obtained 3 and 12 months after diagnosis on all of these patients. Using data from this prospective database, 13 of 26 patients with definite or probable IE who underwent surgery were 30–59 years old and 7 of 26 were ≥65 years of age. One of 13 younger adult patients who underwent surgery for IE died in the hospital before discharge. The remaining 12 younger patients were alive at 3 and 12 months after diagnosis. Four of these 12 younger patients required rehospitalization for complications related to their surgery.

One of seven elderly patients with IE who required surgery died in the hospital before discharge. Five of the six elderly patients who survived through discharge were alive 3 months after onset, and four patients were alive 12 months after onset of illness. None of the six elderly patients who survived hospitalization were rehospitalized because of surgical complications.

Although the above data do not support the finding of Netzer et al. that elderly patients are at greater risk for poor outcomes following surgery for IE, the number of patients in our prospective database who underwent surgery for complications of IE was too small to adequately examine this question and we did not specifically record data on rhythm disturbances or other immediate in-hospital postoperative complications in our database. Further studies designed to examine the risk of complications of surgery for IE are clearly needed. Such studies should examine the impact of age as well as the importance of preoperative factors such as renal disease, left ventricular dysfunction, and valve-ring abnormalities.

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Reference


Amphotericin B Colloidal Dispersion Versus Amphotericin B in the Empirical Treatment of Fever and Neutropenia

SIR—I read with great interest the article by White et al. [1] comparing amphotericin B colloidal dispersion to amphotericin B in the empirical treatment of fever and neutropenia. My question to the authors is: Was a normal saline bolus given to patients prior to their receiving amphotericin B? One of the main conclusions of this article is that amphotericin B colloidal dispersion is less likely to cause renal dysfunction than is amphotericin B. Pre-treatment of amphotericin B therapy with 500 mL of normal saline has been recommended to reduce the incidence of nephrotoxicity [2, 3]. Nowhere in the article is there any mention of normal saline pre-treatment.

At my institution, the standard practice is to administer a normal saline bolus prior to administering amphotericin B to reduce nephrotoxicity. White et al. do mention that a cost-effective analysis was not performed in their study, so it was not possible to determine if the renal safety benefit of amphotericin B colloidal dispersion warrants the cost of a new formulation of amphotericin B. Normal saline may be an inexpensive alternative for reducing the nephrotoxicity associated with amphotericin B, given the high cost of amphotericin B colloidal dispersion.

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References


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Reply

SIR—Normal saline boluses were permitted during the study [1]. Patients at five sites received saline boluses ranging in volume from 250 mL to 1000 mL, once or twice daily. Eleven patients (10.5%) who received amphotericin B, collectively received 68 saline boluses, and six patients (5.5%) assigned to receive amphotericin B colloidal dispersion (ABCD) collectively received 24 boluses. In most cases, saline administration began within 48 hours of study drug initiation, so its use was not likely to be influenced by amphotericin B–related nephrotoxicity. Because clinicians were blinded to drug assignment, use of saline boluses most probably reflected clinical practice at specific sites.

Unfortunately, these data do not clarify the relative benefits of normal saline boluses in the prevention or treatment of amphotericin B–associated nephrotoxicity.

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