showed no therapeutic effect for general chronic seronegative arthritis [8]. The failure of the initial antibiotic treatment with ceftriaxone for our patient hints to a specific effect of doxycycline on C. trachomatis as causative agent.

The severe course of illness in our HIV-infected patient receiving HAART and the unusual swift reaction to doxycycline suggest an inflammatory reaction triggered after immune reconstitution. Initial immunodeficiency probably facilitated a persistent chlamydial infection, whereas immune reconstitution due to HAART triggered the subsequent reactive arthritis [9]. In immune reconstitution syndrome, inflammation is not always self-limited, because of persistently disturbed immune regulation and only partial elimination of the antigen [9]. Accordingly, our patient had severe arthritis with very severe local activity, as well as systemic inflammatory activity, without any signs of self-limitation. In this case, after elimination of the antigen, symptoms rapidly regressed, hallmarking the antigen dependence of the systemic inflammation. In contrast, in patients without immune reconstitution syndrome, symptoms of Reiter's disease are much less dependent on persistent antigen presence, reflected by only moderate or even absent response to specific antibiotic therapy [7, 8].

In conclusion, in HIV-infected patients, Reiter’s syndrome may follow a severe inflammatory reaction triggered after immune reconstitution. Initial immunodeficiency probably facilitated a persistent chlamydial infection, whereas immune reconstitution due to HAART triggered the subsequent reactive arthritis [9]. In immune reconstitution syndrome, inflammation is not always self-limited, because of persistently disturbed immune regulation and only partial elimination of the antigen [9]. Accordingly, our patient had severe arthritis with very severe local activity, as well as systemic inflammatory activity, without any signs of self-limitation. In this case, after elimination of the antigen, symptoms rapidly regressed, hallmarking the antigen dependence of the systemic inflammation. In contrast, in patients without immune reconstitution syndrome, symptoms of Reiter’s disease are much less dependent on persistent antigen presence, reflected by only moderate or even absent response to specific antibiotic therapy [7, 8].

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Unilateral Brachial Plexopathy Associated with West Nile Virus Meningoencephalitis

Sir—Brachial plexopathy occurs as a rare consequence of infections with varicella [1], herpes zoster [2], parvovirus B19, cytomegalovirus [3], HIV [4], and Escherichia coli [5] and of human granulocytic ehrlichiosis [6] but has not yet been reported in association with West Nile virus infection. We report such a case in a 48-year-old man who developed unilateral brachial plexopathy in association with West Nile virus meningoencephalitis.

A right-handed mechanic from Dearborn, Michigan presented to the emergency department of our hospital (Oakwood Hospital and Medical Center, Dearborn, MI) in late August 2002 with sharp, stabbing pains in his back and neck. He was treated for his symptoms and sent home. He returned 3 days later with fever, nausea, vomiting, impaired consciousness, slurred speech, pain, numbness, and progressive weakness of the left arm. The patient’s past medical history was unremarkable. There was no history of trauma, mosquito bites, or recent travel.

The patient had a temperature of 39.4°C with 2+ nuchal rigidity and flaccid paralysis of the left arm. Examination findings were otherwise unremarkable. The results of hematological testing, blood and urine cultures, serum chemistry and enzyme studies, an HIV test, a Venereal Disease Research Laboratory test, and an antinuclear antibody test were normal or negative. An analysis of CSF samples showed a WBC count of 470 cells/mm³ (85% lymphocytes, 10% monocytes, and 5% polymorphs), an RBC count of 10 cells/mm³, a glucose level of 42 mg/dL, and a protein level of 97 mg/dL. PCR analysis of CSF samples was negative for herpes simplex virus. Findings of CT and MRI scans of the head, spine, and chest were unremarkable.

Progressive wasting with weakness of the left deltoid, triceps, brachioradialis, wrist extensors and flexors, supraspinatus, and infraspinatus occurred. Scapular winging developed on the third day of hospitalization. Electromyography findings showed diffuse denervation of the left upper extremity. Sensory conduction was slow or absent, with low compound-muscle action potentials, and was consistent with left-brachial plexopathy.

Tests for IgM antibodies performed on serum and CSF samples obtained from the patient at admission to the hospital were positive for West Nile virus (tests were performed at the State of Michigan Reference Laboratory, Lansing, MI). Results of tests for St. Louis encephalitis, eastern equine encephalitis, and California group virus were negative. The patient’s consciousness, speech, and hand dexterity improved in the 2 weeks after admission. The wasting of the left arm, supraspinatus, and in-
fraspinatus muscles has persisted after discharge from the hospital, although there is slow, continued improvement in response to physical therapy.

More than 4000 cases of West Nile virus infection were reported in the US in 2002. Guillain-Barre [7] and poliomyelitis-like syndromes [8–10] have been reported as a presentation of West Nile virus infection. To our knowledge, the occurrence of brachial plexopathy in association with the flavivirus infection, and West Nile virus infection in particular, has not been previously reported. The precise lateralizing mechanism of such infections is unknown. With this current case, it now appears that unilateral plexopathy may occur as a consequence of West Nile virus infection.

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Treatment Recommendations for Bacterial Vaginosis in Pregnant Women

Sir—We believe that the data presented by Koumans et al. [1] in their recent review of the indications for treatment of bacterial vaginosis (BV) in pregnant women warrant more conservative recommendations. They noted that several studies of treatment of BV have shown a benefit in reducing preterm births among high-risk women who have had a previous preterm birth. We agree that a portion of women with BV who are at high risk for preterm birth may benefit from BV treatment; however, we hold greater concern that the antibiotics used to treat BV appear to increase the rate of preterm birth in other women. Koumans and colleagues [1] virtually ignored these potential harms.

The enthusiasm for screening for and treating BV in high-risk women is based on 3 small studies [2–4]. When making national health policy recommendations, it is important to consider whether promising results are likely to hold when treatment is generalized. Results from the larger National Institute of Child Health and Human Development (NICHD) study [5], which was conducted at multiple academic medical centers across the United States, suggest that the benefits may not hold when generalized. In this study, women with a prior preterm birth who were treated with metronidazole had a nonsignificant increase in the occurrence of preterm birth.

In addition, screening recommendations must consider variations in screening techniques that might occur, as well as the potential harms that may happen in association with false-positive and/or false-negative results of screening. The potential for harm associated with false-positive screening results has been echoed in several studies. In the study by Hauth et al. [2], women who did not have BV but who were randomized to receive metronidazole and erythromycin had a significantly higher risk of delivery at <34 weeks’ gestation than did women who received placebo. A randomized, placebo-controlled trial of treatment for trichomoniasis administered during pregnancy conducted by the NICHD Maternal-Fetal Medicine Units Network found a doubled risk of recurrent preterm birth among metronidazole-treated women who had a previous spontaneous preterm birth, as well as a significantly increased risk of preterm birth among the entire group of treated women, regardless of their BV status [6]. Another trial conducted by the NICHD MFMU Network involving women who tested positive for vaginal fetal fibronectin also found a significantly increased risk of recurrent preterm birth among women with a prior preterm birth who received a 7-day course of metronidazole and erythromycin [7].

Taken together, these 3 clinical trials suggest that there may be a subgroup of women whose pregnancy outcomes are harmed when they receive metronidazole, either with or without a macrolide antibiotic. This concern is particularly acute, given the variety of ways that BV is diagnosed in routine practice and the limited data on the reliability of these tests in that situation [8, 9]. Therefore, the diagnostic methods used in the 3 trials that demonstrated a benefit may not be readily translated to routine practice.

We wish to note that the recommendations by Koumans et al. [1] are in conflict with those of the US Preventive Ser-