type (ST) 354. Isolates PET01 and PET05, identified from cats, belonged to ST93 and a new ST strain, respectively. Isolates EC08 and EC09, from the patients who shared the same hospital room with the pet shop worker, were ST156 (Table). Results of pulsed-field gel electrophoresis were consistent with multilocus sequence typing results and showed that isolates consisted of 5 types (types I to V; online Technical Appendix, http://wwwnc.cdc.gov/EID/article/22/9/16-0464-Techapp1.pdf). Isolate EC07 was clonally related to 4 *E. coli* strains from dogs, according criteria described by Tenover et al. (*10*), suggesting possible transmission of *mcr-1*–harboring *E. coli* between dogs and the patient. Colistin resistance was successfully transferred to *E. coli* C600 through conjugation in all isolates, suggesting that *mcr-1* was located on transferable plasmids.

These findings suggest that *mcr-1*–producing *E. coli* can colonize companion animals and be transferred between companion animals and humans. The findings also suggest that, in addition to food animals and humans, companion animals can serve as a reservoir of colistin-resistant *E. coli*, adding another layer of complexity to the rapidly evolving epidemiology of plasmid-mediated colistin resistance in the community.

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Acetobacter indonesiensis Bacteremia in Child with Metachromatic Leukodystrophy

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To the Editor: *Acetobacter indonesiensis*, first described in 2000 (*1*), belongs to the group of acetic acid bacteria (AAB), which includes the genera *Acetobacter*, *Gluconobacter*, *Asaia*, *Granulibacter*, and others in the family *Acetobacteriaceae*. AAB are of great industrial interest for use in vinegar fermentation processes because they oxidize alcohols or sugars incompletely, which leads

to acetic acid accumulation (*2*). AAB are widespread in nature and can be isolated from various sources, including vinegar, alcoholic beverages, tropical fruits, and flowers (*1,2*). AAB have rarely been associated with human disease. We describe a case of *A. indonesiensis* bacteremia in a child in Germany.

A 9-year-old girl with late-infantile metachromatic leukodystrophy was admitted to Marienhospital Herne, Herne, Germany, on February 9, 2015, for elective fundoplication. Because of her advanced neurologic disability, she required extensive nursing care and had several invasive medical devices, including a port catheter (detailed patient data in online Technical Appendix, http://wwwnc.cdc.gov/EID/article/22/9/16-0566-Techapp1.pdf). Soon after her admission, fever developed, and C-reactive protein levels increased (online Technical Appendix Table 1). Physical examination and further diagnostic investigations (e.g., chest radiograph) revealed no focus of infection. Because she had experienced recurrent pneumonia and candidemia (the latter led to port catheter exchange 1 month previously), antimicrobial drug treatment with piperacillin/tazobactam and caspofungin was administered.

One blood culture, drawn from the port catheter on day 3 of the hospital stay, yielded slowly growing multidrug-resistant bacteria (agar diffusion indicated zones of inhibition only for imipenem, meropenem, fosfomycin, and tigecycline). By partial sequencing of the 16S rRNA gene, we identified the isolate as *A. indonesiensis*. Details of microbiological analyses, colony morphologic features, 16S rDNA-based phylogenetic analysis, and antimicrobial drug susceptibility testing results are given in the online Technical Appendix.

Because the patient clinically responded to piperacillin/tazobactam and caspofungin treatment, therapy was continued for 15 days, although piperacillin/tazobactam showed no in vitro activity against the *A. indonesiensis* isolate. Despite the patient's improved condition, 1 control blood culture drawn from the port on hospital day 10, while she was receiving antimicrobial treatment, yielded *A. indonesiensis*, although another blood culture drawn peripherally on hospital day 14 yielded no growth. Port catheter exchange was advised but was not performed, according to the parents' wishes.

