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***Corynebacterium striatum* Bacteremia: Contamination or a Missed Cause of Infective Endocarditis? A Case Series and Proposed Clinical Algorithm**

Corynebacterium striatum Bakteriye misisi: Kontaminasyon mu, Yoksa İnfektif Endokarditin Gözden Kaçan Bir Nedeni mi? Olgu Serisi ve Klinik Algoritma Önerisi

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Abstract

Corynebacterium striatum is often regarded as a contaminant, potentially delaying the diagnosis of infective endocarditis (IE). We evaluated the clinical characteristics of IE associated with *Corynebacterium striatum* bacteremia, highlighted diagnostic challenges, and proposed a diagnostic algorithm. Five patients with *Corynebacterium striatum* bacteremia who fulfilled the 2023 Duke-ISCVID criteria for IE were retrospectively analyzed. Clinical, echocardiographic, microbiological, treatment, and outcome data were reviewed. Native valve involvement predominated, and persistent bacteremia was the most consistent finding. Vegetations mainly involved the aortic and mitral valves. In one patient, the initial interpretation of *Corynebacterium striatum* as a contaminant delayed the diagnosis of IE. Severe complications were common, and three of the five patients died. Persistent or recurrent *Corynebacterium striatum* bacteremia should not be dismissed as contamination, particularly in patients with compatible clinical findings. Early echocardiographic evaluation should be considered when IE is suspected. We propose a diagnostic algorithm integrating microbiological and clinical findings to support the timely diagnosis of IE.

Keywords: *Corynebacterium striatum*, infective endocarditis, bacteremia

Öz

Corynebacterium striatum, klinik uygulamada sıklıkla kontaminant olarak değerlendirilen bir mikroorganizmadır ve bu durum infektif endokardit (İE) tanısında gecikmeye yol açabilmektedir. Bu çalışmada, *Corynebacterium striatum* bakteriye misisine bağlı İE olgularının klinik özelliklerini değerlendirmeyi, tanısal güçlükleri ortaya koymayı ve pratik bir tanısal algoritma önermeyi amaçladık. 2023 Duke-ISCVID kriterlerini karşılayan beş *Corynebacterium striatum* bakteriye misisi olgusu retrospektif olarak değerlendirildi. Klinik, ekokardiyografik, mikrobiyolojik, tedavi ve sonuç verileri analiz edildi. Natif kapak tutulumu baskındı ve persistan bakteriye misisi en belirgin ortak bulguydu. Vejetasyonlar en sık aort ve mitral kapakta saptandı. Bir olguda *Corynebacterium striatum* üremesinin başlangıçta kontaminasyon olarak değerlendirilmesi İE tanısında gecikmeye yol açtı. Ciddi komplikasyonlar sık görüldü ve beş hastanın üçü yaşamını kaybetti. Persistan veya tekrarlayan *Corynebacterium striatum* bakteriye misisi, özellikle klinik olarak uyumlu olgularda kontaminasyon olarak değerlendirilmemelidir. İE şüphesi bulunan hastalarda erken ekokardiyografik değerlendirme önem taşımaktadır. Bulgularımız doğrultusunda, mikrobiyolojik ve klinik bulguları bütünleştiren pratik bir tanısal algoritma öneriyoruz.

Anahtar Kelimeler: *Corynebacterium striatum*, infektif endokardit, bakteriye misisi



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Introduction

Corynebacterium striatum is a Gram-positive bacillus that is part of the normal flora of human skin and nasal mucosa^[1]. When isolated from clinical specimens, it is often regarded as a contaminant and may be overlooked without further investigation. However, recent studies have demonstrated that this microorganism can cause bacteremia and various invasive infections^[2,3].

Corynebacterium striatum is known to exhibit nosocomial transmission, particularly in intensive care units, in association with prolonged hospitalization, invasive procedures, and broad-spectrum antibiotic use^[4-6]. In addition, *Corynebacterium striatum* has been reported to cause invasive infections, including bacteremia, catheter-related infections, and infective endocarditis (IE)^[2,3,8].

