negative, as was testing for cryptococcal antigens and Mycobacterium tuberculosis in urine.

Examination of a blood smear was negative for Plasmodium species. Widal’s test was negative, as was Wright’s staining. Two stool specimens were negative for parasites. Eight aerobic and eight anaerobic blood cultures were negative after 5 days. Intradermal testing with PPD (5 IU) was negative.

Over the following days, high-grade fever persisted, testing revealed worsening of liver function, and hepatosplenomegaly was found; therefore, other tests were performed for rheumatoid factor, antinuclear antibodies, antibodies to extractable nuclear antigens, and antineutrophil cytoplasmic antibodies, and the results were negative. Complement components C3 and C4 and lymphocyte subpopulations were normal.

An ultrasound scan of the abdomen showed an enlarged spleen (bipolar diameter, 185 mm) with homogeneous structure and low-grade hepatomegaly. A chest roentgenogram demonstrated elevation of the right hemidiaphragm; the heart appeared normal. A CT of the abdomen revealed hepatomegaly and splenomegaly. Transthoracic echocardiography showed thickening of mitral valve leaflets consistent with the presence of endocardial vegetations. Transesophageal echocardiography demonstrated only minimal thickening of the mitral valve leaflets without vegetations. A CT scan of the brain was unremarkable. A high-resolution CT scan of the thorax showed coarseness of the right posterior pleural margin with thickening of lung parenchyma, findings consistent with fibrosis.

Aspiration biopsy of bone marrow was then performed. Cultures of bone marrow were positive for P. acnes after 7 days. Histological studies of a transcutaneous liver biopsy specimen showed an area with nonspecific inflammatory infiltrates. Culture of the biopsy specimen was negative. Blood specimens for aerobic and anaerobic cultures were obtained again. After 10 days, three anaerobic and two aerobic cultures yielded P. acnes.

The patient was treated with ampicillin (3 g iv q.i.d. for 5 weeks), netilmicin (200 mg iv b.i.d. for 15 days), and doxycycline (100 mg b.i.d. orally for 21 days). Defervescence occurred, and the laboratory values returned to normal; hepatosplenomegaly resolved.

In conclusion, our patient met the 1992 ACCP/SCCM (American College of Chest Physicians/Society of Critical Care Medicine) Consensus Conference Committee criteria for sepsis (SIRS [systemic inflammatory response syndrome] plus infection) [3]. A definite diagnosis of endocarditis was not made. To our knowledge, this is the first description of sepsis and bone marrow infection due to P. acnes in a previously healthy individual. Our case report points out the importance of incubating cultures of blood and tissue samples, even those from patients without cardiac or neurogenic prostheses, for at least 14 days to isolate P. acnes.

Luisa Praderio, Lorenzo Dagna, Giacomo Beretta, Gianpaolo Rubin, and Cristina Ossi
Department of Internal Medicine II and Division of Laboratory Medicine, IRCCS H S. Raffaele, Milan, Italy

References
Syphilis was one of the most common diseases at the beginning of the twentieth century in Europe and the United States, but in the 1950s, after the introduction of penicillin, syphilis became uncommon [3]. However, the incidence of syphilis increased dramatically after the emergence of the HIV epidemic [3]. Syphilitic aortitis is not usually recognized clinically until 10 to 30 years after the occurrence of primary infection. Given the short survival rate that characterized HIV disease until the introduction of the current therapeutic modalities, it is not surprising that aortic aneurysms have not been more frequent among patients with HIV. However, given the slow progression of HIV disease achieved with the use of protease inhibitors, it is possible that cardiovascular-related syphilis will become more common. Further to this point it should be noted that in southwestern European countries, a large percentage of HIV patients are drug addicts and prostitutes. These individuals are at high risk for contracting syphilis and frequently do not consult healthcare providers, and, if they do, are often not compliant with therapy. Therefore, treatment of primary disease as well as diagnosis and treatment of latent syphilis may be difficult.

In summary, with the rise in syphilis prevalence (in HIV-infected and non-HIV-infected patients) seen since the appearance of HIV, the low therapeutic compliance often observed in some of these patients, and the longer survival achieved for HIV patients with the new therapeutic regimens, some almost forgotten forms of tertiary syphilis may become more common. Among these syphilitic forms is the aortic aneurysm, which may present as a superior vena cava syndrome, as seen in the patient we described.

Jose M. Olmos, Marta Fernández-Ayala, José A. Gutierrez, José F. Val, and Jesús González-Marcías  
Departamento de Medicina Interna, Servicio de Cirugía Cardiovascular, and Departamento de Anatomía Patológica, Hospital Marqués de Valdecilla, Universidad de Cantabria, Santander, Spain

References

Leishmaniasis of the Tongue in a Renal Transplant Recipient

Immunocompromised patients are at risk of increased morbidity and mortality from visceral leishmaniasis [1]. Several reports have described visceral leishmaniasis in kidney transplant recipients [2]. Mucosal leishmaniasis is rare in the Old World and has been reported most often from the Sudan [3]. Treatment with antimony compounds continues to be the main therapeutic option. However, because of side effects, several alternatives have been tried [4]. We report a kidney transplant recipient with tongue leishmaniasis that responded to therapy with liposomal amphotericin B.

A 55-year-old Sudanese man who had undergone kidney transplantation in 1984 had been maintained on azathioprine and prednisone; his creatinine level was 250 μmol/L. In 1995, he noticed a slowly progressing tongue lesion. There were no

Figure 1. A chest radiograph showing a large noncalcified anterior mediastinal mass in an HIV-infected patient with superior vena cava syndrome secondary to a syphilitic aneurysm of the ascending aorta.