lactam treatment for 10 days with β-lactam treatment until the patients have been afebrile for 48 h (and have been treated for at least 5 days). The study includes adult patients with uncomplicated febrile CAP who initially experience improvement with β-lactam monotherapy. So far, ~100 patients have been enrolled. In the study, we measure body temperature rec-tally 3 times daily and consider the patients afebrile at the second of 2 consec-utive temperatures of ≤37.8°C, without impact of antipyretic drugs. Using this defini-tion, we found that the median duration of fever was 30 h (range, 17–68 h) in a pilot study of 13 patients with pneumococcal CAP and a median Fine’s score of 80 (range, 36–93) who were cured by β-lactam antibiotic monotherapy. In a previous large study of hospitalized pa-tients with CAP, Halm et al. [6] found a median duration of fever of 3 days from onset of therapy until the day when the highest observed temperature was ≤37.2°C.

If short-course β-lactam treatment could be used routinely to treat CAP, the main advantages, compared with standard-course treatment, would be lower cost, lower risk of side effects, better compliance, and, as was shown for amoxicillin in children [8], a favorable impact on the emergence of antibiotic resistance.

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Financial support: The ongoing treatment study is supported by grants from the Research Committee of Örebro County Council and the Örebro University Hospital Research Foundation.

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Clinical Infectious Diseases 2004;38:766–7
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Linezolid-Induced Neuropathy

Sir—Lee et al. [1] recently reported 2 cases of linezolid-associated toxic optic neuropathy. We describe a case in which the prolonged use of linezolid to treat actinomycosis followed by development of acute, irreversible sensory loss and peripher-al neuropathy.

Linezolid has an excellent oral bioavailability and activity against clinical isolates of gram-positive bacteria, including strains resistant to glycopeptides, suggest-ing that it potentially has a role in the management of bone and joint infections [2]. Linezolid can be indicated for chronic infections such as nocardiosis or actino-mycosis when the usual therapy is contraindicated [3, 4]. An increasing number of reports have documented severe ad-verse reactions to linezolid, including reversible myelosuppression. Only 4 cases of severe-sensor motor axonal neuropathy associated with linezolid have been reported [1]. All of these cases occurred in patients treated with linezolid for several months who developed irreversible neuropathy.

A 27-year-old white woman was admitted to the hospital in February 2002 with chronic abscesses on her forearm. The medical history began with a deep wound to her right hand in 1994 complicated by a phlegmon and a broken dor-sal flexor. The patient was treated with surgery and antibiotic therapy, but multiple abscesses appeared on the scar and persisted in spite of treatment with multiple antibiotics. She was admitted to our infectious diseases department in February 2002 with fever (temperature, 38.5°C). Physical examination revealed skin abscesses on the elbow and edema on the forearm. The patient underwent surgical debridement of the abscesses, from which Haemophilus species and Staphylococcus aureus were isolated.

The first course of therapy was clindamy-cin and cefalexin for 8 weeks, and initially the evolution was good. However, at week 9 of treatment (in April 2002), the patient developed fever associated with a new abscess. An MRI showed multiple collections in muscle, with multiple fis-tulae and osteomyelitis. Extensive surgical debridement was performed, and the patient received intravenous penicillin G therapy for 3 weeks, which was switched to roxitromycin and levofloxacin because Actinomyces meyeri was isolated from cul-ture of a perioperative specimen. At week 12 of the new course of treatment (in Au-gust 2002), the patient had to undergo additional surgical debridement because of recurrence of the abscess. Culture of a perioperative specimen yielded group G Streptococcus and a strain of Actinomyces odontolyticus resistant to quinolones, mac-rowlides, and amoxicillin. After this, the pa-tient was treated with linezolid (600 mg b.i.d.).

Linezolid therapy was initially well tol-erated and efficacious. However, at month
6, the patient presented with paresthesia in her extremities, numbness of her legs below the knee, and intermittent sharp pain in both feet. Peripheral sensory loss in the “glove and stocking” distribution was noted. Nerve conduction studies showed sensory motor axonal neuropathy. Linezolid therapy was discontinued, and 5 months later, the patient reported no pain, but nerve conduction studies revealed that peripheral neuropathy persisted. No evidence of factors associated with toxic neuropathy was found.

Linezolid is a highly active oral anti–gram-positive bacterial agent, and it is an attractive antibiotic for the treatment of chronic osteomyelitis. But the tolerance of long-term administration of linezolid is unknown. The mechanisms of the hematological and neurological effects associated with linezolid are unknown [5, 6]. Because of these severe effects, linezolid use must be limited to the treatment of serious infections caused by gram-positive organisms that are drug resistant. In addition to the monitoring of hematological parameters, performance of neurological examinations should be considered during linezolid therapy.

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