IE is an infection of the endocardial surface of the heart and is diagnosed according to the modified Duke criteria. In the updated Duke-ISCVID criteria published in 2023, *Corynebacterium striatum* is recognized as a typical microorganism in the presence of intracardiac prosthetic material, further emphasizing its clinical significance in IE^[7].

In this context, we aimed to highlight the clinical significance of *Corynebacterium striatum* bacteremia, which is frequently considered as contamination, through five cases illustrating the diagnostic challenges associated with IE. The cases were retrospectively identified from our institutional records. In all patients, *Corynebacterium striatum* was isolated from at least one blood culture set, and species identification was routinely performed using matrix-assisted laser desorption/ionization time-of-flight mass spectrometry as part of the standard microbiology laboratory workflow.

Case Report

Case 1

A 75-year-old woman with a history of hypertension and atrial fibrillation presented to the emergency department with severe abdominal pain. Imaging revealed a thrombus occluding the lumen of the superior mesenteric artery, and she underwent emergency surgery for mesenteric ischemia. On postoperative day 5, while being monitored in the intensive care unit, she developed fever (38.1°C), dyspnea, and desaturation, requiring intubation. With preliminary diagnoses of nosocomial pneumonia and intra-abdominal sepsis, antimicrobial therapy was changed to meropenem, teicoplanin, and fluconazole. Peripheral blood, catheter blood, and tracheal aspirate cultures were obtained.

On the day antimicrobial therapy was initiated and again 3 days later, two sets of peripheral blood cultures and catheter blood cultures were obtained while the patient was receiving teicoplanin and meropenem. These cultures grew *Corynebacterium striatum*, indicating persistent bacteremia despite glycopeptide therapy.

Because of the persistent bacteremia, transthoracic echocardiography (TTE) was performed because IE was suspected. The ejection fraction (EF) was 60%, and moderate-to-severe aortic and mitral regurgitation with suspected mitral valve vegetation was observed. Transesophageal echocardiography (TEE) subsequently demonstrated a thrombus in the left atrial appendage, a 3 × 3 mm vegetation on the non-coronary cusp of the aortic valve, an 8 × 5 mm mobile vegetation on the posterior leaflet of the mitral valve, and a 5 × 4 mm vegetation in the left ventricular outflow tract.

Based on *Corynebacterium striatum* bacteremia, left-sided vegetations, fever, valvular insufficiency, and arterial embolic event, the patient was diagnosed with definite IE according to the modified 2023 Duke-ISCVID criteria. Antimicrobial therapy was revised to vancomycin, and cardiovascular surgery consultation was planned. However, the patient died of cardiac arrest on day 4 of vancomycin therapy.

Case 2

A 72-year-old man with chronic obstructive pulmonary disease (COPD) and a history of mechanical mitral valve replacement 13 years earlier was hospitalized because of melena. Initial evaluation showed atrial fibrillation on electrocardiography and a functioning prosthetic mitral valve with an EF of 55% on TTE.

On the second day of hospitalization, he developed fever (38.2°C) and dyspnea. He was admitted to the intensive care unit with a preliminary diagnosis of pneumosepsis, and meropenem therapy was initiated. Two sets of blood cultures obtained during the febrile episode grew *Corynebacterium striatum*. Given the coexistence of prosthetic valve material and bacteremia, IE was considered more likely than contamination. TEE demonstrated a 6 × 8 mm vegetation on the mechanical mitral valve without obstruction, and the patient was diagnosed with prosthetic valve endocarditis. Vancomycin and rifampin were added to the treatment regimen. Although clinical stabilization was achieved, the patient refused further treatment and was discharged at his own request.

