Telescopng Plugged Catheter*  
An Unusual Way of Diagnosing Pasteurella multocida Pneumonia 
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We report a case of Pasteurella multocida pneumonia and its unusual clinical presentation. We also discuss the rarity of its diagnosis by TPC specimens and the delay in both an adequate diagnosis and treatment. (Chest 1991; 99:1517) 

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**Pasteurella multocida** is an unusual cause of disease in man. Well-documented pneumonias due to this organism have rarely been reported in the literature. Moreover, these types of pneumonias are even more infrequent in patients not coming into contact with animals and without underlying pulmonary disease. We report herein a case of *P multocida* pneumonia diagnosed by TPC specimens and with the above mentioned characteristics. 

**CASE REPORT** 
A 32-year-old man suffering from mental retardation was admitted to our hospital emergency room due to polytrauma. There was no history of contact or injury produced by animals. 

Physical examination disclosed a patient in coma with moderate respiratory distress and bleeding copiously through his oral cavity. He was intubated endotracheally and a great amount of blood was obtained through the endotracheal tube. A computerized axial tomographic scan of the brain revealed a left frontal intracerebral hemorrhage without cerebral edema. Shortly after, the patient was admitted to the ICU and mechanically ventilated. An initial chest roentgenogram showed bibasilar alveolar infiltrates and bilateral pneumothoraces requiring tube thoracostomy. On subsequent days, he developed fever, leukocytosis with a shift to the left, thrombocytopenia, and worsened respiratory distress. A chest x-ray examination obtained on the fourth day after admission showed diffuse patchy infiltrates throughout all lung fields (Fig 1). We considered aspiration pneumonia and obtained TPC specimens. Empiric antibiotic therapy was begun with clindamycin and amikacin. Two days later, a preliminary report from the TPC culture yielded 12,000 cfu/ml of enterococci. Accordingly, ampicillin was added to the treatment. Despite antibiotic therapy, his clinical condition deteriorated, and he developed septic shock. 

On the ninth day of hospitalization, the Microbiology Department reevaluated their initial report and informed us that a Gram-negative cocccobaicillus susceptible to penicillin G grew from the TPC culture, subsequently identified as *P multocida*. Penicillin G was given to the patient. However, his clinical status worsened and he eventually died of multiorgan failure 19 days after admission. 

**DISCUSSION** 
*Pasteurella multocida* pneumonia is quite unusual and reports of it have rarely been published in the literature. This organism has not been isolated in well-documented large series of pneumonias that used reliable diagnostic techniques in mechanically ventilated patients. 

Our patient had no history of animal contact, and his pneumonia was diagnosed by TPC specimens, something that has not, to our knowledge, been previously reported. In addition, as has also been described, the organism was initially misidentified as enterococci, and there was a delay in establishing the correct microbiologic diagnosis. Also, when we began adequate treatment, the patient was in septic shock and we were unable to modify his ultimately fatal evolution. Pasteurella multocida is an infrequent clinical finding and its diagnosis by TPC specimens is even more uncommon. Since its introduction in clinical practice, TPC technique has been used increasingly. It is not surprising that with its widespread utilization, more frequent isolation of *P multocida* from the lower respiratory tract will be reported in the near future. Finally, *P multocida* should also be considered a potential etiologic agent of serious lower respiratory tract infections in patients without underlying pulmonary disease or a history of animal exposure. 

**REFERENCES** 
1 Weber DJ, Wolson JS, Swartz MN. *Pasteurella multocida* infections: report of 34 cases and review of the literature. Medicine 1984; 63:133-54 
5 Beyt BE, Sondag J, Rooselvet TS, Bruce R. Human pulmonary pasteurellosis. JAMA 1979; 242:1647-48 