<30 years of age are at higher risk of developing acute hepatitis A than are those aged >40 years (OR, 5.5; 95% CI, 1.2–23.3). Patients who acquired HIV infection during sex had higher rates of natural hepatitis A immunity than did those who acquired HIV infection parenterally (61% vs. 38%; P = .13).

These data support the recommendation of hepatitis A vaccination for patients with HIV infection in developed countries, particularly white patients aged <30 years, because most are not naturally immune. On the other hand, for recent immigrants from Africa and Latin America with HIV infection, prescreening for hepatitis A virus IgG antibody is recommended before routine hepatitis A vaccination, because a large proportion of such patients are naturally immune.

Acknowledgments

Potential conflicts of interest. All authors: no conflicts.

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Klebsiella Liver Abscess: A Coast-to-Coast Phenomenon

Sir—We were delighted to read the article by Rahimian et al. [1], in which the authors reported that Klebsiella pneumoniae was the organism that was most commonly associated with pyogenic liver abscess (PLA) at their New York City institutions (Bellevue Hospital and New York University Downtown Hospital). In February 2005, we described a 5-year study from our institution, Naval Medical Center San Diego, which revealed the same high frequency of K. pneumoniae liver abscesses and showed that several of cases occurred in patients with atypical characteristics (i.e., nondiabetics and non-Asians) [2]. In addition, Rahimian and colleagues noted a markedly decreased mortality rate among patients with K. pneumoniae liver abscess (2.5%). Although we did not focus on this particular point, the mortality rate in our series was atypically low as well (0%).

These 2 studies indicate a trend in the United States toward a predominance of K. pneumoniae as the bacterial agent responsible for PLA. This subtype of PLA is noteworthy, because it leads to a high frequency of bacteremia (which was observed in both studies), as well as to metastatic complications in up to 10% of patients. This latter feature is well described in the Asian literature [3] but is strikingly absent from both of these US-based studies.

Several questions remain unanswered, including what the extent of this trend is throughout the United States and other western countries and whether PLA is becoming associated with decreasing morbidity and mortality rates because of a change in the microbiological characteristics of Klebsiella species or because of improved therapeutic interventions. In addition, we would be interested to know whether more of the patients in the authors’ series presented to the hospital with this condition during the later stages of the 10-year study period, which would indicate a gradual, recent shift in frequency rather than an unrecognized chronic phenomenon. In our review of all US cases of Klebsiella PLA, we found that 7 (58%) of 12 cases were reported after 1998, indicating that the former pattern is more likely.

Acknowledgments

Potential conflicts of interest. All authors: no conflicts.

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Influenza Infections after Hematopoietic Stem Cell Transplantation

Sir—Nichols et al. [1] recently reported the experience of the Fred Hutchinson Cancer Research Center in the management of influenza infection in hematopoietic stem cell transplant (HSCT) recipients during 12 consecutive respiratory-virus infection seasons. Of note, only 62 (1.3%) of the 4797 patients who underwent transplantation during this period had influenza diagnosed within 120 days after transplantation. Because

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Clinical Infectious Diseases 2005;41:272–3
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the patients were not vaccinated during this period, the authors attributed this low incidence to hospital practices and good vaccine coverage of health care workers (HCWs) and family caregivers.

Worldwide HCW compliance with influenza vaccination recommendations has been disappointing, varying from 2% to 36% [2]. At the Clinical Hospital of the University of São Paulo, Brazil, we observed a compliance rate of 34.4% in a recent survey of HCWs who manage high-risk patients. Since 2000, Brazil has showed influenza vaccine coverage rates similar to those of many countries in western Europe [3], which reflects the successful efforts of the Brazilian Health Ministry in vaccination campaigns among elderly patients (82.1% coverage in 2003) but not in other high-risk populations [4].

The authors reported 30%–60% rates of HCW compliance with influenza vaccination recommendations during the study period. Hats off to the Fred Hutchinson Cancer Research Center if their present rates are closer to 60% than to 30%. Recently, the Centers for Disease Control and Prevention reported 51.1% coverage among persons aged ≥65 years and 34.2% coverage among HCWs in the United States [5].

In the article by Nichols et al. [1], no cases of influenza pneumonia or flu-related death were observed among the 9 patients who had been treated with oseltamivir. We have previously reported our experience in treating 41 episodes of influenza in 39 patients during 1 year [6]. We observed a much higher rate of influenza infection (22%) in our study, probably because influenza B virus circulated with great activity in Brazil that year. Second, most of the patients in our study were observed at the outpatient clinic, where only part of the recommended infection-control measures could be implemented. Thus, transmission between patients may have occurred. Third, we also evaluated patients after the sixth month after HSCT, when they became eligible to receive influenza vaccination. The high rate of influenza in our study obviously raised concerns about vaccine efficacy and patients’ compliance with yearly vaccination recommendations. Reviewing the vaccination records, we found an 80% rate of vaccine efficacy but a surprisingly low compliance with seasonal influenza vaccine recommendations [7]. Unfortunately, this question could not be addressed in the study of Nichols et al. [1].

In our study, only 2 (5.1%) of the 39 patients who had been treated with oseltamivir developed pneumonia [6]. Compared with pneumonia rates previously reported in different bone marrow transplant centers (up to 75%), it seems that early introduction of oseltamivir substantially helped to control the development of influenza-related complications in the patients in our study.

In conclusion, good coverage of influenza vaccine must be assured for transplant recipients and HCWs. Patients who are not eligible to receive influenza vaccination because they are within the first 6 months after HSCT are natural candidates for controlled studies evaluating preemptive treatment versus prophylactic treatment with oseltamivir during this period.

Acknowledgments

Potential conflicts of interest. C.M.M.: no conflicts.

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Clinical Infectious Diseases 2005; 41:273–4
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Diagnosis and Treatment of Fungal Endophthalmitis: A Reassessment

Sir—We read with interest the recent report by Sarria et al. [1] on the treatment of Candida glabrata endophthalmitis with caspofungin. We agree that endogenous fungal endophthalmitis would be one of the differential diagnoses for the patient they described. However, the authors do not present any firm evidence for a proven case of C. glabrata endophthalmitis [2]. Without a positive microscopy for fungal elements or culture of vitreous or retina, the case cannot be confirmed.

The funduscropy images demonstrate a white fundal lesion with no signs of significant vitritis, which is normally common in Candida endophthalmitis [3]. Other causes need to be considered, such as non–infection-related processes or lesions due to pathogens, including Staphylococcus aureus, Enterobacter species, or Candida albicans, all of which caused previous episodes of bacteremia in this patient. Clinically, it is impossible to differ-