Tuberculosis and Human T-Cell Lymphotropic Virus
Type 1 Infection

SIR—In a recent review of the infectious complications of human T-cell lymphotropic virus type I (HTLV-1) infection, Marsh [1] suggested that those individuals infected with HTLV-1 may be at increased risk of tuberculosis. This risk may be due to reduced delayed-type hypersensitivity to PPD in asymptomatic patients infected with HTLV-1. Up to 14% of the population in Papua New Guinea are infected with HTLV-1 [2] and this Melanesian virus is genetically distinct from HTLV-1 isolated elsewhere [3].

Tuberculosis is the commonest reason for hospital admissions of adults in Papua New Guinea, and the national incidence of active disease is estimated to be 0.9 per 1,000 population per annum [4]. Tuberculosis complicates symptomatic HIV infection in 69% of patients in Papua New Guinea (author's unpublished data), but as yet, rates of HIV infections are low among patients receiving treatment at tuberculosis clinics.

Despite these findings, investigators who recently studied a heterogeneous population in Papua New Guinea with use of a particle agglutination test [5] failed to detect any patients with HTLV-1 infection among 102 HIV-negative patients with laboratory-proven tuberculosis (86 cases of pulmonary infection and 16 cases of extrapulmonary infection). Although the possibility of an association between tuberculosis and HTLV-1 infection is compelling, it is not yet clinically obvious in Papua New Guinea, where both infections are endemic.

Other established clinical associations with HTLV-1 infection in Papua New Guinea remain elusive. The relatively short life expectancy of Papua New Guinea residents coupled with the long latent period of disease related to HTLV-1 that has been reported elsewhere may make such associations—in particular an association with tuberculosis, which is primarily a disease of children and young to middle-aged adults—difficult to identify. Detection of HTLV-1-related disease in Papua New Guinea may be improved if specific ethnic groups with high seroprevalence rates, such as the highland fringe—dwellers Hagahai [2], are targeted.

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References

Penicillium marneffei Infection Associated with AIDS

SIR—In Duong’s review of Penicillium marneffei infection [1], he stated that the first case of penicilliosis marneffei associated with HIV infection was reported in the United States in 1988 [2]. In fact, two other cases that were not referred to in Duong’s review but that were indexed in MEDLINE were reported in 1988 in France [3] and England [4].

The French case was diagnosed in a 30-year-old homosexual male 9 months after he traveled to Indonesia and Southeast Asia. The patient developed fever associated with pulmonary infiltrates and pleural and pericardial effusion. P. marneffei was cultured from blood, pleural fluid, and bronchoalveolar lavage specimens, and the fungus was identified after it was inoculated into golden hamsters by the Mycology Reference Laboratory at the Pasteur Institute. When we submitted this case to prominent medical journals, we were informed that reporting isolated cases of opportunistic fungi in patients with AIDS was not of interest. Nine years later, P. marneffei definitely appears to be an important “emerging systemic mycosis in AIDS patients traveling or living in southeast Asia” [5].

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References