prolonged courses of oral artesunate to our patient’s neurological syndrome.

Acknowledgments

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References


Medical Treatment of Fish Bone–Related Liver Abscess

Sir—Cases of hepatic abscess due to fish bone penetration are rare and may be fatal. Nisbet et al. [1] reported a case of a fish bone penetrating from the pylorus of the stomach to the liver and causing persistent Streptococcus anginosus infection. Surviving patients described in previous reports were all surgically treated. In this report, we describe a case of liver abscess caused by fish bone penetration in which medical treatment was successful.

A 40-year-old man with a history of hypertension and hyperlipidemia, which had been controlled with medical treatment for 3 years, was admitted to the hospital because of a 1-week history of intermitting chills and concurrent fever. Symptoms had progressively worsened. At admission, the patient reported vague epigastralgia, and he was febrile (temperature, 41.9°C) and had tachycardia (heart rate, 139 beats/min) and hypertension (blood pressure, 195/71 mm Hg). The patient’s abdomen was soft, but it was tender over

Figure 1. Top, An abdominal CT scan with contrast enhancement demonstrates a liver abscess at the lateral segment of the left hepatic lobe, with a linear fish bone (arrow) visible within the abscess. Bottom, A non–contrast-enhanced CT scan in oblique coronal reformation demonstrated that the fish bone was retained in the liver without any sequelae.
antibiotics. All reported cases were treated with either percutaneous transhepatic removal or surgical removal of the fish bone. If there is a strong suspicion of bowel perforation by a foreign body or if a foreign body is detected preoperatively, surgery is considered the treatment of choice in current clinical practice [6, 7]. To the best of our knowledge, this is the first documented case of a hepatic abscess secondary to fish bone penetration that was successfully treated without removal of the foreign body. We thus recommend that medical approaches could be attempted first in such cases, especially when contraindications for surgery exist.

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Fluconazole Prophylaxis for Critically Ill Patients at High Risk for Candida Infection

Sir—I have read with interest the article by Wenzel and Gennings [1] recently published in a supplement of the journal. In this article, the authors comment on the strategy followed at the Johns Hopkins University Hospital for patients in critical care units who are at particularly high risk for Candida infection, which is to give prophylactic anti-Candida antibiotics to all patients expected to be in an intensive care unit for ≥3 days. This strategy has been shown to reduce the overall rate of candidal infections in a study that examined all anatomic sites, but it did not reduce mortality in a surgical intensive care unit at Johns Hopkins University Hospital [2]. However, only 1 patient receiving fluconazole developed a candidal bloodstream infection, and 2 patients receiving placebo developed infection of the blood and the peritoneum [1].