emphasizes the point made by Wallace et al. [1] that all health care providers need to familiarize themselves with infectious diseases endemic to south central Asia, despite the fact that many of these diseases are not commonly seen in the United States. One other point of interest is that a diagnosis of malaria should never be ruled out if the patient was receiving prophylaxis while in the country where infection occurred; prophylaxis may have been a confounder during this patient’s initial presentation and treatment. The fact that the patient was not prescribed an appropriate terminal prophylaxis regimen (e.g., doxycycline, 100 mg/day for 1 month, in conjunction with primaquine [base], 26.3 mg/day for 2 weeks) [3] demonstrates the pitfalls that malaria poses for health care providers not thoroughly conversant with this disease.

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References

Enteric Fever in Mumbai, India: The Good News and the Bad News

Sir—Salmonella continues to be highly endemic in Mumbai, India [1]. We have noticed a worrisome trend in the past 5 years: there has been a steady increase in the absolute numbers of Salmonella enteritidis serotype Paratyphi A isolates recovered from blood cultures (with use of the BACTEC 9050 automated culture system; Becton Dickinson) at our institute, a tertiary care center in central Mumbai. The increase in the rate of isolation of this organism has been remarkable: from only 1 S. Paratyphi A isolate in 1992 to 27 isolates in the first 7 months of this year (table 1). The majority of patients (18 of the 24 patients available for follow-up) who had paratyphoid had received typhoid immunization in the form of the orally administered typhoid vaccine or the injectable capsular Vi polysaccharide vaccines. Immunization protects against Salmonella enterica serotype Typhi but not against S. Paratyphi A. This is not withstanding the fact that infection with S. Typhi is still rampant in the city and shows no signs of abating. To compound matters, the percentage of nalidixic acid–resistant S. Typhi increased from 82% of isolates in 2000 to 88% in 2002, and the MIC of ciprofloxacin (as determined by Etest; AB Biodisk) also increased, from 0.125–1 µg/mL in 2000 to 0.19–1.5 µg/mL in 2002 [2]. However, the good news is that there has been a significant decrease in the prevalence of plasmid-mediated “block” resistance (to chloramphenicol, trimethoprim-sulfamethoxazole, and amoxycillin), from 46% of isolates in 2000 to 17% in 2002. Clearly, the selective antibiotic pressure on S. Typhi of chloramphenicol, trimethoprim-sulfamethoxazole, and amoxycillin is on the ebb, and we could perhaps go back to using these drugs in the future.

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Reduced Acquisition of Vancomycin-Resistant Enterococci: Gown Effect or Confounding?

Sir—The evaluation of gown use and vancomycin-resistant enterococci (VRE) acquisition by Puzniak et al. [1] is timely and relevant. However, we would like to raise several concerns about the methods used in this study and their impact on the study’s findings.

In their study, Puzniak et al. [1] thoroughly collected data on recognized risk factors for VRE acquisition. Table 2 of their article describes the association between such factors and the acquisition of VRE in their cohort [1]. As expected, receipt of enteral feeding, gastric acid suppression, exposure to antibiotics, long duration of antibiotic treatment, high APACHE II score, long duration of mechanical ventilation, and exposure to VRE-colonized patients were all highly associated with the acquisition of VRE. The prevalence of these risk factors in the 2 study groups—those hospitalized during the “gown” pe-

Table 1. Isolates responsible for enteric fever that were recovered from blood culture.

<table>
<thead>
<tr>
<th>Year</th>
<th>S. Typhi</th>
<th>S. Paratyphi A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>96</td>
<td>1</td>
</tr>
<tr>
<td>1994</td>
<td>110</td>
<td>2</td>
</tr>
<tr>
<td>1996</td>
<td>98</td>
<td>4</td>
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<td>1998</td>
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<td>17</td>
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<tr>
<td>2000</td>
<td>240</td>
<td>40</td>
</tr>
<tr>
<td>2002*</td>
<td>106</td>
<td>27</td>
</tr>
</tbody>
</table>

NOTE. S. Paratyphi A, Salmonella enteritidis serotype Paratyphi A; S. Typhi, Salmonella enterica serotype Typhi.

* Data are for January through July.