prior 12 months, including the 2 patients described above who experienced seizures while exposed to the drug. Both patients’ histories included a previous cerebrovascular accident. The presence of an underlying CNS disease—an old cerebrovascular accident (thrombotic or embolic)—in particular—was the unique risk factor for the development of seizures [6]. Elderly patients in internal medicine wards are currently among the most common sources of colonization with ESBL-producing microorganisms. A substantial number of these patients have had a stroke in the past. Carbapenems appear to be the last resource to treat nosocomial infections caused by ESBL enterobacteriaceae. Therefore, it is our opinion that prescribing information for ertapenem should list an old cerebrovascular accident specifically as a relative contraindication to drug use.

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References


Influence of Candida Colonization on the (1–3)
β-D-Glucan Assay

To the Editor—Upton et al. [1] and Ostrosky-Zeichner and Finkelman [2] mentioned our recent article [3] when discussing the influence of Candida colonization on the performance of the (1–3) β-D-glucan assay Fungitell (Associates of Cape Cod) (BG) in the diagnosis of invasive fungal infection (IFI). In our experience, Candida colonization is unlikely to cause false-positive results in the BG assay [3]. We found 3 false-positive results among 29 patients without IFI; none of the 3 patients had mucositis. Although 2 of the 3 patients were colonized by Candida species, other patients who had heavy Candida colonization had negative BG results. The occurrence of false-positive results in the detection of BG is an important problem that reduces the specificity of the test [4]. Two strategies can be followed to reduce the number of false-positive results: first, combination of all available diagnostic fungal markers is warranted.

We believe that the BG assay is a promising fungal marker for serial prospective screening of IFIs in the clinical setting, particularly in immunosuppressed subgroups of persons at high risk for IFI, such as neutropenic, critically ill patients and transplant recipients. In these populations, the incidence of IFI is high, and consequently, incidences of positive predictive value and negative predictive value are also likely to be high [5]. Currently, the value of BG and its impacts on the early diagnosis, preemptive treatment strategies, and therapeutic monitoring of IFI will only be established in the clinical setting with prospective studies that include matched controls in which high-risk subpopulations are prospectively screened for the presence of surrogate fungal markers. Semiquanti-tative surveillance cultures for yeast are important for evaluation of these validation studies. Patients should be screened twice weekly while the risk persists, preferably when screening is combined with risk stratification strategies, as described by Prentice et al. [6]. Another convenient and desirable approach is the separate analysis of the utility of BG in relation to the different etiologic agents of IFI. Because all of the current different surrogate markers of IFI have limitations and discrepancies, comparative prospective studies with matched controls using a combination of all available diagnostic fungal markers are warranted.

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2. Ostrosky-Zeichner L, Finkelman MA. Reply to
Multiloculated Hepatosplenic Abscesses

To The Editor—We note with interest the cases described by Apisarnthanarak et al. [1] detailing the radiological appearance of hepatic and splenic abscesses due to *Burkholderia pseudomallei*. We would like to report 2 differential diagnoses of multiloculated hepatosplenic abscesses: tuberculosis and liver abscess due to *Klebsiella* species.

A 46-year-old woman presented with a 2-month history of fever following recent prolonged residency in China and India. Physical examination was unremarkable, except for the fever, and investigations revealed the presence of a single abscess in the liver and a multiloculated abscess in the spleen (figure 1). Aspirates of the liver abscess were obtained; Gram staining did not demonstrate organisms, and results of bacterial cultures were negative, but subsequent results of culture for acid-fast bacilli were positive for *Mycobacterium tuberculosis*. The patient was treated successfully with standard antituberculous therapy.

A 48-year-old diabetic man presented with a 2-week history of fever. He had not traveled to any areas where melioidosis is considered to be endemic. Physical examination revealed fever and tender hepatomegaly, and imaging demonstrated a multiloculated liver abscess (figure 2). Blood cultures grew *Klebsiella pneumoniae*; aspiration of the abscess was attempted but was unsuccessful. The patient was successfully treated with intravenous ceftriaxone.

Focal hepatosplenic abscesses are an unusual manifestation of tuberculosis [2], but tuberculosis of other organs is an important differential diagnosis of melioidosis in countries where it is endemic. *Klebsiella* species are increasingly recognized pathogens implicated in liver abscesses, especially in some countries where melioidosis is endemic, such as Taiwan and Thailand [3, 4]. It is important to confirm the diagnosis of melioidosis with culture of blood or aspirates, because the therapy of other potential causes of multiloculated abscesses may be significantly different.

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