To the Editor—Cimetidine has been shown to reduce the bioavailability of posaconazole [1], and this interactive effect has also been predicted for proton pump inhibitors [2]. In our center (University Medical Center Groningen; Groningen, The Netherlands), we monitor posaconazole serum trough levels regularly in patients who receive posaconazole as salvage treatment. Serum samples are measured by liquid chromatography tandem mass spectrometry, with a validated method of analysis. In a 58-year-old male patient who was treated for invasive aspergillosis, a significant decrease in the posaconazole serum trough level was observed (figure 1). It appeared that treatment with omeprazole (40 mg once daily) had been started routinely to prevent corticosteroid-induced gastrointestinal hemorrhage. Later, because the patient had no additional risk factors for gastrointestinal hemorrhage, treatment with omeprazole was discontinued. During continued monitoring of posaconazole concentrations, the serum trough concentration increased to baseline levels again (figure 1). Because the proton pump inhibitor was administered for only 3 days, the clinical impact in this patient was likely to be limited; posaconazole levels in tissue tend to be much higher than in serum, and therefore, adequate tissue levels may have been maintained. However, with prolonged proton pump inhibition at a higher dosage, the effect could be profound, with an inherent risk of therapeutic failure. If combination with a proton pump inhibitor can not be avoided, serum levels of posaconazole should be monitored at all times to evaluate absorption, or antifungal therapy should be switched to an alternative compound.

Acknowledgments

Potential conflicts of interest. All authors: no conflicts.

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Clinical Infectious Diseases 2009; 48:839 © 2009 by the Infectious Diseases Society of America. All rights reserved. 1058-4838/2009/4806-0025$15.00 DOI: 10.1086/597110

Oral Rehydration for Cholera

To the Editor—The discussion of William Stevens and the early use of oral rehydration to treat cholera in the article by Daly and DuPont [1] is based on a fundamental flaw. Stevens’s use of an oral saline solution without any glucose or amino acid or other suitable substrate capable of promoting salt and water absorption in patients with cholera would have only aggravated the diarrhea, because patients with cholera cannot absorb oral saline solutions in the absence of such substrate. This was first anecdotally observed by Latta [2], who reported that oral saline aggravated diarrhea in patients with cholera.

Later, this finding was amply confirmed in modern balance studies [3, 4]. In one of these studies, the mean total diarrhea volume was increased to >40 L in patients with cholera who received oral plain saline-electrolyte solution, compared with 14 L in patients who received oral glucose-electrolyte therapy during the oral therapy period [4]. Stevens never presented any quantitative data, and during the period of his research, the concept of balance studies was unknown. However, oral saline without substrate could not have been effective