and ejection fraction were recovered during tigecycline and levosimendan therapy. It is also of note that, despite the recently described evolution of resistance of MDR gram-negative organisms to tigecycline [1], the tigecycline MIC remained unchanged in all K. pneumoniae isolates during the management of our mediastinitis case. These data may prove to be essential for managing serious MDR infections that require prolonged courses of antimicrobial therapy.

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**References**


**Respiratory Syncytial Virus Infection in Patients with Cancer: Still More Questions Than Answers**

To the Editor—Khanna et al. [1] recently reported single-center results in a study of respiratory syncytial virus (RSV) infection in adult patients with hematological malignancies. The article discusses the clinical consequences of RSV infection and its management in severely immunocompromised patients. Here, we add our experience and comment on some important aspects of this infection.

During a prospective study investigating RSV infection in hospitalized children [2], 39 microbiologically confirmed RSV infections were documented among pediatric patients with cancer who received treatment at our institution. Conclusive information on these 39 children is given in table 1. In contrast to the 18% attributable mortality rate in the more severely immunocompromised population studied by Khanna et al. [1], none of our patients died secondary to RSV infection. One 8-year-old girl with acute myeloid leukemia experienced acute respiratory failure due to RSV infection and had to be given mechanical ventilation. She persistently displayed intermittent wheezing and right upper lobe atelectasis for 3 months. Two patients were given treatment with oral ribavirin. One infant with refractory acute lymphoblastic leukemia received a single dose of palivizumab (20 mg/kg by intravenous infusion) without any significant effect on her clinical course.

RSV infection in pediatric patients with cancer who are currently being given treatment with nonmyeloablative conventional chemotherapy may result in significant complications and additional days of inpatient treatment (table 1). It may be the only cause of fever in a patient, but because of diagnostic uncertainties, intravenous treatment with antibiotics is mandatory, particularly for patients with neutropenia or pneumonia.

In 25 (64%) of our 39 patients, the next chemotherapy session had to be postponed because of RSV infection. This may result in decreased dose intensity, with a negative impact on the treatment perspective for the underlying malignancy. In addition, droplet precautions and strict isolation have to be instituted to avoid nosocomial transmission [3], which was the origin of the infection in a significant number of our patients (9 patients [23%]). Viral shedding, detected by antigen testing, was prolonged for up to 43 days (data not shown).

Mainly because of safety and compliance issues and technical difficulties, it is not feasible to give nonintubated infants and young children treatment with ribavirin inhalation delivered at a concentration of 20 mg/mL for 18 h via a small-particle aerosol generator unit and administered via a face mask inside a scavenging tent to prevent environmental contamination [4, 5]. In addition, the objective benefit of this intervention is still under debate [6]. In patients with severe pneumonia due to RSV infection, intravenous administration of ribavirin may be an option [7].

Although Chávez-Bueno et al. [8] reported favorable preliminary data on combination treatment (ribavirin and intravenous palivizumab), de Fontbrune et al. [9] could not demonstrate a significant impact of palivizumab on the clinical course and survival of 19 allogeneic stem cell transplant recipients with RSV infection. Considering the very limited options for highly immunocompromised patients [5, 10], a prospective, randomized, multicenter study of motavizumab—an ultra-potent, affinity-matured, humanized
monoclonal antibody [11]—should be debated for cases of RSV infection.

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**Respiratory Syncytial Virus Infection in Immunocompromised Patients Revisited**

To the Editor—We read with great interest the letter from Simon et al. [1] reporting respiratory syncytial virus (RSV) infection in 39 immunocompromised pe-