

deep extension of the inflammatory infiltrate and those in whom the condition occurs as part of an outbreak. We believe the data in our report support the role of *P. aeruginosa* as the etiologic agent in the lesions in our patients.

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### Glanders in a Military Research Microbiologist

*To the Editor:* The case report by Srinivasan et al. (July 26 issue)<sup>1</sup> makes one wonder when glanders was first suspected as this patient's illness. The patient's work history included potential exposure to *Burkholderia mallei* without personal protective equipment (gloves). Yet the patient was treated twice with agents not indicated for *B. mallei* infection. Once the organism was isolated, appropriate therapy was administered. When did the patient describe his occupational exposure?

For researchers with occupational infections, the taking of a relevant occupational history that leads to prompt, appropriate therapy can be lifesaving.<sup>2</sup> A delay in history taking and delayed specific therapy can result in prolonged illness or death.<sup>3</sup>

Greater attention to safety precautions by researchers and vigilance by research managers will prevent many of these types of exposure. The importance of the occupational history is well documented.<sup>4</sup> Could a support system be available that would rapidly provide information regarding occupational exposure to clinicians caring for ill researchers? Some research institutions actively encourage patients to volunteer occupational information to the physician,<sup>5</sup> but this will not help if the patient does not know about the exposure or is incapacitated. We need to find or develop systems to ensure that physicians receive the necessary information during the initial evaluation.

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The authors reply:

*To the Editor:* The cornerstone of any diagnosis is an accurate, complete medical history. In the case of our patient with glanders, it is interesting to note that all the health care providers involved were aware of the occupational exposure to *B. mallei*, and yet the connection between the patient's job and his illness was not made until he became critically ill. This case underscores the importance of coupling information about exposure with knowledge of the clinical expression of disease. Before this report, glanders had not been reported for more than 50 years, making a low index of suspicion and even a lack of familiarity among primary care physicians completely understandable. We hope that our report will serve as a useful reminder of the manifestations of this unusual disease.

What other lessons can be learned? We agree that researchers should pay close attention to biosafety precautions and that their managers must oversee their adherence to protocols. Researchers should also be aware of the signs and symptoms of the diseases that they study and take responsibility for notifying their health care providers about their exposure. When patients are too ill to do so, this information could come from medical alert tags (like those worn by some patients with diabetes mellitus) or from patients' supervisors or next of kin. In the case we reported, the patient's supervisor provided us with information about exposure and even detailed antimicrobial-sensitivity data at the time of hospital admission.

A final lesson from this case is the importance of reliable clinical information regarding the unfamiliar infections that may arise from biologic warfare. Access to information on the organisms most likely to be used, their transmissibility, the range of potential clinical manifestations, and the most effective treatments is essential to ensure that the medical response is commensurate with the threat to the patient, health care workers, and the community. As concern about bioterrorism grows, we endorse strongly the ongoing efforts to educate physicians about these infections and to formulate plans for responding to such attacks.

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### Sepsis in a Newborn Due to *Pseudomonas aeruginosa* from a Contaminated Tub Bath

*To the Editor:* Vochem et al. (Aug. 2 issue)<sup>1</sup> describe a neonate with disseminated *Pseudomonas aeruginosa* infection that was associated with a contaminated tub bath. Of concern is the description of ampicillin, cefotaxime, and gentamicin as "antipseudomonal chemotherapy" and their use after the isolation of *P. aeruginosa* from the patient's blood and cerebrospinal fluid.

Although this regimen may not have influenced the outcome in this case, neither ampicillin nor cefotaxime has substantial activity against *P. aeruginosa*. Gentamicin is char-