In October 2001, the HIV RNA load and the CD4+ lymphocyte count were 72 copies/mL and 353 cells/mm3, respectively, but the TC and TG levels were 384 and 1882 mg/dL, respectively. Only efavirenz treatment was then stopped (although no other modification of treatment or diet was introduced), resulting in a rapid decrease in TC and TG levels (to 185 and 297 mg/dL, respectively) 8 weeks after discontinuation of efavirenz. The HIV RNA load (<50 copies/mL) and the CD4+ lymphocyte count (391 cells/mm3) had not changed considerably.

Our patient was not receiving any other medication that could have increased his plasma lipid levels, and all samples were realized in fasting conditions. The chronologic events of our patient’s case promote a role for efavirenz in the development of the patient’s severe dyslipidemia. This type of plasma lipid profile previously has been described in patients treated with a protease inhibitor, although, in an evaluation of once-daily combination therapy with emtricitabine, didanosine, and efavirenz, Molina et al. [6] noted that few patients had a moderate increase in their TG level while they were receiving a regimen that contained efavirenz. Doser et al. [7] noted that a substantial proportion of patients remained hypercholesterolemic after their therapy was switched from a regimen that contained a protease inhibitor to treatment with efavirenz. Therefore, we think that the impact of efavirenz on the lipid plasma profile would be better assessed in large cohorts or trials to determine whether the plasma lipid levels of patients treated with efavirenz should be monitored as closely as in those of patients treated with a protease inhibitor.

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References

Eosinophilic Meningitis Due to Angiostrongylus cantonensis

Sr—Vincent Lo Re III and Stephen J. Gluckman have been economical with the facts in their description of a woman with eosinophilic meningitis due to infestation with Angiostrongylus cantonensis [1]. Contrary to the impression given by their report, the correct diagnosis of this condition was made while the woman was hospitalized at Auckland Hospital (Auckland, New Zealand), and it was subsequently sent to one of the authors of the report after the patient had been discharged from the hospital.

As a matter of record, the results reported by Lo Re and Gluckman regarding...
evaluation of CSF samples are inaccurate. Laboratory evaluation of the initial CSF sample revealed no eosinophils (not 3% eosinophils, as reported), and the diagnosis was made clinically, despite this finding. The second lumbar puncture showed 6% eosinophils (not 16% eosinophils, as reported) and was performed both in expectation of eosinophilia developing and in an attempt to help relieve the patient’s headache.

Because a large number of people who arrive in Auckland are either migrants from the Pacific Islands or travelers returning from holidays spent in the Pacific Islands, where the disease is endemic, we are very familiar with eosinophilic meningitis due to *A. cantonensis*, and we see several cases per year. Indeed, 1 of the series of cases mentioned by Lo Re and Gluckman was evaluated and reported by our neurological colleagues at Auckland Hospital [2]. We do not, in general, find diagnosis of eosinophilic meningitis due to *A. cantonensis* to be “a major challenge,” because the condition has a characteristic clinical symptomatology with an appropriate epidemiological history (even without the presence of CSF or peripheral blood eosinophilia, as initially was the case for the woman described by Lo Re and Gluckman [1]) and is familiar to those of us in the fields of infectious diseases and neurology in this part of the world. Having said all that, we acknowledge that the ultimate proof of diagnosis was achieved by the Bangkok group mentioned in the article by Lo Re and Gluckman [1].

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References


### Prolonged Candidemia in Patients with Cancer

Sir—We observed 4 cases of recurrent candidemia in patients with neoplastic disease who had central venous catheters. These cases were especially instructive because they were assessed both by antifungal susceptibility studies and by genotyping analysis performed using a randomly amplified polymorphic DNA (RAPD) technique described elsewhere [1, 2].

Case patient 1 was a 47-year-old woman with a myelodysplastic syndrome who was neutropenic after receiving chemotherapy and who had 3 blood cultures that were positive for *Candida glabrata* (1 isolate was recovered on day 0 [the day that the first blood culture positive for *Candida* was performed], and 2 isolates were recovered on day 9) (table 1). Both susceptibility testing and RAPD analysis revealed that the isolate recovered from peripheral blood on day 0 was different from the isolates recovered from central venous catheter blood and peripheral blood on day 9 (figure 1). On day 22, a different urine isolate was identified by susceptibility testing and RAPD analysis. The patient died on day 23.

For case patient 2, the 3 *Candida parapsilosis* isolates recovered on day 0 and day 17 were found to be identical by use of both susceptibility testing and RAPD analysis; however, on day 30, a fourth isolate was identified as *Candida dubliniensis* (as confirmed by molecular analysis of the species-specific internal transcribed spacer region 2). An isolate recovered from the central venous catheter site after catheter removal was identical to the *C. parapsilosis* isolate recovered previously [3]. The patient survived.

Two other patients with elevated peripheral blood leukocyte counts had multiple positive culture results. One patient had 4 blood cultures positive for *C. albicans* from day 0 to day 12, and another patient had 4 blood cultures positive for *Candida lusitaniae* from day 0 to day 18. The isolates from each patient were found to be identical by both susceptibility testing and RAPD analysis.

These case reports point out the difficulties associated with high-risk patients who have multiple blood cultures that are positive for *Candida* species. For case patient 1, susceptibility testing suggested 3 different strains, whereas RAPD analysis suggested only 2 different strains. Clinical management of such patients would be determined on the basis of the results of susceptibility studies in addition to evaluation of the clinical situation.

A different *Candida* isolate was recovered from case patient 2 on day 30, after the initial *C. parapsilosis* blood culture result was obtained. This patient survived, as did 2 additional patients, both of whom

<table>
<thead>
<tr>
<th>Source of specimen</th>
<th>Day that blood culture was performed</th>
<th>MIC, µg/mL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Flu</td>
</tr>
<tr>
<td>Peripheral blood</td>
<td>0*</td>
<td>&gt;64</td>
</tr>
<tr>
<td>Peripheral blood</td>
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<td>64</td>
</tr>
<tr>
<td>CVC blood</td>
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<td>64</td>
</tr>
<tr>
<td>Catheter urine</td>
<td>22</td>
<td>0.5</td>
</tr>
</tbody>
</table>

* Day that the first blood culture positive for *Candida* was performed.

**Table 1. Antimicrobial susceptibility profile of *Candida glabrata* isolates recovered from case patient 1.**