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SPECTRUM OF GAS WITHIN THE KIDNEY: EMPHYSEMATOUS PYELONEPHRITIS AND EMPHYSEMATOUS PYELITIS

To the Editor:

Candida albicans can indeed cause emphysematous pyelonephritis, as indicated by Evanoff et al (Am J Med 1987; 83: 149–154) in their recent article. However, evidence in support of this observation is lacking in the reference cited by these authors [1]. Neither scrutiny of this reference nor a computer-assisted literature search uncovered a documented case of emphysematous pyelonephritis in which C. albicans was isolated from urine or observed on histologic examination of renal tissue. Such evidence did implicate C. albicans as the pathogen in a case of emphysematous pyelonephritis described in a report not cited by Evanoff et al [2].

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CLINDAMYCIN IN CEREBRAL TOXOPLASMOSIS

To the Editor:

We have read with interest the article by Rolston and Hoy (Am J Med 1987; 83: 551–554) about clindamycin and central nervous system toxoplasmosis. The role of clindamycin in central nervous system toxoplasmosis and the doses to be used are not well established. Kaplan et al [1] have recommended 3,600 mg per day whereas Rolston and Hoy used 1,200 to 2,400 mg per day in their four patients. On the other hand, given the high relapse rate following discontinuation of therapy, an effective suppressive regimen is needed [2]. Although one patient with chorioretinal toxoplasmosis underwent twice-weekly maintenance therapy in Rolston and Hoy's report, they made no further comments on this important point. Among our patients, three of four with acquired immunodeficiency syndrome (AIDS) and central nervous system toxoplasmosis had adverse reactions due to sulfadiazine seven, 11, and 30 days after initiation of therapy, respectively. All three patients showed favorable responses to the association of clindamycin (1,800 to 2,400 mg per day intravenously) and pyrimethamine (25 to 50 mg per day orally) for six weeks, followed by a maintenance regimen of clindamycin 300 mg every eight hours orally plus pyrimethamine 25 mg per day. The three patients died three to nine months after the acute episode of central nervous system toxoplasmosis, due to other infections. Necropsy of two patients and clinical and radiologic pre-mortem findings in the third one showed no evidence of active central nervous system toxoplasmosis.

Reactions to sulfonamides are a frequent and troublesome aspect in AIDS patients [3]. New alternatives are necessary to better treatment of infections like central nervous system toxoplasmosis, Pneumocystis carinii pneumonia, and isosporiasis.

Appropriate doses of clindamycin and levels to be achieved in the brains of AIDS patients with central nervous system toxoplasmosis are not well defined. In experimental murine toxoplasmic encephalitis, clindamycin was effective despite the low levels of the antibiotic found in the brains of infected mice [4].

Our limited experience suggests that 1,800 to 2,400 mg per day of clindamycin plus 25 to 50 mg per day of pyrimethamine for six weeks followed by clindamycin 900 mg per day and pyrimethamine 25 mg per day over an indefinite period may be a rational therapy. Nevertheless, further studies are necessary to evaluate the usefulness and the adequate therapeutic regimen of clindamycin in the treatment of central nervous system toxoplasmosis.

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INFORMATION FOR AUTHORS

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CORRECTION

In the article "Cefoperazone versus Combination Antibiotic Therapy of Hospital-Acquired Pneumonia" by Mangi et al (January 1988, pages 68 to 74), the last line in the footnote to Table V (page 72) is incorrect. The line should read "and *two* of 28 given vitamin K." We apologize to the authors for this omission.