better efficacy in morbidly obese patients infected with more resistant strains, or in the case of immunosuppression. Therapeutic drug monitoring of piperacillin/tazobactam in these special settings could contribute to evaluating and optimizing the PK exposure and guaranteeing antimicrobial efficacy.

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Transparency declarations
None to declare.

References

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Deferasirox in mucormycosis: hopefully, not defeated

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Table 1. Clinical characteristics and outcome of patients treated with deferasirox

<table>
<thead>
<tr>
<th>Patients (n = 7)</th>
<th>Comorbidities</th>
<th>Management</th>
<th>Length of follow-up (months)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1, 65 years, male diabetes skull base</td>
<td>AmB-d + deferasirox + debridement</td>
<td>24</td>
<td>cured</td>
<td></td>
</tr>
<tr>
<td>Patient 2, 59 years, male diabetes skull base with cavernous sinus involvement</td>
<td>L-AmB + deferasirox + debridement; step-down therapy with posaconazole</td>
<td>18</td>
<td>cured</td>
<td></td>
</tr>
<tr>
<td>Patient 3, 38 years, male none post-appendectomy—abdominal wall</td>
<td>AmB-d + deferasirox + debridement</td>
<td>15</td>
<td>cured</td>
<td></td>
</tr>
<tr>
<td>Patient 4, 57 years, male HIV-2 and diabetes rhino-orbital with dural involvement</td>
<td>exenteration of the eye with AmB-d + deferasirox</td>
<td>12</td>
<td>cured</td>
<td></td>
</tr>
<tr>
<td>Patient 5, 68 years, male diabetes rhino-orbital</td>
<td>AmB-d + deferasirox</td>
<td>7</td>
<td>cured</td>
<td></td>
</tr>
<tr>
<td>Patient 6, 3 years, female none bilateral renal</td>
<td>AmB-d + deferasirox + bilateral nephrectomy</td>
<td>6</td>
<td>cured</td>
<td></td>
</tr>
<tr>
<td>Patient 7, 48 years, male diabetes skull base</td>
<td>AmB-d + deferasirox + debridement</td>
<td>2</td>
<td>cured</td>
<td></td>
</tr>
</tbody>
</table>

AmB-d, amphotericin B deoxycholate; L-AmB, liposomal amphotericin B.
Sir,
We read with great interest and a little disappointment the results of the DEFEAT Mucor study, published in this issue of the *Journal of Antimicrobial Chemotherapy*.¹ The study showed a higher mortality in the deferasirox group, probably due to the baseline characteristics of the patients. The theory behind the mechanism of action of deferasirox² and the encouraging results from experimental and open-label studies³ prompted us to use adjuvant deferasirox on a compassionate basis in seven patients with mucormycosis where adequate surgical debridement was not feasible.

The clinical characteristics and outcomes of the seven patients are shown in Table 1. Five of the seven patients had diabetes as the only risk factor. Two of the three patients with skull base mucormycosis probably had an insect bite in the ear as the primary cause. None of the patients had pulmonary mucormycosis, haematological malignancy or neutropenia. This may perhaps explain the uniformly good results and lack of mortality in our series. The commonly known adverse effects of deferasirox, namely renal and hepatic impairment and gastrointestinal haemorrhage, were not seen in our series.

We recognize that the benefit or risk of using adjuvant deferasirox can only emerge from a randomized controlled trial. We believe that there is still a role for deferasirox in patients similar to those in our study, i.e. those with minimal underlying comorbidities where adequate surgical debridement is not possible.

**Funding**
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**Transparency declarations**
None to declare.

**References**