Acalculous Cholecystitis and Microsporidiosis in a Patient with AIDS

Sir—We read with interest the report by Knapp et al. [1] of a case of acalculous cholecystitis in a patient with AIDS in whom Enterocytozoon bieneusi was identified as the sole pathogen. We describe a similar patient whom we treated in 1992.

The patient was a 25-year-old homosexual man who had had multiple episodes of diarrhea. He was found to be seropositive for HIV and hepatitis B virus, and stool examinations disclosed Cryptosporidium cysts. He was referred to our center because of a 7-day history of pain in the right upper quadrant, which was accompanied by vomiting. An abdominal ultrasonogram did not show any abnormalities, but the gallbladder appeared occluded on an oral cholecystogram. Cholecystectomy was performed; stones were not found in the gallbladder. Microscopic examination of the gallbladder mucosa revealed multiple rounded supranuclear cytoplasmic inclusions in the epithelial cells, which were identified as microsporidia and further classified as E. bieneusi by means of electron microscopy. No other microorganisms were identified.

Unfortunately, this case was published in a nonindexed medical journal [2] and thus was not available to Knapp and colleagues. We agree with these authors that microsporidiosis should be suspected in patients with AIDS and cholecystitis.

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References

Tricuspid Valve Endocarditis Caused by Streptococcus bovis

Sir—We were interested in the recent case report by Model and Craig [1] because their patient, as well as one patient whose case was previously reported [2], required surgical intervention.

We wish to draw attention to a similar patient whom we described in a review of Streptococcus bovis bacteremia in Auckland, New Zealand [3]. One of these patients had isolated tricuspid valve endocarditis; he had peripheral stigmata of endocarditis, large lesions were noted on an echocardiogram, features of embolization were seen on a chest radiograph, and multiple blood cultures were positive for S. bovis biotype II [4]. The isolate was susceptible to penicillin (MIC and MBC, 0.06 mg/L). The onset of our patient’s symptoms coincided with surgery for a rectosigmoid adenocarcinoma.

Despite the fact that the vegetation seen on the echocardiogram was large, our patient responded to a 6-week course of high-dose intravenous penicillin monotherapy, and he remained well; no vegetations were visible on an echocardiogram obtained 6 months after treatment. We speculate that his benign course may have been related to the fact that his infection was caused by a less virulent, non-dextran-producing strain of S. bovis [4].

We agree with Model and Craig, who stated that the indications for surgical treatment of tricuspid valve endocarditis remain uncertain. We also agree with their assertion that all patients with endocarditis require early and repeated assessments to determine the need for surgical intervention. However, our case does show that right-sided endocarditis caused by S. bovis can sometimes be managed with medical therapy alone.

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References