Case 3

A 39-year-old man with no known chronic disease presented with approximately 1 month of fever, night sweats, and fatigue. On physical examination, his temperature was 39°C

and his heart rate was 110/min. Because no obvious infectious focus was identified and chest tomography revealed a 5-cm pleural effusion, TTE was performed for further evaluation. It showed an EF of 60%, severe aortic regurgitation, and a 13 × 11 mm mobile vegetation on the aortic valve. With a preliminary diagnosis of IE, three sets of blood cultures were obtained, and empirical therapy with gentamicin and ampicillin-sulbactam was initiated.

All blood cultures grew *Corynebacterium striatum*, and the patient, who also had a positive rheumatoid factor, was diagnosed with definite IE. The aggressive course, characterized by a large vegetation and severe valvular destruction in an immunocompetent patient, was particularly notable.

Because of severe aortic regurgitation and the large vegetation, the patient underwent a Bentall procedure with mechanical aortic valve replacement. Perioperative valve cultures and follow-up blood cultures showed no growth. Given his stable postoperative course, parenteral gentamicin was completed for 2 weeks and ampicillin-sulbactam for 4 weeks. The patient was discharged in good condition with an additional 2-week course of oral amoxicillin-clavulanate.

Case 4

A 60-year-old man with hypertension, type 2 diabetes mellitus, and a history of cerebrovascular disease was admitted to the intensive care unit after cardiopulmonary arrest. On the third day of hospitalization, increased secretions and elevated acute-phase reactants were observed. Because chest tomography showed findings suggestive of aspiration, piperacillin-tazobactam was initiated for presumed aspiration pneumonia and continued for 7 days.

Ten days after completing therapy, the patient developed fever, elevated inflammatory markers, tonic-clonic seizures, and subsequently respiratory arrest. Empirical meropenem therapy was initiated. Because blood and tracheal aspirate cultures did not yield a pathogen and clinical stabilization was achieved, meropenem was discontinued on day 14. However, after treatment discontinuation, inflammatory markers increased again, and blood cultures grew *Corynebacterium striatum*, prompting the initiation of vancomycin. All catheters were exchanged; however, blood cultures obtained on days 4 and 6 of vancomycin therapy remained positive for *Corynebacterium striatum*. Persistent bacteremia despite glycopeptide therapy suggested an underlying intravascular focus.

TTE was therefore performed and demonstrated an approximately 20 × 12 mm vegetation on the mitral valve. These findings were considered compatible with possible IE. Notably, the diagnosis of IE was considered only after bacteremia persisted despite treatment. Although advanced

diagnostic workup and surgical evaluation were planned, the patient died 4 days after TTE.

Case 5

An 82-year-old man with hypertension, COPD, and a grade 1 meningioma in the left parietal lobe had previously presented to another center with severe headache. Cranial computed tomography revealed a cerebral hemorrhage, and computed tomography angiography demonstrated an arteriovenous fistula. He was admitted to the neurosurgery department and underwent surgery for a carotid-cavernous arteriovenous fistula. The patient was intubated and monitored in the neurosurgical intensive care unit for 3 days and was discharged after a total hospital stay of 6 days.

Retrospective review of the investigations from this first hospitalization showed that one set of blood cultures had grown *Corynebacterium striatum*. However, TTE at that time showed no findings suggestive of IE, and the growth was interpreted as contamination because it was present in only one set and the patient's neurosurgical condition was considered the dominant clinical problem. Consequently, no further evaluation for IE was performed, and the patient was discharged.

Eight days after discharge, he was readmitted with a 2-day history of fever, palpitations, cough, sputum production, and wheezing. Chest tomography showed an active infiltrate in the right upper lobe, and he was hospitalized in the infectious diseases department with a preliminary diagnosis of aspiration pneumonia. Given the recent hospitalization and the previous blood culture positivity for *Corynebacterium striatum*, the earlier result was reconsidered as potentially clinically significant rather than as simple contamination. Empirical vancomycin and meropenem therapy was initiated, and two sets of blood cultures and sputum cultures were obtained.

