lase-negative staphylococci strains accounted for 29.7% of the cases, and, in the present series [3], coagulase-negative staphylococci strains accounted for 25.6% of cases. This finding indicates that our results remained remarkably constant throughout the 1996–2004 period. It is true that we initially attributed the absence of coagulase-negative staphylococci strains in swab culture specimens to hypothetical nonreporting by the microbiology laboratory, but we must admit that we were not fully satisfied with this hypothesis and had further discussions with our laboratory staff to make sure that coagulase-negative staphylococci were not under-reported, which, indeed, proved to be the case. Therefore, as indicated in our article [3], all the coagulase-negative staphylococci strains yielded by both swab and bone cultures were, in fact, reported by our laboratory, in accordance with the protocol established in 1996 [2]. The surprisingly small proportion of coagulase-negative staphylococci strains cultured from our patients’ samples—from 5 (5.6%) of 109 samples—which, compared with the proportion cultured from bone samples, was a significant difference (P<.001)—has also been found by others; for instance, in the recent study by Ge et al. [4], Staphylococcus epidermidis was isolated from 111 (6.1%) of 1817 superficial specimens of chronic foot wounds obtained from comparable patients.

In their letter, Tattevin and colleagues also raise the question of whether coagulase-negative staphylococci might be responsible for osteomyelitis complicating chronic foot wounds in diabetic patients. This important question has been under discussion for years; but, at the time of writing this letter, no definite answer has been found. In a review of the current literature, Lipsky [5] already noted in 1997 that microorganisms such as S. epidermidis and Corynebacterium species, which are often considered to be contaminants, have been well documented as pathogens in cases of diabetic foot osteomyelitis. In some studies, up to 50% of deep-bone cultures yielded coagulase-negative staphylococci [6–9]. However, Lipsky also stressed that “it is critical that the specimens for culture be obtained with proper precautions to avoid contamination” [5, p. 1321]. As indicated in our article [3], all the consecutive patients studied underwent surgical percutaneous bone biopsies, which were only performed by only trained senior orthopedic surgeons in the operating room under surgical aseptic conditions of sampling [3]. We believe that all possible precautions feasible in daily practice were taken to avoid contamination of the bone specimens obtained from our patients.

Unlike Tattevin and colleagues, we are not convinced that, if the coagulase-negative staphylococci strains in bone cultures were considered to be true pathogens, this would have an impact on the choice of antimicrobial regimen. In the present study [3], it would only have led to a change in the antibiotic treatment of 3 of the 10 and 5 of the 17 patients with polymicrobial and monomicrobial bone cultures, respectively, for whom a comparison with swab cultures was feasible.

Acknowledgments

Potential conflicts of interest. All authors: no conflicts.

Eric Senneville,1 Hugues Melliez,2 Eric Beltrand,2 Laurence Legout,4 Michel Valette,1 Marie Cazaubiel,1 Muriel Cordonnier,3 Michèle Caillaux,5 Yazdan Yazdanpanah,1 and Yves Mouton1
1Diabetic Foot Clinic and 2Department of Orthopedic Surgery, Dron Hospital, Tourcoing, France

References


Reprints or correspondence: Dr. Eric Senneville, Dron Hospital, 135 Rue du Président Coty, 59200 Tourcoing, France (esenneville@ch-tourcoing.fr).

Clinical Infectious Diseases 2006;42:1811–2 © 2006 by the Infectious Diseases Society of America. All rights reserved. 1058-4838/2006/4202-0032$15.00

Efficacy of Short-Course Intramuscular Pentamidine Isethionate Treatment on Old World Localized Cutaneous Leishmaniasis in 2 Patients

To the Editor—Old world localized cutaneous leishmaniasis (LCL) is a protozoan skin infection that may be imported by travelers to Western countries [1, 2]. The treatment of Old World LCL still remains a real challenge, given the lack of efficacy of oral flucloxazole and antimicrobials (administered either intramuscularly or intradermally) and the limitations of local treatments, such as “boiling the boil” [3]. The efficacy of intramuscular pentamidine isethionate (PI) has been demonstrated for New World LCL due to Leishmania panamensis [4] and Leishmania guyanensis [1, 5]. Therefore, PI may be an alternative for the treatment of Old World LCL. Here, we report 2 cases of Old World LCL that were resistant to first-line treatment and were successfully treated with PI.

