

**Epidemiology** The organisms discussed in this chapter most often inhabit environmental niches (eg, water soil) (Table 20–1), Species of *Acinetobacter* were initially recovered in patient specimens from humid climates, but by the late 1970s, they began to emerge as nosocomial pathogens in more temperate climates, and clinical infections with *Acinetobacter* seem to be higher in the summer months compared with other seasons. It is likely that the humid conditions are more favorable for growth. *Stenotrophomonas maltophilia* is ubiquitous in nature and is closely related to the genus *Pseudomonas*. It was first isolated from a human in 1943 and has undergone several taxonomic updates throughout the years before finally being given its own genus. Both organisms are capable of survival on inanimate objects for extended periods (weeks to months), and this makes them problematic in health care settings, where they frequently colonize the patient environment and health care equipment. In addition to inanimate objects, species of *Acinetobacter* have been reported from the general population and have been identified from a number of human sources, including sputum, urine, feces, and vaginal secretions. Both *Acinetobacter* spp. and *S. maltophilia* can contaminate potable or chlorinated water. Although none of these organisms are considered normal human microbiota, the relatively high prevalence of *Acinetobacter* spp. and *S. maltophilia* in hospitals frequently results in colonization of the respiratory tract of patients. The prevalence of these organisms is evidenced by the fact that, excluding the *Enterobacteriaceae* and *Pseudomonas aeruginosa*, *Acinetobacter* spp. and *S. maltophilia* are the third and fourth most common gram-negative bacilli, respectively, encountered in clinical specimens.