words, the sensitivity of the Duke criteria actually appears to be better than that of the Beth Israel criteria modified with the addition of echocardiographic findings. Furthermore, modification of the Beth Israel criteria may result in the use of various unvalidated and possibly incomparable diagnostic classifications.

Another point raised by Martos-Perez et al. is that of the specificity of the Duke criteria. As previously stated [2], I agree that the Duke criteria should not be substituted for the Beth Israel criteria until their specificity has been evaluated. We initiated such an evaluation in a retrospective study of 100 patients with suspected IE, and we found that the specificity of the Duke criteria was 99% (95% CI, 97%-100%) [3]. It would be interesting to evaluate specificity of both the Duke and the Beth Israel criteria prospectively, as suggested by Martos-Perez et al.

**Chronic Granulomatous Disease Presenting as Severe Sepsis Due to Burkholderia gladioli**

Sir—We read with interest the article by Ross et al. [1] on the successful treatment of Burkholderia (Pseudomonas) gladioli infections in patients with chronic granulomatous disease (CGD). We reported a similar case to the European Society for Paediatric Infectious Diseases in April 1995.

This case involved a 5-year-old child who presented with spiking fevers and multiple hemorrhagic, necrotic pustules that varied in size from 3 mm to 3 cm. Blood and pusule-fluid cultures yielded a “pseudomonad” that differed from Burkholderia cepacia in terms of acid production from ethanol and its failure to produce acid from lactose and maltose in ammonium salt sugar medium; it was identified by the National Collection of Type Cultures Laboratory (Colindale, England) as *B. gladioli*. It was resistant to cephalosporins but susceptible to ciprofloxacin, trimethoprim-sulfamethoxazole (TMP-SMZ) and aminoglycosides. The nitroblue tetrazolium test showed no reduction of dye, confirming a diagnosis of CGD.

The patient was treated with iv ciprofloxacin and gentamicin for 10 days; IFN-γ was administered parenterally for 2 months at a dosage of 50 μg/m over the following weeks, and he continued to receive prophylactic treatment with TMP-SMZ and itraconazole.

Although IFN-γ is not of proven value for treating acute infection, it was administered to this seriously ill child. In keeping with European guidelines [2], it is our practice not to use IFN-γ continuously for prophylaxis but to administer TMP-SMZ and antifungal agents to such patients for life. In the three cases of *B. gladioli* sepsis that have been reported so far, all isolates have been susceptible to TMP-SMZ; it is interesting that of the two patients described by Ross et al., one was taking TMP-SMZ only intermittently, whereas the other was not taking this agent at all. Perhaps prevention of *B. gladioli* sepsis is another argument for the consistent use of TMP-SMZ prophylaxis.

*B. gladioli* infection has now been reported in pneumonic, septicemic, and cutaneous septic-embolic forms and occurs in patients of all ages. We agree with Ross et al., who conclude that this organism should be added to the already long list of potential pathogens recovered from patients with CGD and that its correct identification is important in terms of antibiotic resistance patterns and subsequent treatment.

**References**