Reply

SIR — We thank Dr. Zunich and colleagues for their kind comments about our review. We agree that there is a relative paucity of experience with anti-rhesus D (Rh,D) immunoglobulin; while the preliminary results with this agent for treatment of patients with HIV-related thrombocytopenia are promising, further experience is required. Some of the data of Zunick et al., as well as U. S. Food and Drug Administration (FDA) approval of anti-Rh(D), were not available at the time that our article was accepted and published. WinRho SD is now an FDA-approved drug that is readily available to the practicing clinician.

Aaron E. Glatt and Ajay Anand
Division of Infectious Diseases, Department of Medicine, Catholic Medical Center of Brooklyn and Queens, Jamaica, New York; and Division of Hematology and Oncology, New England Deaconess Hospital, Harvard Medical School, Boston, Massachusetts

Cerebral Lesions in Two Patients with AIDS: The Possible Role of Mycobacterium kansasii

SIR — We read with interest the article by Witzig and colleagues [1], which represents an exhaustive retrospective analysis of the clinical presentations and prognosis of disease caused by Mycobacterium kansasii in HIV-1-infected patients. The patients included in this analysis were from three hospitals in New Orleans, where >8% of patients with AIDS are expected to have M. kansasii isolated and >3% are expected to develop disseminated disease due to M. kansasii.

Witzig et al. mention only a single case of M. kansasii infection in Italy [2], which may lead to a false impression regarding the real incidence of M. kansasii infection in Italy. Furthermore, these authors described some patients with confusion and seizures without commenting on possible CNS involvement. We describe two HIV-infected women with cerebral lesions who repeatedly had M. kansasii isolated from sites other than the CNS.

Patient 1. A 24-year-old woman with a history of drug abuse who was receiving prophylaxis for a previous episode of Pneumocystis carinii pneumonia and for cytomegalovirus retinitis was admitted to our institution for evaluation of fever, night sweats, and cough. Although she had pulmonary symptoms, findings on a chest roentgenogram were normal. During hospitalization, the patient developed ingressive headaches that were associated with photophobia, diminution of memory, and lethargy. MRI of the brain showed multiple abscesses, one of which was in the right pallidum and had a necrotic center. The CSF parameters were normal, and cultures of sputum, urine, blood, and CSF were negative for bacteria, parasites, and fungi. Twenty days later, three serial sputum samples yielded M. kansasii, and antymycobacterial therapy with isoniazid, rifampin, and ethambutol was started. However, shortly after therapy was initiated the patient became comatose and died.

Patient 2. A 30-year-old woman with a history of visceral leishmaniasis was hospitalized because of persistent fever and a productive cough. A chest roentgenogram revealed multiple pulmonary infiltrates and cavities in the left upper lobe. Because she developed seizures and lost consciousness, a CT scan of the brain was obtained; the scan showed a single lesion in the right frontal lobe with associated mass effect. The CSF parameters were normal except for a mildly decreased glucose concentration. Direct examination of four sputum samples and sedimented urine revealed acid-fast bacilli; these organisms were identified as M. kansasii in culture. Therapy with rifampin, isoniazid, ethambutol, and streptomycin was begun, resulting in relief of the symptoms. Five weeks later, a chest roentgenogram showed resolution of the pulmonary lesions, and a repeated CT scan of the brain demonstrated diminution of the cerebral lesion.

These case reports are noteworthy for two reasons. First, the M. kansasii isolates from our two patients accounted for 11.7% of the nontuberculous mycobacteria and non-Mycobacterium avium complex isolates from our patients with AIDS; this percentage is far higher than that (2.9%) reported for similar patients [3]. Second, to our knowledge, a brain abscess due to M. kansasii in a patient with AIDS has been reported only once [4], and a culture of CSF that was positive for M. kansasii was reported for only one additional patient [5]. Cultures of CSF were negative for M. kansasii for both of our patients. However, there was no doubt that the second patient had involvement of CNS as part of disseminated disease caused by M. kansasii because her condition improved following administration of antymycobacterial therapy. Although we could not define the etiology of the cerebral lesions in the first patient, we suspect that M. kansasii played a role.

These findings suggest that M. kansasii, in addition to other documented pathogens, should be considered a possible agent of cerebral mass lesions in patients with AIDS. We therefore stress the need for more-extensive application of efficacious diagnostic procedures in these patients.

Laura Monno, Sergio Carbonara, Danila Costa, Amelia Appice, Marco Rollo, Silvia Coppola, and Gioacchino Angaran
Clinic of Infectious Diseases and Institute of Hygiene, University of Bari, Bari, Italy
References


Dapsone Therapy for Thrombocytopenia in Patients Infected with Human Immunodeficiency Virus

Sir—Glatt and Anand [1] conclude that dapsone therapy for thrombocytopenia in patients infected with HIV remains experimental because the results of our preliminary study [2] reflected the expected range of spontaneous resolution. We agree that our patients were at a relatively early stage of HIV infection, but most of them had chronic thrombocytopenia, and none had had a sustained response to treatment with colchicine, danatrol, intravenous immune globulin (IVIG), or anti-rhesus D (Rh[D]) immunoglobulin [2]. Thrombocytopenia recurred in all patients when therapy with dapsone was discontinued, and their platelet counts increased when therapy was restarted. Moreover, other trials have confirmed the beneficial effect of dapsone in patients with chronic idiopathic autoimmune thrombocytopenic purpura [3, 4]. On the basis of our experience, we believe that dapsone therapy may be useful in some cases of thrombocytopenia in HIV-infected patients.

Glatt and Anand propose that patients with symptomatic HIV-associated thrombocytopenia be treated with IVIG, without distinction between anti-Rh(D) and high-dose IVIG. Although these authors mention that the use of IVIG is hampered by its high cost and the need for hospitalization, they do not mention that anti-Rh(D) cannot be administered to Rh-negative patients. These patients will respond only to treatment with anti-c or with Rh-positive ABO-compatible erythrocytes sensitized in vitro with low-dose anti-Rh(D) [5, 6].

In a previous report, we compared the effectiveness of transfusing intravenous gamma globulin and Rh antibodies into Rh-positive patients and found that both treatments were well tolerated [7]. Our data did not indicate that one form of therapy was well tolerated to the other. Nevertheless, individual responses may be quite different and may not be predicted on the basis of the effectiveness of either therapy alone. We conclude that each of these treatments can be used after failure of the other.

J. M. Durand, P. Lefevre, E. Cretel, G. Kaplanski, and J. Soubeyrand

Department of Internal Medicine, Centre Hospitalier Universitaire Sainte-Marguerite, Marseille, France

References


