Forty-seven percent of patients had previously received zidovudine treatment before stavudine therapy was initiated. These patients had a mean MCV of 103.9 fL (range, 81.3–118.8 fL) at initiation of therapy and a statistically insignificant mean increase in MCV of 2.2 fL (range, 10.3–20.2 fL; \( P = .11 \)) at least 3 months after stavudine was substituted.

Stavudine was used in conjunction with lamivudine therapy for 79 (87%) of the patients. Of 12 patients taking stavudine without lamivudine therapy, 10 (83%) had an MCV of \( > 95.0 \) fL and five (42%) had an MCV of \( > 100.0 \) fL. Lamivudine monotherapy (as used in phase 2/3 trials) is uncommonly associated with macrocytosis (only at doses at least twice as high as those currently administered).

Macrocystosis induced by zidovudine is often associated with anemia. Anemia has not typically been associated with stavudine therapy. In our patients, there was actually a small, but statistically significant, increase in hemoglobin levels with stavudine therapy. This increase was accentuated in patients whose treatment was switched from zidovudine who had an initial hemoglobin concentration of \(< 12 \) g/dL. The mean baseline hemoglobin level for all 91 patients was 13.4 g/dL (range, 8.4–17.2 g/dL), and the mean hemoglobin level after at least 3 months of stavudine treatment was 14.2 g/dL (range, 10.1–17.1 g/dL; \( P < .05 \)). For those patients for whom stavudine was substituted for zidovudine treatment, the mean baseline hemoglobin level was 12.9 g/dL (range, 5.5–17.2 g/dL), and the mean hemoglobin concentration after at least 3 months of therapy was 14.1 g/dL (range, 11.7–17.1 g/dL; \( P < .05 \)).

As treatment of HIV infection has evolved, more complex regimens with five or more drugs in combination are being used. There have been limited clinical trials of many of the drugs before widespread use, and toxicities are discovered only after significant use outside of these trials. Unexplained macrocytosis in an HIV-infected patient receiving combination therapy may lead to an extensive workup for bone marrow or gastrointestinal disease. Alternately, macrocytosis may be attributed to a new agent as a yet undescribed toxic effect. Fortunately, macrocytosis associated with stavudine, at the currently recommended doses, is not associated with anemia.

We conclude that the finding of isolated macrocytosis, without anemia, in a patient being treated with stavudine may be due primarily to stavudine itself and may not warrant further evaluation.

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References
follow-up in September 1998, she remained symptomatic, although the lesions became less extensive.

Co-trimoxazole and dapsone are commonly used as first-line treatment of actinomycetoma, but antimicrobial resistance is a potential problem as several investigators have shown that resistance varies markedly with the species of aerobic actinomycete involved [3–5]. In the Sudan, Gumaa et al. [6] reported 15 cases of craniofacial mycetoma, including eight due to *S. somaliensis* (of which only two responded favorably to dapsone and streptomycin). In a report by Welsh et al. [7], remissions occurred in seven patients with mycetoma due to *Nocardia brasiliensis* who were treated with amikacin alone (one patient) or amikacin combined with co-trimoxazole (six patients). Amikacin and imipenem should be considered as salvage therapy for mycetoma due to *S. somaliensis* resistant to co-trimoxazole clinically and in vitro.

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References