The first report of human infection with AAB can be traced to 2004, when peritonitis, associated with *Asaia bogorensis*, was reported in a peritoneal dialysis patient (*3*). Further reports include a description of *Granulibacter bethesdensis* as a cause of lymphadenitis in patients with chronic granulomatous disease (*4*), isolation of *Gluconobacter* spp. from a culture of blood from an intravenous drug user and of *Gluconobacter* spp. and *Asaia* spp. from sputum samples of cystic fibrosis patients (*5*), a case of *A. bogorensis* bacteremia in an intravenous drug user (*6*), and central venous catheter–associated cases of *Asaia lannaensis* bacteremia in a child with cancer who had received a bone marrow transplant (*7*) and in children who had idiopathic dilated cardiomyopathy (*8*).

Regarding *Acetobacter* spp., only 2 reports on human infection have been published: *A. cibinongensis* bacteremia in a patient receiving chronic hemodialysis with signs of an infected arteriovenous fistula and suspected intravenous drug abuse (*9*) and *A. indonesiensis* pneumonia in a cystic fibrosis patient who was receiving immunosuppressive treatment because of a recent lung transplant (*10*). Similar to the case we report, species identification in those cases was achieved only with the help of sequencing methods in both cases. In the *A. indonesiensis* pneumonia case, results of antimicrobial drug susceptibility testing found that the bacteria showed multidrug resistance, as in the case we report, but susceptibility to aminoglycosides.

Of note, the aforementioned AAB infections all occurred in chronically ill patients or intravenous drug users. Similarly, children with metachromatic leukodystrophy are prone to healthcare- and device-associated infections involving opportunistic pathogens, and frequent use of broad-spectrum antibiotics may predispose the children for infection with multidrug-resistant bacteria. In the case we report, frequent accessing of the port, including for parenteral nutrition, may have further promoted microbial colonization.

Because a focus of infection was not apparent and because *A. indonesiensis* grew in 2 blood cultures independently drawn from the port but not in the blood culture obtained from peripheral venipuncture, we assume the patient's port catheter harbored the infectious agent. The fact that several previously reported AAB infections were catheter-associated may further support our suspicion. However, we could not confirm this assumption because the port was not removed and cultured.

The patient clinically responded to piperacillin/tazobactam and caspofungin treatment, despite a lack of in vitro activity against the *A. indonesiensis* isolate. Although this response might be explained by the presence of a second pathogen (which was not cultured but covered by the given antimicrobial agents), the control blood culture drawn from the port still yielded *A. indonesiensis* and at least argues for persistent colonization of the port. Because of pathogen persistence in blood culture and limited therapeutic options owing to the multidrug-resistance of the isolate, we believe the port should have been removed in this case.

Informed consent was obtained from the patient's parents for publication of this case report.

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Autochthonous Chikungunya Fever in Traveler Returning to Japan from Cuba

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To the Editor: Chikungunya fever is a febrile illness caused by mosquito-transmitted chikungunya virus (CHIKV; genus *Alphavirus*, family *Togaviridae*). Clinical signs and symptoms typically begin with high-grade fever after an incubation period of 2–4 days (*1*). Other common symptoms include polyarthralgia, which is usually symmetric and involves multiple and distal joints, and skin involvement manifesting as a macular or maculopapular rash (*2*). Peripheral lymphadenopathy (most often cervical) and conjunctivitis might also occur (*3*).

Since late 2013, several outbreaks of illness caused by CHIKV have occurred in the Americas, including South America, the Caribbean, and the United States, which are outside this virus's former distribution area (*3*). Although autochthonous transmission of chikungunya fever has been reported in most Caribbean islands, only imported cases have been previously reported in Cuba (*4*). As increased numbers of US tourists visit Cuba after improved diplomatic relations in July 2015, reports of chikungunya fever cases in Cuba are of interest for travelers and healthcare providers. We describe a case of autochthonous chikungunya fever in a man who had traveled from Japan to Cuba.

In late February 2016, a previously healthy 27-year-old man visited a travel clinic in the National Center for Global Health and Medicine (Tokyo, Japan) with fever and rash. In mid-February, he had traveled to Havana and Santiago de Cuba in Cuba by way of Toronto, Ontario, Canada, for 11 days of sightseeing. He used no insect repellent during the trip and was unaware of any mosquito bites. When he sought care, he reported a high-grade fever (39°C) for 24 hours and several symptoms since the day of his return: retro-orbital pain, malaise, congested conjunctivas, and a