In summary, studies have demonstrated that *P. carinii* may not have been sufficiently considered for patients whose common feature is immunosuppression due to a variety of reasons, including therapy for malignancy and organ transplantation. Although the prevalence of PCP among HIV-1–positive individuals has received more attention, it is clear that heightened awareness of the possibility of PCP in any significantly immunosuppressed patient would be prudent. Without question, further research will be essential to provide more in-depth fundamental information about the nature of this intriguing opportunist.

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**References**

3. Herezi GP, Caceres E, Atkins JT, Reuben J, Doyl JM. *Pneumocystis carinii* pneumonia in infants who were exposed to human immunodeficiency virus but were not infected: an exception to the AIDS surveillance case definition. Clin Infect Dis 1997; 25:739–40.

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**Correcting the Historical Record: Diagnosis and Management of Group A Streptococcal Pharyngitis**

SIR—In their guidelines for diagnosis and management of group A streptococcal infections [1], Bisno et al. err in stating that the only antibiotic therapy actually examined in controlled studies and shown to prevent rheumatic fever is penicillin. Chlortetracycline [2] and oxytetracycline [3] were evaluated in clinical trials of sufficient size to determine their effectiveness in preventing rheumatic fever. A significant reduction in the number of cases of rheumatic fever was demonstrated with chlortetracycline treatment, while the reduction with oxytetracycline treatment was borderline ($P = .07$).

Perhaps the authors meant to say that of currently recommended antibiotics, penicillin is the only one that has been evaluated in clinical trials. The criterion for choosing other antibiotics is a high rate of eradication of the infecting organism. My colleagues and I observed in our paper on chlortetracycline that eradication of the infecting organism is necessary to prevent subsequent episodes of rheumatic fever.

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**References**


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**Reply**

SIR—Houser’s critique is well taken. We erred in not mentioning the tetracycline data [1]. As he correctly surmised, however, our guideline was directed toward currently recommended therapy for acute streptococcal pharyngitis. As Houser et al. pointed out in their 1953 report [2], penicillin was more effective than aureomycin in eradicating streptococci, decreasing antistreptolysin formation, and preventing rheumatic fever. Moreover, ~10% of group A streptococci in the United States are currently resistant to tetracycline [3], while these organisms remain uniformly susceptible to penicillin. Then, as now, penicillin remains the therapy of choice for streptococcal pharyngitis.

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