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] with 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 protheses, for at least 14 days to isolate *P. acnes*.

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References

Superior Vena Cava Syndrome Secondary to Syphilitic Aneurysm of the Ascending Aorta in a Human Immunodeficiency Virus—Infected Patient

Superior vena cava syndrome (SVCS), a well-known entity resulting from obstruction of the superior vena cava, usually occurs because of mediastinal tumors [1]. We describe a patient with previously undiagnosed HIV infection who developed SVCS because of a syphilitic aneurysm of the ascending aorta.

A 48-year-old man was admitted to our hospital (Santander, Spain) because of progressive swelling and redness of his face, neck, and arms of 4 days’ duration. He was a nonsmoker, and he did not give a history of venereal disease. He denied having any homosexual relationships, but there was a history of sexual contact with prostitutes.

His blood pressure was 130/80 mm Hg in each arm. Arterial pulses were brisk in all extremities. His face and neck were diffusely swollen, and his jugular veins were distended bilaterally to the angle of the mandible while he was examined in an upright position.

Laboratory findings included a hemoglobin concentration of 10.6 g/dL, a normal mean corpuscular volume, a WBC count of 5,200/mm³ (20% lymphocytes), and an erythrocyte sedimentation rate of 74 mm/h. Chest radiographs showed a large anterior mediastinal mass (figure 1). A CT scan of the chest showed an aneurysm of the ascending thoracic aorta, with partial thrombosis, compressing the superior vena cava. Venereal Disease Research Laboratory (VDRL) and *Treponema pallidum* hemagglutination (TPHA) tests on serum were positive (titers, 1:256 and 1:1,280, respectively). Evaluation of a CSF sample with use of VDRL and TPHA tests was negative. Serologies for antibodies to HIV were positive, both ELA and Western blot. The CD4+ lymphocyte count was 475/mm³, and the plasma viral load was 17,000 copies/mL.

During a thoracotomy, a large saccular aneurysm involving the entire ascending aorta and compressing the superior vena cava was resected. Histological evaluation of the resected aneurysm showed miliary gummas in the tunica media and scant multinucleated cells between the epithelioid cells of the granulomas. Postoperative re-
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.

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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