When two sets of blood cultures again grew *Corynebacterium striatum*, the bacteremia was considered clinically significant, and further evaluation for IE was planned. TEE demonstrated severe mitral regurgitation, rupture of the chordae tendineae, and mild aortic regurgitation. Funduscopic examination showed no Roth spots, and the rheumatoid factor was negative. Because of recurrent *Corynebacterium striatum* bacteremia and rupture of the chordae tendineae, the patient was considered to have possible IE, and vancomycin therapy was continued for 6 weeks. Meropenem therapy was completed for 2 weeks for pneumonia, and the patient was subsequently discharged.

Approximately 1 month later, he presented again with fever, fatigue, redness of the left leg, and general deterioration. Doppler ultrasonography of the left lower extremity showed findings consistent with thrombophlebitis. Follow-up TTE

demonstrated severe mitral regurgitation, rupture of the chordae tendineae, and a 7 × 7 mm mass prolapsing into the left ventricle. Three new sets of blood cultures grew *Corynebacterium striatum* that was resistant to penicillin G but susceptible to vancomycin, teicoplanin, and linezolid. Cranial magnetic resonance imaging revealed findings compatible with new cardioembolic subacute cortical infarctions. Repeat TEE showed severe mitral regurgitation and rupture of the posterior chordae tendineae.

Based on persistent/recurrent *Corynebacterium striatum* bacteremia, valvular pathology, and embolic complications, the patient was diagnosed with IE. Cardiovascular surgery recommended surgical intervention, but the patient declined the procedure. An additional 6-week course of vancomycin therapy was planned. During follow-up, he developed intraventricular hemorrhage and intracranial shift, underwent neurosurgical intervention, and died during the postoperative period.

This case represents an important missed diagnostic opportunity because the *Corynebacterium striatum* growth identified during the first hospitalization was initially interpreted as contamination.

The clinical and microbiological characteristics of the cases are summarized in Table 1. The 2023 Duke-ISCVID classification, the major and minor diagnostic criteria fulfilled by each patient, and the key clinical implications derived from each case are presented in Table 2.

Discussion

Although *Corynebacterium striatum* has long been regarded as a contaminant in clinical specimens, it has increasingly been recognized as a cause of invasive infections in recent years^[2,9]. Its increasing frequency, particularly in bacteremia and device-related infections, suggests that the clinical significance of this organism should be reconsidered.

In the literature, IE caused by *Corynebacterium* species has been reported predominantly in older patients and in association with prosthetic valves^[8]. In contrast, only one patient in our series had a prosthetic valve, whereas the majority had native valve involvement. This finding suggests that *Corynebacterium striatum* should not be considered exclusively a prosthetic valve pathogen. Recent case reports also support the occurrence of native valve IE^[10,11] in patients without predisposing structural heart disease.

A comparison of our findings with those of previously published studies is presented in Table 3^[8-11,14].

As shown in Table 3, most previously reported cases involved prosthetic valves or isolated cases of native valve IE with

Table 1. Clinical and Microbiological Characteristics of Patients with *Corynebacterium striatum* IE.

Case	Age/sex	Comorbidities	Valve type	Valve involved	Vegetation size, mm	Persistent/recurrent bacteremia	Echocardiographic findings	Treatment	Complications	Outcome
1	75/F	HT, AF, mesenteric ischemia	Native	Aortic + mitral	3 x 3 (aortic), 8 x 5 (mitral), 5x4 (LVOT)	Yes	TTE/TEE: multiple vegetations, LAA thrombus	Vancomycin	Arterial embolic events, cardiac arrest	Death
2	72/M	COPD, prosthetic MV	Prosthetic	Mitral	6 x 8	No	TEE: vegetation on mechanical MV	Vancomycin + rifampin	None	Discharged
3	39/M	None	Native	Aortic	13 x 11	No	TTE: large mobile vegetation, severe aortic regurgitation	Ampicillin-sulbactam + gentamicin → Bentall procedure with mechanical aortic valve replacement	Severe aortic regurgitation	Recovered
4	60/M	HT, type 2 DM, cerebrovascular disease	Native	Mitral	20 x 12	Yes	TTE: large vegetation	Vancomycin	Sepsis	Death
5	82/M	HT, COPD, grade 1 meningioma	Native	Mitral	7 x 7	Yes	TTE/TEE: severe MR, rupture of the chordae tendineae, and a mass prolapsing into the left ventricle	Vancomycin	Cardioembolic cerebral infarctions, intraventricular hemorrhage	Death

