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References


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Reply

Sir—The letter from Dr. Johnson about the value of infectious diseases specialists is provocative but shortsighted. Dr. Byl and colleagues have made progress in understanding the value of infectious diseases specialists’ services. Although they could not clearly demonstrate a correlation between consultations and the death rate among bacteremic patients, the frequency of death was fortunately small. A larger number of cases might have added power to the numbers and confirmed the positive relationship proposed.

Even if an inverse correlation with involvement of infectious diseases specialists and mortal outcome were found to be statistically significant, this would not necessarily translate into more consultations. The concept that scientific principles determine market share is naive. Just think how different our world would be if “alternative” medical therapies, nutrition supplements, or even legal services had to justify their existence on the basis of a rigorous demonstration of benefit to health care.

Another problem with investigating the value of infectious disease consultations and follow-up services is that they are not a standardized commodity and hence are difficult to measure. Every physician is different and performs differently. Every medical community is also different and may offer a host of incentives and disincentives that outweigh the clinical value of a consultation. The value of experience in HIV care has been clearly documented in a staff model health maintenance organization, yet the number of infectious disease consultations has not increased [1].

Our specialty is one in which we have no unique procedure but must compete in expertise and value with other medical specialists, as well as primary care physicians. This is not an easy task, but it is an important one. We must continually demonstrate our ability, availability, and affability if we want to be consulted again. The value of infectious disease consultations must be continually demonstrated by every individual in the field and often in unique situations. Our specialty must be oriented to change and ready to respond to the challenges of emerging infections and managed care [2].

In addition, the value of infectious diseases specialists should be judged not only by numbers of consultations but also on the basis of their ability to lead and manage a variety of related services, such as infection control, clinical microbiology, antibiotic therapy, outpatient intravenous antibiotic therapy, and medical education. The benefits of our total contributions may again be difficult to demonstrate statistically, yet they are becoming increasingly appreciated, as demonstrated by the growing number of advertisements for infectious diseases specialists in medical journals and the continued focus on infectious diseases in the popular press and other media [3].

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References


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Herpes Simplex Virus Peritonitis

Sir—The report of peritonitis due to herpes simplex virus (HSV) in a patient undergoing peritoneal dialysis [1] is of interest. However, it is unfortunate that the authors did not attempt to determine whether the infection was due to HSV type 1 or type 2, which would have implications about the source of the infection. Evidence of HSV-2 would support the hypothesis—implied by the case history but not specifically discussed—that the infection resulted from reactivation of genital herpes, perhaps due to contiguous infection in relation to the gynecologic surgery for uterine cancer 6 months earlier.

Monoclonal antibody reagents that can distinguish between HSV-1 and HSV-2 antigens in tissue specimens are readily available [2]. In addition, type-specific serological tests using Western
Correspondence

Blot or other immunoblot technologies have been available commercially for several years, and tests based on other methods are offered by a number of research laboratories [3]. (Type-specific serology would help determine the etiology in this case if reactive only for HSV-1 or HSV-2 but not if positive for both virus types.)

Finally, the case report states that the patient reported “no history of cold sores,” but there is no mention of genital herpes, which is at least equally pertinent.

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References

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Report of the First Cases of Cutaneous Leishmaniasis in East Timor

Str—According to the World Health Organization’s division of control of tropical diseases statistics, leishmaniasis currently affects ~12 million people in 88 countries, and it is estimated that 350 million people are exposed to the risk of infection by the different species of Leishmania parasites. The French military medicosurgical group, part of the International Force for East Timor (INTERFET), is deployed in Dili (the capital of East Timor) in the context of a humanitarian mission for medical support of the local population. Here we report 46 cases of cutaneous leishmaniasis detected in November 1999 during daily free clinic consultations for people in that area.

The detected cutaneous lesions had been developing for 1–3 months, and all the clinical criteria were consistent with cutaneous leishmaniasis. Diagnosis was confirmed by direct microscopic examination of lesion specimens stained with May-Grünwald-Giemsa reagent, showing typical intracellular parasites.

The patients were treated with metronidazole and local dressing. Clinical follow-up was not possible because of their refugee status and permanent mobility.

These cases are, we believe, the first to occur in this territory and in all of Indonesia. Species-identification procedures are being pursued.

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