Ophthalmia neonatorum due to Branhamella (Neisseria) catarrhalis
Case reports

RONAN J P GARVEY AND THOMAS A G REED
From the Public Health Laboratory and the Department of Genitourinary Medicine, Royal Infirmary, Leicester

SUMMARY In two cases of conjunctivitis in neonates Branhamella (Neisseria) catarrhalis was identified as the causative organism. A misdiagnosis of gonococcal ophthalmia neonatorum would have been made in both cases if the diagnosis had been based on morphological grounds alone. Thus, full identification of the pathogen in cases of neonatal conjunctivitis is important to avoid the medical and social consequences of a misdiagnosis of gonorrhoea.

Introduction

Branhamella catarrhalis, usually considered a commensal of the upper respiratory tract, has been reported in association with endocarditis, septicaemia, meningitis, urethritis, sinusitis, otitis media, and lower respiratory tract infections. Only one case of neonatal conjunctivitis due to B catarrhalis has previously been reported. It has been suggested that a Gram-stained film alone is sufficient to make a diagnosis of gonococcal ophthalmia neonatorum. The two cases reported here illustrate the importance of identifying the pathogen in order to avoid the obvious medical and social consequences of a misdiagnosis of gonorrhoea.

Case report (1)

CLINICAL FEATURES
A male infant weighing 3·8 kg was born in February 1978 after a normal pregnancy and delivery. On the second day postpartum a slight discharge was present in the left eye and was treated by lavage with normal saline. On the third day the discharge had increased and a swab was taken before treatment with chloramphenicol 1% ophthalmic ointment was started. A Gram-stained film of the discharge showed profuse polymorphonuclear leucocytes (PMNL) and intracellular and extracellular Gram-negative diplococci; on the following day a Neisseria species was isolated. Intramuscular penicillin 100 000 units twice daily was given. Cervical and urethral swabs were taken from the mother and a urethral swab from the father. On the fifth day the Neisseria species was identified as B catarrhalis. The chloramphenicol eye ointment and the penicillin were continued (the latter for three days only). On the eleventh day the eye discharge had completely cleared and the baby was sent home.

MICROBIOLOGY
The Neisseria species was identified as B catarrhalis by its growth on nutrient agar at room temperature and by its failure to produce acid from 1% glucose, maltose, and sucrose. The organism was sensitive to penicillin and chloramphenicol by disc diffusion tests. Neisseriae were not isolated from the mother or father.

Case report (2)

CLINICAL FEATURES
A female infant weighing 3·5 kg was born in January 1981 after a normal delivery. The pregnancy was uneventful except for a vaginal infection with Candida albicans in the fourth month, which was successfully treated with nystatin. The puerperium was complicated by a dental abscess on the fourth day, which was treated with flucloxacillin. At birth the baby had a mild icterus and “spots” on the skin in the groin. The icterus was treated with phototherapy and the spots with flucloxacillin after a swab had been taken. On the fourth day postpartum the baby developed a discharge in the eyes, which was treated by lavage with normal saline. On the seventh day the discharge had not improved and a swab was taken before treatment with chloramphenicol 0·5%
Ophthalmia neonatorum due to Brachamella (Neisseria) catarrhalis

eyedrops was started. A Gram-stained film of the discharge showed profuse PMNL and intracellular and extracellular Gram-negative diplococci; on the following day a Neisseria species was isolated. Cervical and urethral swabs were taken from the mother. On the ninth day the Neisseria species was identified as B. catarrhalis. As the discharge from the eyes had cleared no further action was taken and the baby was sent home.

Microbiology
A Gram-stained film of the “spots” in the baby’s groin showed profuse PMNL and Gram-positive cocci. *Staphylococcus aureus* was isolated and was found to be resistant to penicillin but sensitive to flucloxacillin by disc diffusion tests. The Neisseria species was identified by its growth on nutrient agar at room temperature, by its failure to produce acid from 1% glucose, maltose, and sucrose, and by its ability to reduce nitrate. It was sensitive to penicillin and chloramphenicol by disc diffusion tests. Neisseriae were not isolated from the mother’s cervix or urethra.

Discussion
Ophthalmia neonatorum is defined as a conjunctivitis occurring in the first month of life. At one time *N. gonorrhoeae* was the commonest causative organism but is now relatively rare. Clinically, ophthalmia due to the gonococcus is not easily distinguished from that due to other organisms. The baby is usually infected during or before delivery (the latter as a complication of premature rupture of the membranes). The incubation period is about 1-3 days. The eye discharge often occurs bilaterally and at first is slight. It may be accompanied by chemosis and swelling of the eyelids. If recognised and treated promptly no complications should occur.

*B. catarrhalis* is a commensal of the upper respiratory tract and occasionally of the female genital tract. Only one case of its isolation from a neonatal conjunctivitis has been reported. It was isolated from the eye of a 3-week-old girl with unilateral conjunctivitis who had received prophylactic tetracycline ophthalmic ointment at birth. The conjunctivitis had been present for at least nine days. It responded to sulphacetamide ophthalmic solution.

In the first of our cases the membranes ruptured 1½ hours before delivery and neisseriae were not isolated from the parents’ genital tracts. This suggests that the infection may have been acquired after delivery. In the second case the membranes ruptured 9½ hours before delivery but the presence of established staphylococcal sepsis at birth suggests that the period may have been longer than this. The failure to isolate neisseriae from the mother’s genital tract may have been because flucloxacillin had been given for a dental abscess; thus, it is difficult to assess when the baby was infected.

In both these cases and in the case of Spark *et al* the *B. catarrhalis* appeared to be acting as a sole pathogen although the presence of a coexisting infectious agent, such as a *Chlamydia* species, cannot be excluded. If a diagnosis had been made on the basis of a Gram-stained film alone in these cases, an erroneous diagnosis of gonococcal ophthalmia neonatorum would have been made. Misdiagnosis of gonorrhoea has obvious medical and social consequences and these cases emphasise the importance of fully identifying the organism in suspected cases.

We wish to thank Dr J D Abbott, Public Health Laboratory, Withington Hospital, Manchester, for confirming the identity of the *B. catarrhalis* in case 2.

References
Ophthalmia neonatorum due to \textit{Branhamella (Neisseria) catarrhalis}: Case reports
Ronan J P Garvey and Thomas A G Reed

\textit{Br J Vener Dis} 1981 57: 346-347
doi: 10.1136/sti.57.5.346

Updated information and services can be found at:
http://sti.bmj.com/content/57/5/346

\textit{These include:}

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/