AF, atrial fibrillation; COPD, chronic obstructive pulmonary disease; DM, diabetes mellitus; HT, hypertension; IE, infective endocarditis; LAA, left atrial appendage; LVOT, left ventricular outflow tract; MV, mitral valve; TEE, transesophageal echocardiography; TTE, transthoracic echocardiography; F, female; M, male.

Table 2. 2023 Duke–ISCVID classification and clinical implications of the five patients.

Case	2023 Duke–ISCVID classification	Major criteria fulfilled	Minor criteria fulfilled	Clinical implication
1	Definite IE	Positive blood cultures for <i>Corynebacterium striatum</i> ; echocardiographic evidence of vegetations	Fever; predisposing condition (moderate-to-severe aortic and mitral regurgitation); vascular phenomenon (mesenteric arterial embolism)	Persistent bacteremia despite appropriate antimicrobial therapy should prompt immediate evaluation for IE.
2	Definite IE	Positive blood cultures for <i>Corynebacterium striatum</i> ; prosthetic mitral valve vegetation	Fever; predisposing condition (prosthetic valve)	<i>Corynebacterium striatum</i> bacteremia in patients with prosthetic valves should be considered highly suggestive of IE rather than contamination.
3	Definite IE	Positive blood cultures for <i>Corynebacterium striatum</i> ; aortic valve vegetation	Fever; predisposing condition (severe aortic regurgitation); immunologic phenomenon (positive rheumatoid factor)	Native valve IE may occur even in immunocompetent patients and may follow an aggressive clinical course.
4	Definite IE*	Persistent positive blood cultures for <i>Corynebacterium striatum</i> ; mitral valve vegetation	Fever	Persistent bacteremia despite glycopeptide therapy strongly suggests an uncontrolled endovascular focus and warrants prompt echocardiographic assessment.
5	Definite IE	Recurrent positive blood cultures for <i>Corynebacterium striatum</i> ; echocardiographic evidence of valvular destruction (rupture of the posterior chordae tendineae with severe mitral regurgitation)	Predisposing condition (severe mitral regurgitation); vascular phenomenon (cardioembolic cerebral infarctions)	A single positive blood culture should not automatically be dismissed as contamination in patients with compatible clinical findings; recurrent bacteremia warrants reassessment for IE.

*Case 4 was classified as definite IE according to the 2023 Duke–ISCVID criteria based on persistent positive blood cultures, echocardiographic evidence of vegetation, and compatible clinical findings. IE, infective endocarditis.

Table 3. Comparison of *Corynebacterium striatum* IE with published reports.

Study	Number of cases	Valve type	Persistent bacteremia	Affected valve	Complications	Mortality
Bläckberg et al. ^[8]	30	Mostly prosthetic	Frequent	Mitral and aortic	Embolic events and heart failure	Moderate to high
Dilmen et al. ^[9]	1	Native	Present	Mitral	Valve destruction	None
Usuda et al. ^[10]	1	Native	Absent	Aortic	None	None
Biscarini et al. ^[11]	1	Native	Absent	Mitral	None	None
Marull and Casares ^[14]	1	Prosthetic	Present	Mitral	Sepsis	Present
Present study	5	Mostly native	Frequent (persistent/recurrent)	Mitral + aortic	Embolic events, valvular damage, neurological complications	High (3/5)

IE, infective endocarditis.

relatively favorable outcomes. In contrast, our series was distinguished by a predominance of native valve involvement, frequent persistent or recurrent bacteremia, and a markedly higher rate of severe complications and mortality. These findings suggest that *Corynebacterium striatum* may cause a more aggressive form of disease than previously appreciated.

