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Case 25-2014: A Man with Ulcerative Colitis and Bloody Diarrhea

TO THE EDITOR: The Case Record contributed by Hohmann et al. (Aug. 14 issue),1 regarding a man with ulcerative colitis in whom bloody diarrhea developed soon after fecal microbiota transplantation (FMT), highlights the difficulty in distinguishing cytomegalovirus (CMV) as a direct cause of disease from its being an “innocent bystander” in patients with CMV infection and active ulcerative colitis. However, the authors also reported an apparent case of diarrheal disease caused by Blastocystis hominis transmitted by means of FMT without describing the complex debate as to whether this organism is a true enteropathogen.

In developed countries, blastocystis is detectable in more than 50% of healthy persons with the use of polymerase-chain-reaction–based assays.2 No difference in the prevalence of blastocystis exists between hosts with gastrointestinal symptoms and those without such symptoms,3 and symptoms that are attributed to blastocystis infection may not improve even after the elimination of the organism.4 The organism has been shown to be capable of both long-term colonization2 and spontaneous disappearance without intervention.4,5 Physicians offering FMT should carefully monitor FMT recipients for infectious complications but must be aware that presence is not the same as causation.

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THE DISCUSSANT REPLIES: We understand the controversy surrounding B. hominis (an anaerobic protozoan), and the case referenced in the discussion, reported by a Canadian physician, highlights it nicely. The patient had recurrent Clostridium difficile infection, and the spousal donor, who had no gastrointestinal symptoms, had stool that tested positive for B. hominis (no other donor was readily available). The FMT cured the C. difficile infection, but intermittent loose stools lasting months subsequently developed, with positive tests for blastocystis. A course of nitazoxanide cured the symptoms.

At a recent American Gastroenterological Association conference on FMT, physicians noted that blastocystis was a common finding in donor stool specimens (e.g., in 6 of 38 specimens that were screened in an Australian study).1 The consensus of practitioners was that it would not be advisable to use such specimens for FMT. Attendees did not mention other cases of transmission of infectious agents by FMT. Representatives of the Food and Drug Administration highlighted the possibility of transmission of currently unknown infectious agents and the need for judicious use and careful follow-up of recipients of FMT.
Catheterization of the Urethra in Girls

TO THE EDITOR: As Manzano et al. noted in their Video in Clinical Medicine (July 10 issue), it is sometimes difficult for the examiner to identify the urethral meatus when attempting to perform catheterization of the urinary bladder in girls. In such instances, it may be helpful to draw the labial tissue upward by moving the nondominant hand anteriorly after spreading the labia majora with two fingers.

If the meatus remains hard to visualize, we suggest enlisting an assistant for the following maneuver, which we term “labial lift.” Both the examiner and the assistant should gently grasp one of the labia majora — the examiner on the side of her nondominant hand and the assistant opposite. Together, they lift the labia anteriorly, laterally, and caudad (Fig. 1). As shown in the figure, using the corner of a small piece of sterile gauze helps to maintain a comfortable hold on the labia, which may become slippery after sterile preparation. We have found that this technique seldom fails to allow the necessary visualization of the meatus.

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THE AUTHORS REPLY: This is a very nice alternative to the use of downward traction to the cephalad fold of the vaginal introitus downward.