Mosquito bites were observed on 18 patients (14.8%), 7 of whom had ≥5 bite marks. Using a multivariate logistic regression model adjusted for age, sex, CD4 count, HIV load, and HIV-transmission group, we identified an independent association between lipoatrophy and (1) a history of having been bitten by mosquitoes in the 3 months before the study (OR, 2.44; 95% CI, 1.06–5.59) and (2) the presence of mosquito bites at the time of physical examination (OR, 10.13; 95% CI, 2.65–38.73). No specific type of ART was found to be associated with mosquito bites.

Lipoatrophy has been increasingly described among individuals who receive nucleoside reverse-transcriptase inhibitors [1]. Lipoatrophic subcutaneous tissue may present a more accessible capillary network and an increased release of volatile substances from the skin surface. A similar mechanism, triggered by increased blood flow, has been suggested as an explanation for the attraction of mosquitoes to the skin of pregnant women [2]. Whether the observed increase in mosquito bites may result in greater risk for insectborne infections, such as those caused by *Leishmania* and *Plasmodium* species, can only be speculated. The association of lipoatrophy with an increase in mosquito bites has no bearing on HIV transmission, because insect vectors play no role in the spread of HIV [4].

**References**


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**Recurrent Nonmenstrual Toxic Shock**

Str—Andrews et al. [1] recently published a review entitled “Recurrent Nonmenstrual Toxic Shock Syndrome: Clinical Manifestations, Diagnosis and Treatment.” As their title suggests, although recurrent menstrual toxic shock is not uncommon, few reports of this syndrome have been published. The authors review 9 previous cases and report 3 of their own, including 1 in a patient with AIDS.

In 1992 we described 5 patients with a recalcitrant, erythematous desquamative disorder associated with toxic shock toxin-1 (3 patients), staphylococcal enterotoxin A (1 patient) and staphylococcal enterotoxin B (1 patient) [2]. Three of the 5 patients died; autopsies of 2 patients confirmed residual staphylococcal infection, and, interestingly, both survivors developed recurrent disease. All patients were homosexual men. One of the patients significantly improved after receiving commercial iv gammaglobulin, which contains staphylococcal toxin antibody [3]. Indeed, the HIV-1–infected patient treated by Andrews et al. [1] also responded favorably to iv gammaglobulin.

We suggested that the recalcitrant, erythematous desquamative disorder was related to defective chemotaxis [4], but observed that a lack of staphylococcal toxin antibody formation could also play a role. Therefore, the disorder—the characteristics of which have subsequently been confirmed [5, 6]—may have an immunologic relationship to recurrent nonmenstrual toxic shock syndrome in patients infected with HIV-1; patients with these disorders likely lack staphylococcal toxin antibody production. The absence of toxin antibody may be due to the “superantigen” molecular behavior of staphylococcal toxins.

**Antifungal Prophylaxis and the Rate of Bacteremia among Neutropenic Patients**

Str—We recently published an article in *Clinical Infectious Diseases* that explored the possible association between antifungal prophylaxis and the rate of documented bacteremia among febrile neutropenic patients with cancer [1]. This