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**Strongyloides stercoralis Infection as a Manifestation of Immune Restoration Syndrome?**

Sir—Kim and Lupatkin [1] describe a patient with fever, eosinophilia, hepatitis, and Strongyloides stercoralis larva in stool, as revealed by microscopy. These clinical features developed after diagnosis of HIV-1 infection and commencement of HAART and are attributed by the authors to immune restoration. Empirical therapy for cerebral toxoplasmosis was also initiated with pyrimethamine and sulfadiazine, as was therapy with dexamethasone. The patient’s condition responded to standard therapy with ivemectin.

A more likely explanation for this case is that the patient experienced an exacerbation of subclinical *S. stercoralis* infection following the institution of high-dose corticosteroid therapy. Corticosteroid therapy has long been recognized as the major risk factor for development of severe disease and disseminated strongyloidiasis in people with asymptomatic carriage of *S. stercoralis* [2, 3]. Furthermore, it has been noted that it is rare to develop disseminated strongyloidiasis in the absence of corticosteroid therapy. Although it was initially hypothesized that the immunosuppression secondary to HIV infection would result in an increased incidence of disseminated strongyloidiasis, such a rise in incidence has not been observed. For example, a general lack of correlation between HIV infection and strongyloides hyperinfection has been observed in regions where both are endemic, such as sub-Saharan Africa and Brazil [4]. We, therefore, suggest that the case presented may merely reflect *S. stercoralis* carriage progressing to clinical disease following the use of dexamethasone.

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**References**


**Tropical Pulmonary Eosinophilia**

Sir—In a recent article, Boggild et al. [1] tackled the problem of imported cases of tropical pulmonary eosinophilia (TPE). However, the diagnostic procedure that was used raised some concerns about the accuracy of the filarial etiology of the reported syndrome. TPE, as underlined by Boggild et al. [1], is characterized by pulmonary infiltrates and blood eosinophilia. This clinical picture can have various noninfectious or infectious etiologies; among the helminthiases, these include ancylostomiasis, strongyloidiasis, and visceral larva migrans (a major form of toxocariasis, which have been recognized as parasitic etiologies of pulmonary eosinophilia [2, 3]). Toxocariasis, a helmintho-zoonosis found worldwide, appears to be an especially common cause of pneumonitis with eosinophil infiltrates; 9 of 57 Argentine pediatric patients displayed this symptom [4].

How helminthiases other than bancroftian filariasis were ruled out was not reported by Boggild et al. [1]. Moreover, the diagnosis of filarial TPE was dependent on the results of an ELISA, the exact procedure of which was not described. ELISA that uses extracts of heterologous filaria worms is known to cross-react with serum samples from other roundworm diseases [5], but the use of recombinant antigens could resolve this problem [6]. Given these facts, we were surprised that Boggild et al. [1] did not test for circulating filarial antigens to ascertain the bancroftian origin of their TPE cases. Since its first use in the field by the middle of the 1990s [7], detection of the so-called Og4C3 antigen, by either immunochromatography (“card test”) or ELISA, has proven to be a specific and sensitive method for the immunodiagnosis of *Wuchereria bancrofti* infections [8]. It is currently considered a major tool for the control of lymphatic filariasis [9]. We recognize that this test is unable to detect *Brugia malayi* infections, but none of the patients included in the study by Boggild...
et al. [1] was from an area where *Brugia* lymphatic filariasis is endemic. Since the end of 2001, we have routinely used the commercial ELISA version of the Og4C3 assay (Tronto). Of the patients attending the consultation unit of our hospital who were immigrants from or residents of a tropical area, 165 were tested by ELISA (Bordier Affinity Products) for the presence of filarial antibodies and Og4C3, on the basis of the presence of clinical signs consistent with a filarial infection (bankrofiaisis, loiasis, or onchocerciasis), and/or blood eosinophilia. Of 17 patients who had significant filarial ELISA results (op- or blood eosinophilia. Of 17 patients who had significant filarial ELISA results (optical density of \( \geq 900 \)), 1 patient was found to be infected with hookworm, 5 had strongyloidiasis, and 2 probably had toxocariasis. None of the cross-reacting serum samples from these patients had detectable Og4C3 antigen.

Therefore, the possibility of bancroftian filariasis in patients 2, 8, 9, 13, and 15 from the study by Boggild et al. [1], who had a moderate level of antifilarial antibodies, appears to be questionable. The efficacy of diethylcarbamazine therapy cannot be considered circumstantial evidence of filaria infection, because this drug was found to be effective for treatment of toxocariasis [10].

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Impact of Recommendations by Clinical Microbiologists on Antimicrobial Treatment in the Intensive Care Units of a Dublin Teaching Hospital

Sir—We read with interest the article by Lo et al. [1] regarding adherence to recommendations made during infectious diseases (ID) consultations. The data, which were from a prospective cohort study of 465 consultations at 2 large tertiary care centers, revealed an overall rate of compliance to recommendations of 80%. Compliance was higher when recommendations involved therapy, compared with those that involved diagnostic procedures (92% vs. 70%). Only 5% of consultations were made in the surgical intensive care unit (ICU). In his editorial commentary, Tenenbaum [2] highlights the fact that, at his institution, ID physicians have little impact when it comes to altering inappropriate antimicrobial use in the ICU. In this era of increasing concern about antibiotic stewardship, there have been a number of studies investigating the impact of ID consultative care on patient treatment in various settings [3–5].

In light of the findings by Lo et al. [1] and with regard to the difficulties highlighted by Tenenbaum [2], we would like to outline the consultative practice at the ICUs at our institution. Beaumont Hospital (Dublin, Ireland) is a 650-bed tertiary referral center and contains the national neurosurgical center for the Republic of Ireland. There is a 10-bed general ICU and an 11-bed neurosurgical ICU, both of which are open. On a daily basis, from Monday to Friday, a specialist registrar and/or consultant from the clinical microbiology service, together with a specialist registrar and/or consultant in intensive care medicine, review data for all patients in both ICUs. At other times, advice on patient treatment is given, if required, by the consultant clinical microbiologist on call. Recommendations are made on these daily rounds on the basis of clinical features, radiological findings, laboratory results (including microbiolog-