CORRESPONDENCE

Successful Resolution of Progressive Multifocal Leukoencephalopathy after Combination Therapy with Cidofovir and Cytosine Arabinoside

Str.—We read the interesting article by Blick et al. [1]. We challenge the conclusions made by the authors.

Blick et al. point out that improvement in their patient’s condition was not related to antiretroviral therapy because progressive multifocal leukoencephalopathy (PML) developed 3 months after this treatment was applied. Certainly some opportunistic infections, such as cytomegalovirus retinitis, can develop soon after antiretroviral therapy is started [2]. However, this particular therapy can prevent the development or relapse of cytomegalovirus retinitis [3]. Therefore, the diagnosis of opportunistic infections in the early weeks of antiretroviral treatment does not necessarily mean this treatment will fail in the long term. The immune system needs more time to reconstitute itself [4], and the effect of antiretroviral therapy on opportunistic infections might be observed only after improvement of immune status.

Some investigators [4] observed improvement in the outcome of PML after antiretroviral therapy. We also observed extended survival in 2 patients who received this treatment (2 and 4 years of follow-up) and were previously diagnosed with PML by cerebral biopsy. The effect of cytosine arabinoside (ara-C) on PML has not yet been proved to be favorable [5]. However, Blick et al. suggest that ara-C and cidofovir, not antiretroviral therapy, caused improvement in their patient’s condition. We believe that this conclusion is unfounded. Perhaps they should have suggested that the combination of ara-C, cidofovir, and antiretroviral therapy had a favorable effect.

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References

Practice Guidelines for Evaluating New Fever in Critically Ill Adult Patients

Str.—In the excellent article [1] recently published in Clinical Infectious Diseases, O’Grady et al. comment on numerous noninfectious causes of fever, including 2 types of hyperthermia, malignant hyperthermia and neuroleptic malignant syndrome. However, they fail to point out that hyperthermia is a common finding in intensive care unit patients who do not have either of these 2 distinct conditions. Patients may be unable to control their temperature because of a variety of central and peripheral mechanisms [2]. In this era of increasing antimicrobial resistance, attention to this entity might allow less use of antibiotics for patients with “hyperthermia” and not “fever,” who simply need to have heat dissipation increased by simple measures.

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References

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Clinical Infectious Diseases 2000;30:234 © 2000 by the Infectious Diseases Society of America. All rights reserved. 1058-4838/2000/3001-0055$03.00

Amoxicillin versus Sparfloxacin in the Treatment of Presumed Pneumococcal Pneumonia

Str.—I believe that the conclusions reached by Aubier et al. [1] in a recent trial comparing amoxicillin with sparfloxacin for the treatment of presumed pneumococcal pneumonia were flawed, as was their presentation of safety results.

Equivalent therapeutic outcomes were achieved with both regimens. This result, rather than favoring sparfloxacin, argues that the added spectrum of activity of sparfloxacin, although possibly important for certain nonpneumococcal pathogens in