
Infectious Diseases illustrates a case of the fluke infection Dicrocoelium dendriticum. The case is presented as more likely to be a rare true infection than a more commonly recognized spurious infection caused by ingesting infected animal liver. The African female patient had recurring intestinal symptoms compatible with a true Dicrocoelium infection, and she denied having eaten animal liver in the past. However, Dicrocoelium eggs were only seen on a single random stool specimen, and additional laboratory examinations were refused. False (spurious) infection was excluded only because of information provided by the patient about her eating habits. The only reliable available methods to differentiate true from spurious infection are repeated stool examinations of specimens from patients with a diet from which liver is excluded and examination of duodenal or biliary fluid. Admittedly, these methods could not be pursued for the reported case. This woman should be considered to have had a possible but not proven case of true Dicrocoelium infection.

I also question whether this infection, be it true or spurious, represents Dicrocoelium dendriticum infection rather than infection due to the related pathogen Dicrocoelium hospes. The latter species is a common parasite in cattle and, rarely, sheep in tropical West Africa.

Almost all cases of D. hospes infection in humans have been shown to be spurious; the patients had eaten infected beef liver, and after a period of maintaining a liver-free diet, they were later found to have no eggs in their stool [2]. I have seen a number of such cases in expatriates and Peace Corps volunteers in West Africa who submitted stool specimens. Odei [3] recorded numerous spurious infections due to D. hospes in northern Ghana. He believed that 2 “cattle boys” had true infections, because they denied having eaten animal liver. Again, however, true infection cannot be confirmed by a suspect dietary history and without repeated examinations of stool specimens from persons maintaining a diet that is assured of being free of animal liver.

Acknowledgments

Potential conflicts of interest. M.S.W. has served on the speakers’ bureau for GlaxoSmithKline.

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References


Dicrocoelium dendriticum or Dicrocoelium hospes

To the Editor—The Photo Quiz by Sing [1] in the 1 January 2007 issue of Clinical Infectious Diseases illustrates a case of the fluke infection Dicrocoelium dendriticum. The case is presented as more likely to be a rare true infection than a more commonly recognized spurious infection caused by ingesting infected animal liver. The African female patient had recurring intestinal symptoms compatible with a true Dicrocoelium infection, and she denied having eaten animal liver in the past. However, Dicrocoelium eggs were only seen on a single random stool specimen, and additional laboratory examinations were refused. False (spurious) infection was excluded only because of information provided by the patient about her eating habits. The only reliable available methods to differentiate true from spurious infection are repeated stool examinations of specimens from patients with a diet from which liver is excluded and examination of duodenal or biliary fluid. Admittedly, these methods could not be pursued for the reported case. This woman should be considered to have had a possible but not proven case of true Dicrocoelium infection.

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Idiopathic CD4+ T Lymphocytopenia Disclosed after the Diagnosis of Visceral Leishmaniasis

To the Editor—Visceral leishmaniasis is an infection caused by Leishmania species, a group of intracellular protozoan parasites that are transmitted by various species of sandflies [1]. Immune system response against leishmaniasis is mainly mediated by active recruitment of Leishmania-specific CD4+ and CD8+ T cells to the sites of infection [2]. Leishmaniasis is an endemic infection in many areas of Spain, mainly diagnosed in individuals with HIV infection [3]. Although T cell response is crucial for the control of leishmaniasis, this opportunistic infectious disease has not been previously reported in association with idiopathic CD4+ T lymphocytopenia.

A 38-year-old man presented to the hospital with fever, asthenia, and weight loss in the previous 2 weeks, with no special organ affection. He had a nonrele-

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of Navy, the Department of Defense, or the US Government.

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A 38-year-old man presented to the hospital with fever, asthenia, and weight loss in the previous 2 weeks, with no special organ affection. He had a nonrele-
vant history of disease or exposure, except for “idiopathic eczema” that had been topically treated with steroids. He was not taking any systemic drug. The findings of a general physical examination were normal. Laboratory evaluation revealed the following findings: WBC count, 3.7 × 10^6 cells/L (0.85 × 10^6 absolute lymphocytes/L); hemoglobin level, 13 g/dL; and platelet count, 159 × 10^9 platelets/L. Chest radiographs were normal. Thoracic and abdominal CT demonstrated a moderately enlarged liver and spleen, but significant lymphadenopathies were not found. Diverse microbiologic tests all had negative results. Serological testing was negative for HIV. A bone marrow biopsy demonstrated numerous free and intramacrophage Leishmania species. Intravenous liposomal amphotericin B was administered at a dosage of 5 mg/kg on days 0, 1, 2, 3, 4, 10, and 21. Fever disappeared 24 h after the first dose was administered. The general performance of the patient improved in the next week, and he was discharged from the hospital. Eight months later, he was admitted to the hospital again with a 4-week history of fever and chills. He related that his current symptoms were similar to those he had experienced at the time of the first hospital admission. The results of serological testing and viral load measurements for HIV were negative. Leishmania species were found in bone marrow. Intravenous liposomal amphotericin B was administered again. A more complete series of immunological tests demonstrated normal levels of immunoglobulins (IgG, IgA, and IgM) and complement factors (C3 and C4). The patient’s CD4+ T lymphocyte count was 134 cells/mm^3 (9% of total lymphocytes). Six months later, the patient was asymptomatic for leishmaniasis, and his current CD4+ T lymphocyte count was 109 cells/mm^3 or 3% of total T cells (measured on at least 2 occasions) in the absence of HIV infection and any other known immunodeficiency or therapy associated with lymphocytopenia [4]. The present patient fulfilled these criteria. Idiopathic CD4+ T lymphocytopenia has been associated with various opportunistic infections, such as histoplasmosis, cryptococcosis, aspergillosis, mycobacteriosis, Pneumocystis jiroveci infection, polyoma virus infection, cytomegalovirus infection, and human papillomavirus infection, as well as hematologic malignancies [5, 6]. To our knowledge, this is the first reported case of visceral leishmaniasis in a patient with idiopathic CD4+ T lymphocytopenia. This type of immunodeficiency should always be considered in patients with visceral leishmaniasis and no alternative immune system disease.

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References


Wound Infection and Septic Shock Due to Aeromonas trota in a Patient with Liver Cirrhosis

To the Editor—Aeromonas trota has never been reported as a cause of wound infection and septic shock. A 78-year-old woman with hepatitis C virus–related liver cirrhosis (Child classification B) fell into a pond while she was riding a motorcycle and experienced multiple laceration and abrasion wounds on her face and hands. When the patient arrived at the emergency department 1 h after the accident, her blood pressure was 126/70 mm Hg. One day later, the patient developed fever (temperature, 38.6°C), hypotension (blood pressure, 88/38 mm Hg), and erythematous change and pus discharge from a wound on her left hand. Laboratory examinations revealed a WBC count of 10,200 cells/mm^3, with 82% neutrophils. Because of the impression of wound infection associated with septic shock, empirical treatment with intravenous floroxef (1 g every 8 h) was administered. Complete septic analyses, including cultures of urine, ascites, blood, and pus discharge from the infected wound on her left hand were performed prior to initiation of antibiotic therapy. The urinalysis result was negative for pyuria, and analysis of ascites revealed a neutrophil count of 50 neutrophils/mm^3. Two days later, the pus culture yielded confluent growth of...