Cytological examination should always be performed to establish a differential diagnosis as early as possible.

Patrick Blanco, Jean-François Viallard, Marie Beylot-Barry, Isabelle Faure, Patrick Mercié, Béatrice Vergier, Jean-Luc Pellegrin, and Bernard Leng
Service de Médecine Interne et Maladies Infectieuses, Service de Dermatologie, and Laboratoire d’Anatomo-pathologie, Hôpital du Haut Levêque, Pessac, France

References

Management of Progressive Outer Retinal Necrosis with Cidofovir in a Human Immunodeficiency Virus–Infected Patient

Progressive outer retinal necrosis (PORN) is necrotizing retinitis due to varicella-zoster virus (VZV) infection that has a rapidly progressive course usually resulting in bilateral blindness in most affected patients. Although systemic combination therapy with ganciclovir/foscarnet might have an effect on the course of PORN, the average final visual acuity is still not better than hand movements [1].

Cidofovir is a novel nucleotide analogue with activity against herpesviruses; the phosphorylated products of cidofovir can act as an intracellular storage reservoir with long-acting antiviral activity. Herein, we report the case of an HIV-infected patient with PORN whose visual acuity was markedly improved by cidofovir treatment.


A 31-year-old drug user with HIV infection (CD4 T helper cell count, 33/μL; Centers for Disease Control and Prevention’s classification, C3) had been admitted to the hospital because of disseminated VZV infection, which was treated by intravenous and oral acyclovir for 16 days followed by maintenance therapy with oral famciclovir. Two months later, the patient developed VZV keratitis and anterior uveitis of his right eye, which progressed to posterior uveitis and PORN with rapid loss of visual acuity to 0.3 despite famciclovir treatment (figure 1). Intravenous cidofovir was chosen as salvage therapy (given once weekly for 2 weeks and once thereafter at a dose of 5 mg/kg of body weight with concomitant oral probenecid [4 g] and intravenous saline treatment).

The patient’s visual acuity improved and has stabilized (for 16 months) at 0.5 after five treatment cycles. Fundoscopy showed that the active inflammation had markedly improved, with residual scarring of the retinal periphery. Spreading of the infection to his left eye was completely prevented.

Extensive retinal necrosis and rhegmatogenous retinal detachment are the major complications of PORN, which cannot be reliably prevented by standard combination therapy with ganciclovir/foscarnet. The favorable outcome in our case suggests that cidofovir may be a promising therapeutic alternative, possibly because of the longer antiviral action of this novel drug.
Figure 1. A. Central cotton wool spots and beginning peripheral progressive outer retinal necrosis in an HIV-infected patient before treatment with cidofovir. B. After treatment with cidofovir, active inflammation ceased, central ischemia disappeared, and there is retinal scarring at the sides of the previous necrosis.

K. Schliefer, H. O. C. Gümbel, J. K. Rockstroh, and U. Spengler
Department of General Internal Medicine, University of Bonn, Bonn, and Department of Ophthalmology, University of Frankfurt, Frankfurt, Germany

Staphylococcus saprophyticus as an Unusual Agent of Nosocomial Pneumonia

*Staphylococcus saprophyticus* is a well-known and frequent etiologic agent of urinary tract infections [1]. It causes infections in young women, elderly men, and children [2, 3]. Rare cases of sepsis following pyelonephritis have been documented [4]. It is described as a bacterium of zoonotic origin, which has been isolated from pigs, cattle, goats, and other animals [5, 6]. Recently, we cloned and characterized an adhesive and autolytic surface protein of *S. saprophyticus* (AAS), which is a major adhesion factor for the organism [7]. Herein, we report a case of *S. saprophyticus* pneumonia after neurosurgical intervention. To our knowledge, no cases of nosocomial infection by *S. saprophyticus* have been reported, nor has *S. saprophyticus* been described yet as a pulmonary pathogen.

A 61-year-old man presented with intracerebellar hemorrhage caused by a hypertensive crisis during anticoagulative therapy (international normalized ratio, 3.55; prothrombin time, 17%). The patient underwent emergency craniotomy and was extubated soon after neurosurgical intervention. Three days later, his pulmonary condition deteriorated, and mechanical ventilation had to be used again. Seven days after craniotomy, he had mild hyperthermia (temperature, 38.3°C) and purulent bronchial secretion. One day later, the inflammatory parameters (C-reactive protein level and leukocytic elastase level) were elevated. A chest roentgenogram showed a new infiltrate in the left lower lobe. The patient was given intravenous therapy with cefazidime (2 g q12h); the patient had no signs of urinary tract infection.

Bronchoalveolar lavage (BAL) was performed, and quantitative bacteriologic culture of the BAL fluid was done. Gram staining of the BAL sediment showed high counts of gram-positive cocci and

Reference