Reply to Dylewski

To the Editor—We thank Dr. Dylewski [1] for the feedback on our article [2]. It is understood that the usefulness of nucleic acid amplification (NAA) tests varies with the prevalence of the disease among the population being tested. In our article, we do not advocate NAA testing for all specimens submitted for culture. For patients whose specimens have negative acid–fast bacilli (AFB) smear results, our recommendation is to order NAA testing for those patients for whom there is a high suspicion of tuberculosis (TB) disease. The recommendation of the Centers for Disease Control and Prevention (CDC) is “that NAA testing be performed on at least one respiratory specimen from each patient with signs and symptoms of pulmonary TB for whom a diagnosis of TB is being considered” [3, pp. 7–8]. In addition, CDC guidelines state that “NAA tests should not be ordered routinely when the clinical suspicion of TB is low” [3, p. 9]. Furthermore, we do not recommend that laboratories assess which specimens should receive NAA testing. Clinical judgment is essential to optimize the use of these tests. In New York City, we ask that health care providers request NAA testing for patients who have specimens that have negative AFB smear results and in whom there is a high suspicion of TB.

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Serum Cross-Reactivity with Aspergillus Galactomannan and Cryptococcal Antigen during Fatal Disseminated Trichosporon dermatis Infection

To the Editor—We read with great interest the article by Ruan et al [1] describing a cohort of patients with trichosporonosis. We recently treated a patient who developed fatal disseminated Trichosporon dermatis infection after cord blood transplant with aplasia. The yeast was successively isolated from 6 blood cultures, fluid from 2 bronchoalveolar lavages, a colic biopsy sample, and a skin lesion. Identification was confirmed at the French National Reference Center for Mycoses and Antifungals by sequencing the internal transcribed spacer.

The day the first positive hemoculture result was observed, antifungal prophy- laxis with caspofungin (50 mg/day for >4 weeks) was replaced with voriconazole because of a strongly positive serum galactomannan index (7.2 by the Platelia Aspergillus assay; Bio-Rad). Additionally, during the 6 days following this switch 2 serum samples were positive for both galactomannan (index, 7.6 and 6.9) and cryptococcal antigen (positive at a dilution of 1:40) (CALAS; Meridian Bioscience). Data on this patient are shown in Figure 1.

As identified by Ruan and colleagues, the blood and lungs are the primary sites of Trichosporon infection. In our patient, clinical and biological features were indis- putably consistent with invasive tricho- sporonosis. Thoracic computed tomog- raphy showed nonspecific ground-glass opacities (suggesting either an infectious process or a hemorrhagic infarction), but no characteristic features of aspergillosis (ie, dense and well-circumscribed abnormalities with or without a halo sign, air- crescent sign, or cavities) were observed. Criteria for proven, probable, or possible invasive aspergillosis or cryptococcosis were not met [2]. Caspofungin, which is inactive against Trichosporon species, is an effective salvage treatment for invasive aspergillosis [3]; breakthrough aspergillosis during caspofungin therapy is exceptional- ly. Importantly, cerebrospinal fluid and urine, 2 major targets of Cryptococcus neoformans, were negative for cryptococcal infection by both antigen testing and culture. Ruan and colleagues reported a rate of candidemia of 32% during the same hospital course (which was not always simulta- neous with Trichosporon infection) but found neither aspergillosis nor cryptococcosis. We thus consider it extremely unlikely that a simultaneous triple infection with Trichosporon, Aspergillus, and Cryptococcus would have occurred in the patient whose history is reported here.

Some Trichosporon antigens share de- terminants with the capsular polysaccha- ride of C. neoformans [4]. Dalle et al [5] have reported that both C. neoformans and C. laurentii antigens could cross-react with Aspergillus galactomannan determination. We propose that T. dermatis harvests ant- igens that share common epitopes with both cryptococcal antigen and galacto- mannan. To assess this hypothesis, we tested the supernatant from the T. der- matis culture for its reactivity in the Platelia Aspergillus assay and in the deter- mination of cryptococcal antigen titers [5]. The galactomannan index was 2.9 and the cryptococcal antigen titer was positive at 1:40, thereby supporting the notion that
Figure 1. Timeline for a patient who developed fatal disseminated *Trichosporon dermatis* infection after cord blood transplant with aplasia. D, days after transplant.

*T. dermatis* antigens are cross-reactive with both *Aspergillus* galactomannan and *Cryp-
tococcus* capsular antigen.

Neither galactomannan index determination nor cryptococcal antigen detection were reported by Ruan and colleagues in their seminal description of 19 patients with invasive trichosporonosis [1]. We wonder whether these were explored and, if so, what the results were.

In conclusion, the present observation strongly suggests that galactomannan and cryptococcal antigen positivity occurs during the course of invasive *Trichosporon* infection, potentially leading to misdiagnosis, inaccurate evaluation of prognosis, and inadequate therapeutic interventions.

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Severe Acute Respiratory Disease in the Setting of an Epidemic of Swine-Origin Type A H1N1 Influenza at a Reference Hospital in Entre Ríos, Argentina

To the Editor—By April 2009, a novel swine-origin H1N1 type A influenza virus was shown to cause severe disease among several patients in the United States and Mexico [1, 2]. On 11 June 2009, the World Health Organization declared an influenza pandemic caused by this novel virus, with Argentina reporting 343 confirmed cases [3]. By 11 July 2009, there were 2,928 confirmed cases of novel H1N1 influenza (resulting in 94 deaths) reported in Argenti-
tina, including 52 cases (resulting in 1 death) in the province of Entre Ríos [4].

The first confirmed case of novel H1N1 influenza in this province was reported on 18 June 2009, and the number of suspected cases increased to 330 by 4 July 2009. For these suspected cases, the age distribution was as follows: 11% of patients were <5 years of age, 17% of patients were 5–11 years of age, 60% of patients were 15–50 years of age, and 12% of patients were >50 years of age. The Hospital San Martín is a 250-bed public teaching hospital for adult patients in Paraná, the main city (with 350,000 inhabitants) of the