Patient 1 was a 19-year-old man who returned from Mali (in west Africa) in December 2004. He presented with a 9-
A 6-month history of multiple cutaneous lesions, 1 ulcer on the left arm that was associated with nodular lymphangitis, and a nodule on the right elbow. Seven months earlier, he had been treated ineffectively in Mali with intramuscular injections of meglumine antimoniate. At admission, direct examination of a Giemsa-stained skin swab specimen revealed *Leishmania* species. The patient was assumed to be infected with *Leishmania major*, given the geographical location where he acquired LCL. A 6-week course of oral fluconazole (200 mg daily) failed to cure the patient clinically and parasitologically. Intramuscular PI (a 3-mg/kg dose given initially and then once again 2 days later) was administered during hospitalization. The treatment was well tolerated. Three months later, both the nodular and the ulcerative skin lesions had been cured, with hyperpigmented scar remaining, and the nodular lymphangitis had disappeared.

Patient 2 was a 50-year-old French woman who traveled to Egypt in January 2005 and who presented in September 2005 with a 6-month history of multiple skin lesions. Two months before her admission, she had received a diagnosis of LCL and had received a 6-week course of treatment with oral fluconazole (200 mg daily) without clinical success. Indeed, at admission, there were 3 papulonodular skin lesions on her face, 1 ulcer on her right elbow, and 2 maculopapular erythematous lesions each on her left knee and right forearm. Direct examination of a Giemsa-stained skin swab specimen confirmed the presence of *Leishmania* species. The patient was assumed to be infected with *L. major*, given the geographical location where she acquired LCL. Intramuscular PI (a 4-mg/kg dose given initially and then once again 2 days later) was administered during hospitalization. The treatment was well tolerated. Two months later, all of the cutaneous lesions had disappeared, some of which had left scars.

These 2 cases, in which first-line treatment with intramuscular antimimonials or fluconazole failed, suggest that short-course treatment with intramuscular injections of PI may be as effective for Old World LCL as it is for some forms of New World LCL. Indeed, in Colombia, treatment with 4 injections of PI (3 mg/kg given every other day) yielded a 96% cure rate in an area where *L. panamensis* predominates [4]. Pentamidine is also considered to be the first-line treatment in French Guiana, where 2 injections of PI (4 mg/kg of pentamidine base every other day) yielded a 95% cure rate in 205 patients infected with *L. guyanensis* [6]. In an open-label study of 11 cases of imported LCL, three 4-mg/kg intramuscular injections of pentamidine base given every other day yielded a success rate of 73% with good tolerance [7].

According to our results, and because the use of pentamidine salts is limited by their toxicity (which is sometimes dose dependent), we recommend administering 2 intramuscular injections of 3 mg/kg PI on days 0 and 2 of treatment for LCL therapy. Additional investigations are needed to assess the effectiveness, safety, and modalities (e.g., daily dose and number of intramuscular injections) of PI for the treatment of Old World LCL.

Acknowledgments

**Potential conflicts of interest.** All authors: no conflicts.

**Stéphane Jauréguiberry,**1 Gentiane Graby,2 and Eric Caumes2

1Service des Maladies Infectieuses et Tropicales, Hôpital Tenon, and 2Service des Maladies Infectieuses et Tropicales, Hôpital Pitié-Salpêtrière, Assistance Publique des Hôpitaux de Paris, Paris, France

**Reference**


**What Can We Learn from Studies Comparing Linezolid with Vancomycin in Neutropenic Patients When Vancomycin Dosages Are Not Optimized?**

To the Editor—Jaksic et al. [1] compared the safety and efficacy of linezolid (600 mg every 12 h), and vancomycin (1 g every 12 h) in febrile neutropenic patients. Although the authors specified that coinvestigators were allowed to monitor vancomycin levels in serum, in accordance with local practice, the article does not indicate whether adjustment of the vancomycin dosage could be performed throughout the study. The usual recommended intravenous dose of vancomycin is 30 mg/kg/day in adults; use of this dosage achieves serum concentrations of 25 mg/L (peak level) and 2 mg/L (trough level) in healthy volunteers [2], but pharmacokinetic studies of vancomycin therapy in neutropenic patients have shown a 3-fold increase of the initial volume of distribution and a shortened (3-fold) half-life, compared with values in healthy subjects [3, 4]. Although there have never been any definitive data correlating vancomycin efficacy and concentration, most experts will aim to achieve trough serum concentrations of ≥15 mg/L in patients with potentially severe infections [5], as