formed for our patients, our data corroborate the findings of Dromer et al. and demonstrate that epidemiological and clinical variations can also be observed in cryptococcal infections in the United States.

Nina Singh
Infectious Disease Section, Veterans Affairs Medical Center, Pittsburgh, Pennsylvania

References

Reprints or correspondence: Dr. Nina Singh, Infectious Disease Section, VA Medical Center, University Drive C, Pittsburgh, Pennsylvania 15240.
Clinical Infectious Diseases 1997;24:744-5
This article is in the public domain.

Geography Correction
SIR—Dr. Claire Panosian’s excellent review of the 20th edition of Manson’s Tropical Diseases [1] has a factual error in the last paragraph. Amoy (Xiamen) is not in Formosa (Taiwan). It is on the coast of mainland China.

While working in Amoy, Patrick Manson did indeed provide the first description of the man-mosquito cycle in lymphatic filariasis due to Wuchereria bancrofti. He considered the mosquito to be the “nurse” that harbored parasite larvae until they were ready to reinfect humans. Manson believed that humans became infected by swallowing water that contained dead, infectious mosquitoes. He published his research in 1877 and 1878. It was not until 1900 (3 years after Ronald Ross, Manson’s protégé, showed that the bites of mosquitoes transmit malaria) that it was shown that the bites of mosquitoes also transmit filariasis.

Myron G. Schultz
Rollins School of Public Health, Emory University, Atlanta, Georgia

Reference

Reprints or correspondence: Dr. Myron G. Schultz, 635 Greystone Park, N.E., Atlanta, Georgia 30324.
Clinical Infectious Diseases 1997;24:745
© 1997 by The University of Chicago. All rights reserved.
1058-4838/97/2404-0036$02.00

Ocular Toxoplasmosis as the Presenting Manifestation of Human Immunodeficiency Virus Infection

SIR—We read with interest the report by Montoya and Remington [1] describing their important observation that ocular toxoplasmosis in adults may be due to postnatally acquired Toxoplasma gondii infection and does not always represent a late sequela of congenital infection. Two of their patients had HIV infection. The authors point out that toxoplasmic chorioretinitis is the second most common infectious cause of ocular lesions in HIV-infected patients and that most cases of ocular toxoplasmosis in these patients result from newly acquired disease or from organisms newly disseminated to the eye from extraocular sites of disease. We report an additional case of ocular toxoplasmosis; the findings emphasize that ocular toxoplasmosis may be the presenting manifestation of HIV infection.

A 29-year-old woman who had been well until 3 months before admission to the hospital developed symptoms of decreased vision and pain in her left eye. She was evaluated by her ophthalmologist who diagnosed toxoplasmic chorioretinitis of the left eye. Toxoplasma serology was significant for “positive IgM” and “low positive IgG” titers of antibody as determined by EIA (SmithKline Beecham Clinical Laboratories, Tucker, GA). Testing for antibod-

Figure 1. MRI of the brain of an HIV-infected patient with ocular toxoplasmosis reveals multiple contrast-enhancing lesions, some of which are ring-enhancing; these lesions are visible in the region of the gray-white matter interface, the periventricular white matter, and the basal ganglia. The large, irregular, ring-enhancing mass in the left basal ganglia region is associated with midline shift. Note the small, contrast-enhancing left globe, which reflects postsurgical changes.
ies to HIV was not done at that time. The patient was treated with sulfisoxazole and later with clindamycin plus pyrimethamine and prednisone with only transient improvement in her condition. Six weeks before admission, she underwent attempted repair of a detached retina and left vitrectomy, with subsequent blindness in her left eye. All treatment with antibiotics was stopped 4 weeks before admission.

The patient then presented to our institution for evaluation of fever and malaise of 1 month’s duration and slurred speech, unsteady gait, and a decrease in mental status that had progressed over the 2-week period before admission. An MRI scan (figure 1) revealed multiple contrast-enhancing intracerebral lesions with surrounding edema and midline shift. Serologies revealed a “positive IgG” titer and a “negative IgM” titer for toxoplasmosis by use of microparticle EIA (Abbott IMX, Chicago).

Despite the patient’s claim that she had no risk factors for HIV infection, her ELISA and western blot tests were positive for antibodies to HIV. Her CD4+ cell count was 60/µL, and the viral burden was 505,000 copies/mL of plasma. She began receiving treatment with dexamethasone and sulfadiazine/pyrimethamine for toxoplasmosis; she also began receiving antiretroviral therapy. Her neurological status partially improved following therapy.

After counseling, the patient’s heterosexual partner was tested for HIV and was also found to be seropositive for HIV by ELISA and western blot tests; his CD4+ cell count was 180/µL. On specific questioning, he confirmed a history of intravenous drug use many years ago.

The findings in this case highlight the fact that ocular toxoplasmosis may be the presenting manifestation of HIV infection. In a previous report from France [2] in which all HIV-infected patients were screened and 3% were found to have toxoplasmic chorioretinitis, the diagnosis of ocular toxoplasmosis preceded the serological diagnosis of HIV infection in 5 (11%) of 45 patients. However, it may not be widely recognized by ophthalmologists and other physicians who initially evaluate these patients that a diagnosis of ocular toxoplasmosis should prompt screening for HIV infection. If such testing had been performed for our patient, it is possible that interventions to prevent the intracerebral manifestations of toxoplasmosis might have been beneficial. As previously emphasized [2], all HIV-seropositive individuals with ocular toxoplasmosis should be evaluated for cerebral toxoplasmosis.

We recommend that all adult patients with newly diagnosed ocular toxoplasmosis be screened for HIV infection. All physicians should be aware that ocular toxoplasmosis may be the presenting manifestation of HIV infection. With the increasing efficacy of antiretroviral therapy and prophylaxis for opportunistic infections, early diagnosis may significantly improve the quality of life for patients found to be HIV seropositive.

Claire Pomeroy, Robert Noble, Malkanthie McCormick, and Byron Young

Division of Infectious Diseases, Department of Medicine, and Division of Neurosurgery, Department of Surgery, University of Kentucky Chandler Medical Center, Lexington, Kentucky

References