One of the most striking findings of our study was the diagnostic difficulty encountered during the clinical course. In one patient,

Corynebacterium striatum isolated from a single blood culture set was initially interpreted as contamination, leading to a delay in diagnosis. However, subsequent recurrent bacteremia, valvular pathology, and embolic complications demonstrated that this initial interpretation was incorrect. These findings emphasize that even a single positive blood culture should not be automatically dismissed as contamination, particularly in patients with compatible clinical findings.

The clinical significance of *Corynebacterium striatum* should be reconsidered, especially in the presence of persistent or recurrent bacteremia. In our series, persistent bacteremia was observed in multiple patients despite appropriate antimicrobial therapy, suggesting an underlying intravascular focus. This finding highlights the need for further investigation, including echocardiographic evaluation. To facilitate clinical decision-making, we developed a practical, stepwise diagnostic and management algorithm that integrates clinical and microbiological findings and provides a structured framework for distinguishing contamination from true infection and supporting the early diagnosis of IE (Figure 1).

This flowchart summarizes a stepwise clinical approach incorporating the evaluation of the clinical context, the

number and persistence of positive blood cultures, and patient-related risk factors. Persistent or recurrent bacteremia or multiple positive blood cultures should prompt further investigation, including echocardiographic evaluation for IE. Early recognition and appropriate management may reduce complications and improve clinical outcomes.

The algorithm integrates key clinical variables, including the number and persistence of positive blood cultures, the presence of intravascular devices, and patient-specific risk factors. It emphasizes that even a single positive blood culture should not be automatically dismissed as contamination, particularly in patients with compatible clinical findings. Furthermore, it highlights the importance of early echocardiographic evaluation in cases of suspected deep-seated infection, particularly IE.

Nosocomial transmission represents another important issue, particularly among critically ill patients^[4-6,12]. In our series, bacteremia developed in patients with prolonged hospitalization and a history of invasive procedures, supporting the role of *Corynebacterium striatum* as a nosocomial pathogen.

Antimicrobial resistance also poses a major challenge in the management of *Corynebacterium striatum* infections. Previous studies have reported resistance to multiple antimicrobial classes, including beta-lactams and quinolones^[2,8,15,16]. In our series, glycopeptides were the most commonly used agents, highlighting their importance in the treatment of severe infections.

The high mortality observed in our study is noteworthy. A considerable proportion of patients developed severe complications, including embolic events, valvular destruction, and clinical deterioration. The prognosis appeared to be worse in cases with delayed diagnosis and persistent bacteremia. These findings indicate that *Corynebacterium striatum* is not a benign organism and may lead to serious outcomes when not recognized and managed appropriately.

The main limitations of this study include its retrospective design, incomplete antimicrobial susceptibility data in some cases, and the relatively small sample size. Nevertheless, given the rarity of *Corynebacterium striatum* IE, such case series can provide valuable clinical insights.

Although *Corynebacterium striatum* is frequently considered a contaminant in clinical practice, our findings demonstrate that it may represent a clinically significant and potentially fatal cause of IE.

