The recent review by Pappas et al. of infectious diseases as depicted in the movies was fascinating, but it is obvious that Hollywood is in urgent need of some fresh ideas for such cinema. The colorful language of our specialty and the variety of deadly or disgusting real-life pathogens could make for cinematic thrillers of almost any genre. I offer some examples with suggested titles.

The soft-tissue virulence of “flesh-eating” group A streptococci is truly frightening to anyone who has witnessed the full-blown toxic syndrome. When they do get around to making the movie, it might be titled “Eschar Wars—Flesh-Eating Strep Unchained!” Another scary skin flick might be “Creeping Eruption—It Will Make Your Skin Crawl!”

Worms could be cast as repulsive beasts of the cinema. “To Helminth and Back!” might be the title of a movie about battling and surviving Strongyloides hyperinfection. The gastrointestinal tract would be a favored location for the wormy thriller “From the Depths of the Bowels Comes—Attack of the 30-Foot Tapeworm!” Even the lowly pinworm would make you squirm in your seat—in fact, it will do it for you! The eyeworm and tongueworm are creepy crawlers that could make the victim’s life a living helminth.

The “Crypt Trilogy” could be 3 films. The first, “The Crypt Abscess,” might feature a foolhardy venture into the foul lair of the dreaded vancomycin-eating Enterococcus. Not many movie-goers would have the guts to experience Number 2: “Cryptosporidium: Loose in Milwaukee!” The final film would be “Crypto: Curse of the Mummy’s Yeast Infection,” the amazing true story of archaeologists stricken with cryptococci released during the unwrapping of ancient mummies.

In the film “Deep Space Infection,” plucky astronauts would disinfest satellite abscesses and dodge asteroid bodies. Unspeakeable horrors also lurk in our inner body spaces, as might be seen in “Ozena—Enter the Nare if You Dare!” Another film could be “Out of the Jaws of the Hounds from Hell Comes—The Dysgonic Fermenters!” seeking hapless, spleenless victims.

The blockbuster thriller “Thoracic Park” would feature ferocious Pseudomococci, as well as galloping consumption by TB Rex and its berserk cousin, the Battey Bacillus.

For the casting of spy or crime thrillers, the field of infectious diseases offers both felons and special agents, such as the Eaton and Norwalk agents. One film could be “The Yellow Peril,” in which a viral agent code-named “B” joins forces with a shadowy coconspirator, the Delta agent, to cause an international outbreak of fulminant hepatitis. One possible crime thriller might be called “Murder Most Foul,” in which a mad microbiologist creates ineradicable, multiple-drug–resistant anaerobes that he injects into unwilling experimental subjects.

The ongoing war against emerging pathogens, such as the severe acute respiratory syndrome coronavirus, is a real-time documentary of an unfinished saga starring public health workers, infectious diseases specialists, microbiologists, and research scientists. Most of us are bit players in the trenches, but we all have a role in contributing to a happy ending.

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Apparent Failure of Moxifloxacin to Prevent Ciprofloxacin- and Levofloxacin-Susceptible Pseudomonas aeruginosa Bacteremia in Neutropenic Patients Undergoing Peripheral Blood Stem Cell Transplantation

Srf—Fluoroquinolones are frequently used for antibacterial prophylaxis during the neutropenic period associated with peripheral blood stem cell transplantation because of their excellent oral bioavailability and activity against most gram-negative bacteria [1].

From 1 January 1998 through 31 May 2003, a total of 1183 hematopoietic stem cell transplantation procedures were performed at our institution (Mayo Clinic; Rochester, MN). Antibacterial prophylaxis was started 1 day before transplantation and continued until neutrophil engraftment (absolute neutrophil count, >500
Levofloxacin was used until October 2001, when gatifloxacin was substituted. In March 2003, moxifloxacin replaced gatifloxacin as a result of changes in the hospital formulary. Before the switch to moxifloxacin, only 5 (0.4%) of 1138 patients who had undergone peripheral blood stem cell transplantation had developed *Pseudomonas aeruginosa* bacteremia while they had severe neutropenia (absolute neutrophil count, <100 neutrophils/mm$^3$). Cultures of peripheral blood samples and blood obtained via long-term indwelling central venous catheters yielded *P. aeruginosa* susceptible to ciprofloxacin and levofloxacin but with reduced susceptibility to moxifloxacin. The isolates were different by SpeI PFGE [2]. No evident source of infection was identifiable.

Few studies have addressed the in vitro activity of moxifloxacin against ciprofloxacin-susceptible *P. aeruginosa*, compared with levofloxacin and gatifloxacin, in a single group of isolates [3]. Therefore, we determined the MICs for 27 clinical isolates from various sources collected at our institution. The following MIC$_{90}$ values were determined: ciprofloxacin, 0.25 μg/mL (range, 0.125–0.5 μg/mL); levofloxacin, 1 μg/mL (range, 0.25–4 μg/mL); gatifloxacin, 2 μg/mL (range, 0.125–2 μg/mL); and moxifloxacin, 4 μg/mL (range, 0.125–4 μg/mL). No mutations known to confer resistance to fluoroquinolones were identified in genes encoding DNA gyrase (*gyrA*; codon 83 and 87) or topoisomerase IV (*parC*; codons 80 and 84) [4] among these 27 isolates.

Moxifloxacin has not been approved by the US Food and Drug Administration for the treatment of *P. aeruginosa* infection. Of the fluoroquinolones tested, moxifloxacin exhibited the lowest in vitro activity against *P. aeruginosa*. Along with the observed emergence of ciprofloxacin- and levofloxacin-susceptible *P. aeruginosa* bacteremia in neutropenic peripheral blood stem cell transplant recipients receiving moxifloxacin, this cautions that it is important to recognize the suboptimal antipseudomonal activity of this fluoroquinolone when selecting from the available fluoroquinolones. The anaerobic activity of moxifloxacin may also have favored emergence of *P. aeruginosa* bacteremia in our patients. When selecting an agent from the currently available fluoroquinolones, moxifloxacin should not be used if activity against *P. aeruginosa* is required.

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