cultures have ~85%–95% yield, the latter procedure appears to be superior and the best choice for effective therapy.

We neglected to mention the amylase level of our patient in our report; it was 22 U (normal range, 15–125 U), which suggested that our patient’s ascites was not the result of pancreatitis, pancreatic pseudocyst, mesenteric vein thrombosis, pancreatic and some nonpancreatic neoplasms.

We look forward to the use of PCR technology and newer biomolecular probes, which should provide us with more sensitive and specific tests to diagnose tuberculous peritonitis, which is the 6th most common manifestation of extrapulmonary tuberculosis.

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Metronidazole Resistance in Clostridium difficile

Sir—Jang et al. [1] reported high-level resistance to metronidazole in Clostridium difficile isolates obtained from horses. To determine whether metronidazole resistance was of clinical importance in human patients with C. difficile-associated diarrhea (CDAD), we analyzed clinical C. difficile isolates obtained from patients with CDAD who failed to respond to metronidazole treatment [2]. Prospective surveillance at one VA Medical Center over a 10-year period documented only 14 (2%) treatment failures among 632 episodes of CDAD treated with metronidazole [3]. We tested the susceptibility of all 10 available C. difficile isolates from the metronidazole treatment failures and 20 C. difficile isolates from contemporary control CDAD cases (CDAD cases successfully treated with metronidazole) using E-test and agar dilution methods. The MIC (mean ± SD) of metronidazole failure-associated C. difficile isolates was similar to the MIC (mean ± SD) of isolates from metronidazole success cases (E-test; 0.23 ± 0.21 vs. 0.29 ± 0.19 µg/ml; P = 0.4) [2]. All isolates had an MIC < 1 µg/ml by E-test and by agar dilution; therefore, we concluded that treatment failures could not be attributed to decreased susceptibility of the infecting C. difficile strain to metronidazole.

Recent reports from China, France, and Spain have found clinical C. difficile isolates with reduced susceptibility to metronidazole [4–6]. Wong et al. [4] recovered a clinical C. difficile isolate with an MIC >64 µg/mL. Although the other 99 C. difficile isolates tested had an MIC <2 µg/mL, this report is the first well-documented case of a metronidazole-resistant strain of C. difficile in a patient with CDAD. Barbut et al. [5] identified 6 C. difficile isolates with MIC values for metronidazole that ranged from 8 to 32 µg/mL among 198 isolates recovered from a clinical laboratory in France in 1991 and 1997. Five of the 6 isolates were nontoxigenic strains and were therefore clinically insignificant. In addition, there was no trend of resistance between the 2 time periods. A preliminary report from Spain noted an increase of metronidazole resistance in clinical isolates obtained in 1998, compared with those obtained in 1993 (14% vs. 6%) [6].

Surveillance for metronidazole resistance in C. difficile in other populations needs to be performed to determine whether metronidazole resistance in C. difficile is an important or emerging clinical problem. For now, metronidazole remains an inexpensive, highly effective treatment for CDAD.

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SIR—On 4 January 2000, the National Flu Surveillance Network issued an advisory that placed Michigan on an Influenza Alert. The reason for this alert was that cases of influenza were diagnosed at one of their surveillance sites every other day. The 2-page Alert was sent via fax to television stations, and, presumably, other media outlets. It contained background information about the network, a description of the outbreak classification system, a paragraph warning that influenza can be fatal, a sentence listing of some influenza symptoms, and information about the test kit ZstatFlu.

After we received multiple calls from the local media, we requested copies of the faxed information. Although clearly stated in the materials, some in the media had not realized that the National Flu Surveillance Network is not a government agency but is rather sponsored by Zyme Tx. (Oklahoma City), the manufacturer of ZstatFlu.

This year’s influenza outbreak aside, we feel that the use of such alerts highlights some important ethical and public health issues. First, can any private entity claim that a state is on alert? Second, when announcements from private entities occur, should they be specifically labeled so that they are identified as different than announcements from government agencies? Third, in this case, did a private entity purposely use the media purposely to intensify patient concerns about influenza as part of a marketing plan to increase use of their product?

Although we acknowledge that physician and patient awareness of influenza is a laudable goal, we feel that non-governmental organizations need to clearly identify materials that are promotional; that the media need to closely monitor the source and authenticity of such materials; and that no private entity has the authority to place a region or state on alert.

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Levofoxacin-Resistant Pneumococcus

SIR—Wortmann and Bennett [1] report the isolation of Streptococcus pneumoniae from the blood and CSF of a patient who had received 4 days of levofloxacin therapy (500 mg orally once daily). In order to assess the likelihood that this might occur in the future, it is important to know the levofloxacin MIC of the pathogen. Pharmacodynamic principles would suggest that strains with levofloxacin MICs of 4–8 μg/mL would be unlikely to be eradicated by the dosage of levofloxacin they used. The authors described “a zone of inhibition of zero” determined by the E-test (AB Biodisk, Piscataway, NJ). The E-test gives a quantitative MIC and is not read in terms of a zone diameter. Could the authors clarify the MIC of the E-test? If indeed there was no inhibition at all around the E-test, are the authors suggesting that the MIC of this strain is 32μg/mL, which is the appropriate interpretation of a levofloxacin E-test with no zone of inhibition?

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