Venezuela, where anemia and severity of anemia in Northeastern cases from an area in India where malaria is endemic [8]. Only a few reports, such as one recently published by Kochar et al. [8], have described severe malaria in P. vivax infection. We consider our report to be relevant in demonstrating that P. vivax infection ultimately may present, albeit less frequently, with severe malaria manifestations, such as severe thrombocytopenia and hemorrhagic episodes (both of which occurred among a group of our patients). In support of our conclusions [2], the report by Kochar et al. [8] demonstrated the occurrence of severe anemia and severe thrombocytopenia associated with bleeding diathesis that required intensive care support. Coinciding with our observation of a distinction between immune and nonimmune populations, Kochar et al. [8] also included only cases from an area in India where malaria is endemic [8].

We are in the process of preparing a report to further describe the frequency and severity of anemia in Northeastern Venezuela, where P. vivax infection is endemic. We believe that our report [2], along those of with Kochar et al. [8], and Antinori et al. [1], demonstrates that hematological abnormalities associated with P. vivax infection are clinically relevant and could be associated with severe malaria, and their pathogenesis deserves further research.

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What Does “Culture of Life” Mean for an Undocumented Immigrant?

SIR—We read with interest the article by Anstead et al. [1] about the use of posaconazole for the treatment of refractory coccidioidomycosis; however, we feel case report 6 deserves further comments. The patient, a 28-year-old man who initially had a favorable outcome with prolonged posaconazole therapy, eventually died of progressive disease because, as “an undocumented immigrant, [he] was returned to Mexico, where he ran out of medications” [1, p. 1774]. According to the Declaration of Geneva, adopted by the Second General Assembly of the World Medical Association in 1948, physicians should not permit considerations of ethnic origin or nationality to intervene between their duty and their patient [2]. In France, there is a law stipulating that a patient cannot be returned by force to his or her country of origin if an interruption of care that may have severe health consequences would occur [3]. Obviously, physicians cannot always interfere with immigration policies. However, in light of the long debate about “culture of life” politics surrounding the case of Terri Schiavo, for whom the clinical signs of life were not obvious [4], the discontinuation of posaconazole for this 28-year-old ambulatory Hispanic man raises the following questions for Anstead et al. [1]: (1) what was done to prevent this patient’s expulsion from the United States, given the knowledge that it was likely a death sentence, and (2) did the pharmaceutical company that manufactures this precious investigational drug try to deliver it to the patient after he had been returned to Mexico?

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Reply to Tattevin et al.

Sir—Dr. Tattevin et al. [1] pose two questions regarding the patient (an illegal immigrant) from case study 6 in our article [2] about patients treated with posaconazole. They asked, “(1) what was done to prevent this patient’s expulsion from the United States, given the knowledge that it was likely a death sentence, and (2) did the pharmaceutical company that manufactures this precious investigational drug try to deliver it to the patient after he had been returned to Mexico?” [1, p. 1212].

In answer to the first question, the patient was enrolled in the trial and received medical care regardless of his nationality (he was a Mexican citizen living illegally in the United States and was treated at University Health System, a public institution in the United States). He received medications for HIV infection from the state of Texas. However, federal immigration authorities abruptly sent the patient back to Mexico. This happened before any of the physicians involved in his care could intercede on his behalf. We are also uncertain whether any condition that is not immediately life-threatening would prevent deportation of an illegal immigrant. Furthermore, it is unfortunate that the patient himself was poorly compliant with antiretroviral therapy and never achieved either HIV suppression or immune reconstitution. Because of this, he was at high risk for death due to AIDS, regardless of whether or not he remained in the United States.

In regard to the second question, the pharmaceutical company enrolled this patient in the trial without asking questions about his residency status. However, once a patient in a clinical trial is unable to obtain follow-up care, for whatever reason, it would be unethical to continue administration of an experimental drug that might have unforeseen adverse effects. At the time of this study [2], it was unknown whether the drug was lifesaving. This clinical trial was not being conducted in Mexico, and because there could not have been appropriate follow-up, it was not possible for the company to supply the drug. This patient’s situation illustrates an unfortunate reality: we live in a have or have-not world in terms of the distribution of medical (and all other) resources, and lines on a map sometimes count for more than human suffering.

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The Importance of Culture for Diagnosing Tuberculosis

Sirs—We read with interest the article by Munyati et al. [1] elucidating causes of chronic cough in 544 primary health care attendees with a high prevalence of HIV infection. For this study, tuberculosis diagnosis was attempted using both acid—fast bacillus smear and solid-media mycobacterial culture. A total of 83% of the study population was HIV-infected, making this an ideal population to address what role culture should play in the diagnosis of tuberculosis in areas where HIV is epidemic. Of the 544 clinic attendees with a chronic cough, 184 (34%) had microbiologically confirmed tuberculosis (by positive smear and/or culture results), and 19 (10%) of these 184 had tuberculosis confirmed by culture alone. Of the 162 HIV-infected patients with tuberculosis diagnosed on the basis of bacteriological test results, 17 (10%) had the diagnosis microbiologically confirmed by culture results alone. In addition, 17 (27%) of 62 HIV-infected patients diagnosed with tuberculosis who had negative smear results had cultures positive for Mycobacterium tuberculosis. We therefore strongly disagree with the authors’ conclusions that “the findings of TB culture added relatively little to the findings of fluorescent microscopy of concentrated sputum specimens” [1, p. 1818].

Since 1996, the World Health Organization has promoted tuberculosis case detection through sputum acid—fast bacillus smear microscopy [2]. Although simple and inexpensive, this method is less sensitive than mycobacterial sputum culture [3, 4], particularly among HIV-infected patients. Emerging data demonstrate the significant benefit of sputum culture for detection of tuberculosis in HIV-infected patients. Recently, our research group has shown that as many as one-third of asymptomatic HIV-infected patients with CD4 cell counts $\geq 200$ cells/mm$^3$ have subclinical tuberculosis that can only be detected using sputum culture [5]. Follow-up data on this small group of HIV-infected patients indicated that 90% were still alive at 2 years, raising the possibility that detection by sputum culture and early treatment may improve the outcome of HIV-associated tuberculosis.

Mycobacterial sputum culture is generally considered too impractical and too