The predominance of native valve involvement, frequent persistent or recurrent bacteremia, and high mortality observed in our series underscore the need for increased

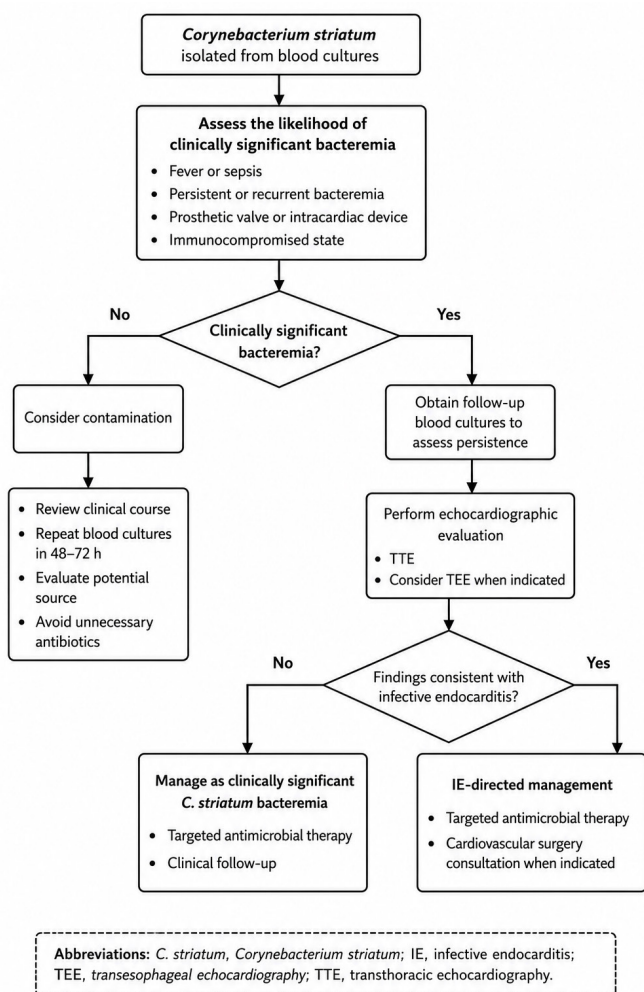


Figure 1. Proposed diagnostic and management algorithm for *Corynebacterium striatum* bacteremia. The algorithm provides a stepwise approach that integrates the clinical context, blood culture patterns, and bacteremia persistence to distinguish contamination from true infection and guide the evaluation for IE and appropriate management.

clinical awareness. Misclassification as contamination may lead to delayed diagnosis and worse clinical outcomes.

Clinicians should maintain a high index of suspicion when *Corynebacterium striatum* is isolated from blood cultures, particularly in the presence of persistent or recurrent bacteremia or repeated positive blood cultures. Early echocardiographic evaluation should be strongly considered to facilitate the timely diagnosis of IE and appropriate management.

Ethics

Informed Consent: Because of the retrospective design of the study and the anonymization of patient data, the requirement for informed consent was waived.

Footnotes

Authorship Contributions

Concept: D.K.Ö., H.T., Design: D.K.Ö., H.T., Data Collection or Processing: D.K.Ö., H.T., Analysis or Interpretation: D.K.Ö., Literature Search: D.K.Ö., Writing: D.K.Ö.

