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## PROSTATIC AND RENAL ASPERGILLOSIS IN A PATIENT WITH AIDS

### To the Editor:

*Aspergillus* infections generally occur in immunosuppressed patients. Acquisition of this pathogen occurs by direct inoculation or inhalation of spores. The high relapse rate of infection during the neutropenic phase of acute leukemia is likely due to the proliferation of the organism in the human host. Although the lung is the most common site involved, 10% to 25% of cases show hematogenous spread leading to abscess formation in the brain, gut, heart, liver, spleen, kidney, thyroid gland or skin. Primary location in these same organs can also occur (1). We recently cared for an AIDS patient with renal and prostatic aspergillosis.

The patient was a 32-year-old man with a history of parenteral drug abuse. The diagnosis of AIDS was made after he developed *Pneumocystis carinii* pneumonia 3 years earlier. He had been on steroid treatment for thrombocytopenia the previous year. He was admitted because of fever, abdominal tenderness in the left lower quadrant, dysuria, and constitutional symptoms of 1 month's duration. On physical examination he was febrile, pale, and cachectic. A painful mass was felt over the left flank. Transrectal prostate examination suggested the presence of an abscess. A complete blood count showed a hemoglobin concentration of 4 g/dL, a platelet count of  $64 \times 10^3/\mu\text{L}$ , and a leukocyte count of  $6.2 \times 10^3/\mu\text{L}$ , with 66 CD4 lymphocytes per  $\text{mm}^3$ . Urinary sediment contained 4 to 7 red blood cells and 15 to 18 leukocytes per high

power field. Urine cultures were negative. Chest radiograph was normal. Ultrasound and computerized tomographic examination of the abdomen disclosed a  $10.5 \times 6$  cm solid mass located in the upper pole of the left kidney, without extension to the perinephrenic adipose tissue. The mass contained several cysts. A prostatic abscess was found by ultrasonographic examination. Fine needle aspiration biopsies were performed of the renal and prostatic masses, and *Aspergillus fumigatus* was isolated after culture of both specimens. Treatment was begun with amphotericin B; itraconazole was substituted owing to nephrotoxicity, with clinical improvement and reduction in the size of both masses. The patient died 8 weeks later from gastrointestinal bleeding of unknown origin.

Primary involvement of the genitourinary tract by *Aspergillus* is unusual. Twenty-four cases of renal aspergillosis have been described in the literature, 7 of them in AIDS patients (2-4). After a MEDLINE bibliographic search (1989-1998), we have been unable to find any other case of renal and prostatic aspergillosis in AIDS patients. Although unusual, *Aspergillus* infection is increasing in these patients, especially in those with advanced stages of immunosuppression (CD4+ count of 50 cells/ $\text{mm}^3$  or less). It has not been associated with neutropenia or corticosteroid treatment.

Most cases of renal aspergillosis present with focal symptoms like hematuria or dysuria, or by mimicking renal stone disease, although a constitutional syndrome can be the presenting complaint. The differential diagnosis includes renal pyogenic abscess, multilocular cystic nephroma, and hydatid cyst. Treatment should include percutaneous evacuation of purulent material or nephrectomy, along with amphotericin B. An alternative treatment involves high doses of oral itraconazole (600 mg/d) followed by 400 mg

per day for a long period (years) (5). Most relapses are associated with severe immunosuppression, residual involved tissue in the nephrectomy site, or an inadequate dose of itraconazole.

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## SERENDIPITOUS PROPHYLACTIC PACEMAKER TREATMENT FOR HYPERKALEMIA

### To the Editor:

We recently encountered a patient with an unusual electrocardiogram. At first glance, the tracing was most puzzling; however, a subcutaneous "lump" on the right upper chest wall consistent with a pacemaker helped in the diagnosis. When the electrolytes arrived moments later, all became clear. The indications for a transvenous pacemaker in this patient were not entirely obvious to us, but in retrospect we were glad that he had one.

An 86-year-old man was brought to the hospital because of profound weakness and confusion. His blood pressure was 75/40 mm Hg, and his