of tuberculosis disappeared with no evidence of recurrence at 1-year follow-up.

Drug interactions between Rif and protease inhibitors have prompted clinical studies of HIV-infected patients that have documented the efficacy of Rib as a substitute for Rif in the 6-month antituberculous regimen [2–4]. Intolerance to Rif is not rare and could be another indication for Rib. The tolerance profile of Rib is distinct from that of Rif, and there is no indication that cross-toxicity is of concern [5]. In conclusion, a regimen that contains Rib could be the first-choice alternative for the treatment of patients with tuberculosis who are intolerant to Rif.

Pierre Tattevin, Mathieu Revest, Mathieu Dupont, Cédric Arvieux, and Christian Michelet
Clinique des Maladies Infectieuses, Hôpital Pontchaillou, Rennes, France

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Association of TT Virus Primary Infection with Rhinitis in a Newborn

Str—TT virus (TTV), which was discovered in 1997, is the first identified circovirus-like virus that infects humans. To date, TTV has not been formally associ-ated with any disease in humans, even when highly divergent TTV isolates that belong to the SEN family are present, as reported by Chamberland in a recent review [1]. In the general population, reported prevalences of TTV infection are up to 80% [2], and the virus is most often detected in serum and saliva [3]. Transmission of the virus is suspected to occur through multiple pathways and, in particular, through saliva droplets. Mother-to-infant transmission of TTV is uncertain and is not well documented [4, 5]. We report the findings of early follow-up of a full-term female newborn, along with the findings for both parents.

Oral swabs were used to obtain saliva samples from the mother (M) and father on days −25, −19, and +28 (with respect to the newborn’s delivery date) and from the newborn (N) on days +3, +4, +6, +9, +11, +13, and +28. A total of 10 µL of a Chelex-100 (Bio-Rad)–extracted DNA solution [6] was amplified using highly conserved primers located in the viral untranslated region and a standard PCR protocol [7]. First-round primers were COM1sens (5′-CRSWKMCGAA-TGGYWGAGTTTWY-3′) and COM-2rev (5′-GCCCCGAAATTGCCCCCTWGAC-TKCG-3′), and second-round primers were COM1sens and TTSPErev (5′-HCG-GCAACCGGCCCGGAGAC-3′). Control PCR consisted in β-globin gene amplification.

TTV genome was detected in all samples obtained from the mother and in none of those obtained from the father. Very high virus loads were transiently present in the samples obtained from the newborn on days +4, +6, and +9 only. PCR products M(−25), M(+28), and N(+4) were cloned and, for each 15 clones, were sequenced. Phylogenetic analysis of these clones as well as the reference sequences confirmed the specific amplification of TTV genome. Each group of sequences (M[−25], M[+28], and N[+4]) constituted an independent evolutionary cluster (genetic heterogeneity, 28.3%–30.4%). However, PCR primers specifically designed from N(+4) sequences permitted amplification of a sequence from the M(−25) sample, which showed 100% identity with the N(+4) sequence.

This finding strongly suggests that the strain that infected the newborn was acquired from the mother during delivery or during the postpartum period. That the transmitted strain appears to be distinct from the dominant strain that infected the mother suggests that all TTV strains do not have the same potential for interhuman transmission.

Follow-up of the newborn’s natural history was performed in parallel to TTV DNA detection. Of interest, the newborn experienced clinical symptoms of a benign “viral” rhinitis from days +4 to +10, including clear nasal discharge; no fever, diarrhea, or cutaneous rash; and a spontaneous recovery. Neither the mother nor the father harbored corresponding clinical signs. This episode corresponded exactly to the period of positive detection of TTV in saliva and is suggestive of the etiological implication of TTV infection. Therefore, this report might be the first to describe the clinical symptoms associated with primary infection with TTV, and it should permit the association of TTV with extrahepatic disorders to be envisaged, despite its initial suggested implication.

Philippe Biagini,1 Rémi N. Charrel,2 Philippe de Micco,12 and Xavier de Lamballerie1
1Etablissement Français du Sang Alpes-Méditerranée and 2Faculté de Médecine, Unité des Virus Emergents (EA3292 and IFR48), Marseille, France

References


Reprints or correspondence: Dr. Xavier de Lamballerie, Laboratoire de Virologie Moleculaire, Tropicale et Transfusionnelle, 27, Blvd. Jean Moulin, 13005 Marseille, France (virophdm@gulliver.fr).

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