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References

1. Bernard K. The genus *Corynebacterium* and other medically relevant coryneform-like bacteria. *J Clin Microbiol*. 2012;50:3152-3158.
2. Silva-Santana G, Silva CMF, Olivella JGB, Silva IF, Fernandes LMO, Sued-Karam BR, Santos CS, Souza C, Mattos-Guaraldi AL. Worldwide survey of *Corynebacterium striatum* increasingly associated with human invasive infections, nosocomial outbreak, and antimicrobial multidrug-resistance, 1976-2020. *Arch Microbiol*. 2021;203:1863-1880.
3. Chen FL, Hsueh PR, Teng SO, Ou TY, Lee WS. *Corynebacterium striatum* bacteremia associated with central venous catheter infection. *J Microbiol Immunol Infect*. 2012;45:255-258.
4. Lee PP, Ferguson DA Jr, Sarubbi FA. *Corynebacterium striatum*: an underappreciated community and nosocomial pathogen. *J Infect*. 2005;50:338-43.
5. Leonard RB, Nowowiejski DJ, Warren JJ, Finn DJ, Coyle MB. Molecular evidence of person-to-person transmission of a pigmented strain of *Corynebacterium striatum* in intensive care units. *J Clin Microbiol*. 1994;32:164-169.
6. Wang X, Zhou H, Chen D, Du P, Lan R, Qiu X, Hou X, Liu Z, Sun L, Xu S, Ji X, Li H, Li D, Zhang J, Zeng H, Li Z. Whole-genome sequencing reveals a prolonged and persistent intrahospital transmission of *Corynebacterium striatum*, an emerging multidrug-resistant pathogen. *J Clin Microbiol*. 2019;57(7):e00683-19.
7. Fowler VG, Durack DT, Selton-Suty C, Athan E, Bayer AS, Chamis AL, Dahl A, DiBernardo L, Durante-Mangoni E, Duval X, Fortes CQ, Fosbøl E, Hannan MM, Hasse B, Hoen B, Karchmer AW, Mestres CA, Petti CA, Pizzi MN, Preston SD, Roque A, Vandenesch F, van der Meer JTM, van der Vaart TW, Miro JM. The 2023 Duke-International Society for Cardiovascular Infectious Diseases Criteria for Infective Endocarditis: Updating the Modified Duke Criteria. *Clin Infect Dis*. 2023;77:518-526.
8. Bläckberg A, Falk L, Oldberg K, Olaison L, Rasmussen M. Infective endocarditis due to *Corynebacterium* species: clinical features and antibiotic resistance. *Open Forum Infect Dis*. 2021;8:ofab055.
9. Dilmén S, Kilic S, Torun A. A rare case of aggressive infective endocarditis due to *Corynebacterium striatum*. *Cureus*. 2023;15:e44903.
10. Usuda D, Kojima Y, Ono R, Kaneoka Y, Kato M, Sugawara Y, Shimizu R, Inami T, Nakajima E, Tsuge S, Sakurai R, Kawai K, Matsubara S, Tanaka R, Suzuki M, Shimozaawa S, Hotchi Y, Osugi I, Katou R, Ito S, Mishima K, Kondo A, Mizuno K, Takami H, Komatsu T, Nomura T, Sugita M. Native valve endocarditis caused by *Corynebacterium striatum* without underlying structural heart disease or indwelling cardiovascular medical devices: a case report. *BMC Infect Dis*. 2024;24:939.
11. Biscarini S, Colaneri M, Mariani B, Pieri TC, Bruno R, Seminari E. A case of *Corynebacterium striatum* endocarditis successfully treated with an early switch to oral antimicrobial therapy. *Infez Med*. 2021;29:138-144.
12. Orosz L, Söki J, Kókai D, Burián K. *Corynebacterium striatum*-Got Worse by a Pandemic? *Pathogens*. 2022;11(6):685.
13. Oliva A, Belvisi V, Iannetta M, Andreoni C, Mascellino MT, Lichtner M, Vullo V, Mastroianni CM. Pacemaker lead endocarditis due to multidrug-resistant *Corynebacterium striatum* detected with sonication of the device. *J Clin Microbiol*. 2010;48:4669-4671.
14. Marull J, Casares PA. Nosocomial valve endocarditis due to *Corynebacterium striatum*: a case report. *Cases J*. 2008;1:388.
15. Soriano F, Zapardiel J, Nieto E. Antimicrobial susceptibilities of *Corynebacterium* species and other non-spore-forming gram-positive bacilli to 18 antimicrobial agents. *Antimicrob Agents Chemother*. 1995;39:208-14.
16. Goldner NK, Bulow C, Cho K, Wallace M, Hsu FF, Patti GJ, Burnham CA, Schlesinger P, Dantas G. Mechanism of high-level daptomycin resistance in *Corynebacterium str*