months, 4 patients with CFS who were receiving iv placebo had a mean symptom score of 0.5. When assessed 6 months after initiation of treatment with iv ganciclovir, the entire cohort of 11 patients who had CFS had a mean symptom score of 0.38. At month 12 of the study, the mean cumulative symptom score was 0.28, and at month 18, the mean symptom score was 0.19.

This study is preliminary; however, either the protocol or a modification of the protocol may be helpful in a suitably sized, randomized, double-blinded, placebo-controlled trial of the use of antiviral therapy for patients with CFS [8].

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Fascioliasis in Antalya

Sir—We read with interest the Brief Report by Mannstadt et al. [1] that describes triclabendazole therapy in the management of biliary obstruction due to Fasciola hepatica infection. The patient’s history of travel to our region, Antalya, in Turkey, attracted our attention most. As you know, in travel medicine it is important to know the diseases to which the traveler might be exposed during his journey. We live and work in Antalya and want to share our experience with fascioliasis.

Fascioliasis is endemic in Antalya, and in 1998 we saw 2 cases with which we had the same difficulties in diagnosis and treatment that were described by Mannstadt et al. [1]. A 58-year-old man and his 27-year-old son who had been investigated for malignancies were referred to our clinic because of fatigue, anorexia, and right-upper-quadrant pain. Laboratory tests revealed the following for both patients: eosinophilia, high levels of acute-phase reactants, hepatic parenchymal heterogeneity and nonshadowing particles in the gallbladder visible on an ultrasonogram, and multiple hypodense structures within the liver visible on a CT scan. Because the 2 patients were members of the same family and had similar symptoms at the same time, our attention was directed to the possibility of infectious disease—particularly parasitic infections, because of the finding of eosinophilia. However, several microscopic examinations of stool samples revealed no ova or parasites. Although serological testing was not available at our university, the diagnosis of fascioliasis was made on the basis of microscopic examination of an aspirate obtained by means of ultrasonogram-guided gallbladder aspiration [2]. For treatment, Novartis Pharma AG provided the nonregistered compound triclabendazole. We then contacted the Department of Parasitology at Ege University in Izmir, Turkey, and sent them serum samples from the 2 patients. Results of serological tests for F. hepatica showed positive antibody titers.

We have since gained more experience with F. hepatica infection, and recently we have diagnosed 32 cases of fascioliasis on the basis of either the findings of radiology and serological tests or examination of stool samples. These patients’ signs and symptoms have recently been reported [3]. Because fascioliasis is endemic in Antalya, we have planned a seroepidemiologic study to determine its prevalence.

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References

Isolation of Leclercia adecarboxylata from an Infant with Acute Lymphoblastic Leukemia

Str—Although Leclercia adecarboxylata was initially described in 1962 [1], reports of clinically significant infections involving this motile, gram-negative bacillus are uncommon. In the world’s literature, 8 cases have been reported in which L. adecarboxylata was isolated from infected patients [2, 3]. In 4 of these cases, L. adecarboxylata was isolated from the blood of patients with an underlying medical condition (2 patients with hepatic cirrhosis, 1 child who was receiving long-term total parenteral nutrition, and 1 adult with neutropenia who had received a bone marrow transplant). In the other 4 cases, L. adecarboxylata was isolated from patients with mixed microbial infection (from lower extremity wound infections in 3 patients and from the sputum of 1 patient with adult Still’s disease and pneumonia), which raises questions regarding the organism’s role in these infections. We write to report another case involving an infant with acute lymphoblastic leukemia (ALL).

In September 2000, we admitted to the hospital an 11-month-old girl with ALL and a chief complaint of chills and fever (temperature, 38.6°C). Her medical history was notable for a diagnosis of ALL at 4 months of age and multiple episodes of bacteremia during periods of neutropenia. The findings of a physical examination were significant for oropharyngeal mucositis, severe diaper dermatitis, and a small anal fissure. A complete blood count revealed 10.3 × 10^11 WBCs/mm^3 (84% neutrophils, 5% band forms, and 11% lymphocytes). On the basis of antimicrobial sensitivities known from the patient’s previous episodes of bacteremia, she was treated empirically with iv gentamicin and ciprofloxacin. Cultures of 2 blood samples obtained within 24 h of admission and prior to treatment yielded Staphylococcus aureus and L. adecarboxylata. The State of California Microbial Disease Laboratory confirmed the identity of L. adecarboxylata by means of biochemical testing. The organism was susceptible to all antimicrobial agents tested, including amikacin, ampicillin, cefazolin, cefepime, cefotaxime, ceftriaxone, cephalexin, ciprofloxacin, gentamicin, piperacillin, tobramycin, and trimethoprim-sulfamethoxazole. The fever, chills, and bacteremia resolved within 24 h, and on day 5 after admission to the hospital, the patient was discharged home to complete a 10-day course of iv gentamicin and cefazolin.

Previous reports have suggested that L. adecarboxylata infection in otherwise healthy adults is found primarily as one component of a polymicrobial wound infection. Infection with L. adecarboxylata alone, as determined by the results of blood cultures, has been found only in patients whose immune defenses are compromised by an underlying medical condition. Although our patient did not have neutropenia, she was immunocompromised as a result of cancer chemotherapy and interrupted physical barriers (mucositis, diaper dermatitis, and anal fissure). Testing of antimicrobial agents demonstrated pansensitivity. However, as in 4 of the 8 previous cases, the clinical significance of L. adecarboxylata in our patient’s infection remains unclear because it was isolated together with Staphylococcus aureus. The reporting of additional cases of L. adecarboxylata infections could help clinicians develop a better understanding of the pathogenic potential of this organism.

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