

Reply

We agree with the suggestion of Shopsin et al. [1] that adding chromosomal and mec DNA genotyping information would help to clarify the derivation of community-onset isolates of MRSA. Our simpler algorithm for categorizing isolates used only information routinely available to clinicians because, in the vast majority of the studies that we reviewed, it appeared that these were the only data available [2]. A classification algorithm based completely on clinical epidemiology would be of value to those without routine access to advanced genotyping techniques. Such a classification strategy would provide some degree of uniformity, which was lacking among the many studies that we reviewed. In addition, in infection-control efforts to prevent the spread of MRSA, accurately determining the reservoir for spread is of more interest than is the actual derivation of individual MRSA isolates. Those considering implementation of a surveillance-culture program to control nosocomial spread should not assume that such testing—and its attendant cost—is routinely necessary for optimal control of MRSA. Control of nosocomial spread by simply identifying carriers and placing them under contact precautions has been repeatedly documented [3–12].

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References


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strongyloidiasis complicating AIDS. [3]

facilities and lack of awareness are other

factors that might explain this fact.

Treatment of Strongyloides hyperinfection is difficult, especially in a rural setting, where the choice of drugs is severely limited, as was well-illustrated by this case. Treatment with the most common antihelminthic agent available in rural Uganda, mebendazole, was clearly ineffective.

Albendazole and single-dose ivermectin therapy were both temporarily effective in clearing intestinal larvae. A higher dosage of albendazole was no better than a standard dosage in treatment of disseminated disease. A 3-day course of therapy with ivermectin, on the other hand, resulted in an apparent clearance of larvae from all body sites, resulting in a sustained larvae-free period until the death of the patient due to underlying immunosuppression.

This report shows that Strongyloides hyperinfection syndrome does occur in association with AIDS in Uganda. It also suggests that albendazole and single-dose ivermectin may be useful in treatment of uncomplicated AIDS-associated Strongyloides infection. However, in the presence of dissemination, a longer course of ivermectin appears superior. The presence of Strongyloides in a patient’s stool and the concurrent presence of chest symptoms should prompt clinicians to examine sputum samples for larvae.

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The NOW S. pneumoniae Urinary Antigen Test Positivity Rate 6 Weeks after Pneumonia Onset and Among Patients with COPD

Sir—The recently published study by Gutierrez et al. [1] provides additional information on the performance of the NOW Streptococcus pneumoniae urinary antigen test (Binax) and confirms the findings of other studies [2, 3]. For adults with community-acquired pneumonia (CAP), the test has an estimated sensitivity of 75%–85% among bacteremic patients and 50%–80% among nonbacteremic patients.

Included among the unresolved issues regarding the performance of the NOW assay are, first, the duration of test positivity after onset of pneumococcal infec-

tion and, second, the positivity rate among patients with chronic obstructive pulmonary disease (COPD) who may be colonized by or infected with S. pneumoniae [4]. We present data to help clarify both of these issues.

Of the 120 patients with CAP and positive NOW urinary antigen test results in our study [3], 80 had urine samples that were collected at follow-up ~6 weeks after admission to the hospital (median interval after onset of symptoms, 49 days [range, 33–89]; median interval after collection of first urine sample, 43 days [range, 31–82]). When unconcentrated samples were tested using the NOW assay, 38 (48%) of these samples yielded positive results. The longest duration of positivity of test results for any patient in our study was 89 days after onset of symptoms. Although we do not have more-recent urine samples from these patients, which would allow us to better characterize the duration of antigen positivity, our findings indicate that S. pneumoniae antigen can be detected in urine for several weeks following pneumococcal pneumonia. It is possible that S. pneumoniae antigenuria may be very prolonged in some patients, as is the case with Legionella antigenuria [5]. The practical implications of these findings apply to patients with pneumonia who have recently had a previous episode of pneumonia for whom a positive urinary antigen test result may be due to the first episode.

To evaluate the NOW assay among patients with COPD, we tested urine samples obtained from 97 patients with COPD (defined as those with a history of chronic progressive symptoms [cough, wheeze, or breathlessness] with objective evidence of irreversible airflow obstruction on spirometry) who had no clinical or radiographic evidence of pneumonia. Forty-nine urine samples were collected from patients during exacerbations of COPD, and the remaining 48 samples were collected from patients with stable COPD during routine outpatient visits. Nasopharyngeal swab specimens and sputum samples (if avail-