susceptibility studies, azithromycin 500 mg/day for 3 days was prescribed. On 26th of May (day 51), the patient remained asymptomatic. At that time, additional rectal and throat swabs were taken and the eradication of *NG* was confirmed. Epidemiological contact tracing information did not lead to further testing of the other three partners he had in previous three months.

Case B was the male sexual partner of case A for a period of 45 days prior to the onset of symptoms. He was seen by his general practitioner on day 4 of the onset of urethral discharge. Urethral swab and serological testing were performed and he was treated with doxycycline 100 mg, twice a day for seven days. Symptoms resolved on the second day of treatment. No additional swabs were taken. On day 13, microbiological results showed *NG* with a MIC to tetracycline 1.5 mg/L, ciprofloxacin >32 mg/L, ceftriaxone 1.5 mg/L. Testing for HIV and syphilis was negative. This patient was recalled and advised to alert his sexual partner. Apart from his current partner he had no relevant epidemiological and contact tracing information to consider.

Although there are some incongruities in the clinical development of the cases, patient B became asymptomatic despite being treated with an antibiotic for which the strain of *NG* was resistant, and although patient A was always asymptomatic, we think that the finding of in vitro resistance, together with the recent reports in the literature[3] should trigger an alert regarding the emergence of these highly resistant strains.

Some lessons from our experience can be highlighted:

Firstly, emphasis should be placed on collecting urethral, rectal and pharyngeal swabs, especially from men having sex with men even if they are asymptomatic.[4] Secondly, it is crucial to ensure that clinicians are aware of the latest guidelines on sexually transmitted diseases.[5,6] In our opinion, both patients received empirical treatment with suboptimal antimicrobial regimens. Finally, it is necessary to review the empirical ESC treatments, and the break-points of resistance by the sensitivity observed in each country.

Unfortunately, the spread of gonococcal isolates resistant to ceftriaxone in our country is probably only a matter of time, since public health alerts and extensive sampling of all anatomical sites are not systematically performed. Furthermore, the ability to identify, invite for testing and adequately treat all those potentially infected is quite difficult due to the high promiscuity of some of the infected subjects.

Therefore, as experts are already stressing[7,8] the use of AMR surveillance standards is a must to better understand the mechanisms of emergence and spread of AMR. Recent detection of treatment failures with cefixime in Europe[9,10] and the detection of a strain with high ceftriaxone MIC (2 mg/L) in Japan[11,12] which also caused treatment failure highlight the need for enhanced AMR and clinical failures surveillance.

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Aspergilosis vertebral en un paciente cirrótico: una causa infrecuente de espondilitis

Vertebral aspergillosis in a cirrhotic patient: An uncommon cause of spondylitis

Sr. Editor:

La aspergilosis es una infección característica de inmunodeprimidos como pacientes con inmunodeficiencias congénitas o adquiridas, neutropenia o trasplante, aunque de forma ocasional puede aparecer en situaciones asociadas a menor inmunodepresión como diabetes, cirrosis, alcoholismo, patologías autoinmunes o insuficiencia renal. La aspergilosis pulmonar, sinusal y diseminada son las formas clínicas más comunes, siendo la osteoarticular una forma de infección poco frecuente que suele afectar a la columna vertebral. Se presenta un caso de espondilitis lumbar por *Aspergillus fumigatus* en un paciente cirrótico y se revisan las principales características clínicas de esta entidad.

Se trata de un varón de 53 años, diagnosticado de cirrosis hepática mixta (enólica y virus C) y broncopatía crónica que ingresa por ascitis. Tres meses antes había sido ingresado por una neumonía comunitaria por microorganismo no filiado con respuesta clínica y radiológica a tratamiento antibacteriano. Tras efectuarse tomografía computarizada (TC) torácica y cateterismo cardíaco fue diagnosticado de hipertensión pulmonar de causa no determinada, siendo remitido a consulta para completar estudio de probable síndrome de apnea del sueño. El paciente refería dolor lumbar con irradiación ciática de un mes de evolución. No había presentado fiebre, paresia ni alteración de esfínteres. En la exploración destacaba la presencia de ascitis, edemas y dolor a la presión en columna lumbar, sin déficit neurológico focal ni de reflejos tendinosos. En la analítica presentaba leucocitosis ($13{,}0 \times 10^9$/l), neutrofilia (80%) y PCR elevada (22 mg/l). Se realizó una resonancia nuclear magnética de columna lumbar con gadolinio que mostró signos de espondilitis a nivel de L2-L3 y colección líquida de 2,5 cm en psoas izquierdo (fig. 1). Los hemocultivos, la serología frente a *Brucella* y el test de tuberculina fueron negativos. Se efectuó punción percutánea del absceso paravertebral siendo negativa la tinción de Gram y auramina, así como el cultivo para aerobios, anaerobios y la PCR panbacteriana y específica frente *M. tuberculosis*. En medio de Sabouraud se aisló al cuarto día un hongo filamentoso identificado como *A. fumigatus* complex. Con el fin de descartar una posible contaminación de la muestra se solicitó galactomanano sérico que fue positivo en dos determinaciones consecutivas (3,6 y 3,2 ng/ml, respectivamente). Aunque la radiografía de tórax al ingreso era normal, se efectuó una TC torácica que no mostró datos sugerentes de aspergilosis pulmonar. Se pautó tratamiento con voriconazol oral (4 mg/kg/12 horas) permaneciendo el paciente estable hasta dos semanas más tarde en que presentó de forma brusca hipoten-