In Support of Dr. Thomas C. Butler

Sir—It was with shock and awe that we read the recent article by Murray et al. [1] that detailed the plight and accomplishments of our colleague Dr. Thomas C. Butler. We are grateful to the authors for educating us about Dr. Butler’s case. Our previous knowledge had been obtained through the mainstream media and, in retrospect, was obviously superficial and lacking in substance.

Our efforts to learn more about the case through an Internet search were rewarded with a wealth of information. Although

Dr. Joseph Dalovisco [2], then president of the Infectious Diseases Society of America (IDSA), wrote, on behalf of the IDSA, an eloquent letter to then–Attorney General John Ashcroft in support of Dr. Butler, we are unaware of other organized efforts by the IDSA to support our colleague.

We call on the leadership of the IDSA to use their resources to allow us to show solidarity with Dr. Butler, and support his defense. As the IDSA has done in the past for other political issues, it could make available form e-mails posted on the IDSA Web site that would allow members to individually contact elected and appointed officials to voice support of Dr. Butler. Alternatively or additionally, a booth for petitions and/or financial contributions could be made available at this year’s annual meeting of the IDSA.

In the meantime, we ask others to join us in contributing to Dr. Butler’s legal defense fund. Our thoughts and prayers will be with Dr. Butler and his family.

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References


Do Not Abandon Amphotericin B as an Antifungal Bladder Irritant

Sir—Drew et al. [1] have written a cogent review on amphotericin B bladder irrigation for “treatment” of candiduria. They correctly indicate that the amphotericin B dosage and the method of delivery (continuous bladder irrigation vs. intermittent daily catheterization) have not been standardized. They suggested that treatment should be systemic rather than local.

Jacobs et al. [2] reported that amphotericin B bladder irrigation has a better response rate than fluconazole therapy (96% vs. 73%), but mortality rates were greater in the group of patients receiving amphotericin B. This indicated that amphotericin B bladder irrigation alone does not address the invasive nature of funguria, particularly in patients who are immunocompromised or who require urologic manipulation.

As a practicing urologist, I agree that the removal or change of an indwelling urinary catheter is a first step that may allow candiduria to resolve. However, a typical clinical presentation involves an elderly patient who has an indwelling urinary catheter and grossly purulent urine that yields a Candida species. In many such cases, removal of the catheter does not result in resolution of candiduria. What other options are there? The effectiveness of fluconazole may be diminished because the patient is infected with a non-albicans species of Candida and/or has impaired renal function that decreases the concentration of drug in the urine.

Fluconazole is not the cure-all drug for all fungal infections. Few data are available on the effectiveness of treating candiduria with newer agents, namely echinocandin, caspofungin, and voriconazole. Systemic therapy with amphotericin B and even fluconazole has the potential for adverse effects. Irrespective of its shortcomings, amphotericin B bladder irrigation has been effective in controlling localized infection (or intense colonization). Despite some bladder discomfort, amphotericin B blad-