by immunofluorescence though both these sera and the previous sera were found to be positive by Western blot (C. Mary, unpublished data). The N-methylglucamine and interferon-gamma combination was re instituted and this restored a normal body temperature, improved the general status, partially relieved the hepato-splenic tumour syndrome and normalized the myelogram.

More than 50 cases of visceral leishmaniasis have been reported during HIV infection and this parasite seems to have developed an opportunistic behaviour in this situation.4 The use of antimoniais and pentamidine often gives disappointing results in HIV-infected patients whereas there are only a few alternative, less effective therapies.5

Interferon-gamma was found to be capable of potentiating the anti-leishmanial effect of glucamine both in vitro and in vivo.6  This combination induced a partial remission on two occasions in our kala-azar patient in whom a more conventional therapeutic regimen was ineffective. Clinical studies are under way to specify the optimum protocol.7

Alain Lafeuillade,1,2 Robert Quilichini,1 Catherine Dhiver,5 Charles Mary,5 Jean Albert Gastaut,1

1Centre d’Informations et de soins de l’immunodéficience humaine (C.I.S.I.H.), Hôpital Salvador, 249 Boulevard de Sainte Marguerite 13009 Marseille; 2Service de Médecine Interne et Hématologie, Hôpital Chalucet, 83000 Toulon and 3Laboratoire de Parasitologie, Hôpital de la Timone, 13005 Marseille, France.

Pneumococcal bacteraemia: a late complication following endoscopic variceal sclerotherapy

SIR,

A low rate of blood culture positivity after elective endoscopic injection sclerotherapy (EIS) has been reported when blood cultures are obtained 5 and 10 minutes after this procedure.1 We here report an episode of pneumococcal bacteraemia in a cirrhotic patient occurring 10 hours after an emergency EIS procedure. A similar delay in the appearance of bacteraemia due to other microorganisms may be responsible for an underestimated incidence of bacteraemia following EIS in previous investigations.2

A 68 year old male alcohol-associated cirrhotic patient was admitted because of massive haematemesis. Physical examination revealed jaundice and ascites. Endoscopy revealed the presence of oesophageal varical bleeding and an EIS procedure using an Olympus Q-10 fibroscope was performed. A total of 15 ml of 5% ethanolamine oleate was injected and bleeding was controlled. On the seventh hospital day, haematemesis recurred and a further EIS procedure was performed. Ten hours after sclerotherapy, the patient developed high fever (39°C) and chills. A chest film was clear. Acetic fluid and urine cultures were negative. Three sets of blood cultures yielded growth of Streptococcus pneumoniae. Oropharyngeal exudate was unfortunately not obtained. Cefamandole 1 g every 6 hours, during 7 days, was administered. The symptoms improved after treatment and no overt gastrointestinal bleeding occurred again after sclerotherapy until discharge 2 weeks later.

Studies that have evaluated the incidence of bacteraemia following EIS have shown a marked variability of results, ranging from 5% to 50%.1,4 On the other hand, although oropharynx or contaminated endoscopes have been implicated as the source of the bacteraemia, most of the microorganisms isolated (Corinebacterium spp., Staphylococcus epidermis, Bacillus spp.,1 corresponded to skin flora and they were not simultaneously isolated from pharyngeal or from endoscopy surveillance cultures. These data are controversial and the role of prophylactic use of antibiotic in this setting is therefore not well defined. Our findings point to the oropharynx as the most probable source of bacteraemia, since there was no evidence of coexisting lung or peritoneal pneumococcal infection in this case.

To the best of our knowledge, delayed pneumococcal bacteraemia following EIS has not been previously reported. The development of bacteraemia later than it is currently recognized, as occurred here, could explain the low rate of bacteraemia found when blood cultures are obtained immediately after an EIS.1

Bacteraemia due to S. pneumoniae following EIS may be a life-threatening event in the cirrhotic patient, and it could be favoured by the abnormal splenic function present in these patients. Late pneumococcal bacteraemia must be suspected in this setting. Pneumococcal vaccine administration and/or antibiotic prophylaxis in these cases deserves further evaluation.

References

José M. Aguado,
José Napal,
Maria J. Alsar,
Department of Internal Medicine,
Hospital 'Marqués de Valdecilla',
39008 Santander, Spain.

References
1. Low, D.E., Shoenut, J.P., Kennedy, J.K., Harding, G.K.M.,
   Den Boer, B. & Miedkier, A.B. Infectious complications of
   endoscopic injection sclerotherapy. Arch Intern Med 1986, 146:
   569 – 571.
2. Camara, D.S., Gruber, M., Barde, C.J., Montes, M., Caruana,
   J.A. & Chung, R.S. Transient bacteremia following endo-
  scopic injection sclerotherapy of esophageal varices. Arch
3. Cohen, L.B., Korsten, M., Scherl, E.J., Velez, M.E., Fisse,
   R.D. & Arons, E.J. Bacteremia after endoscopic injection
4. Gerhartz, H.H., Sauerbruch, T., Weinzirll, M. & Ruckdeschel,
   G. Nosocomial septicemia in patients undergoing
   sclerotherapy for variceal hemorrhage. Endoscopy 1984, 16:
   129 – 130.

Recurrent episodes of enterococcaemia from an
infected Hickman line precipitated by ganciclovir
infusion
Sir,
Cytomegalovirus (CMV) is the commonest cause of
life-threatening viral infections in patients with
the acquired immunodeficiency syndrome (AIDS).
Treatment of manifestations such as retinitis and pneumonitis
requires lifelong maintenance therapy as the relapse rate
is high if only primary treatment is given.1 Hickman and
Broviac catheters are frequently used for long term
venous access2 either to administer ganciclovir or fos-
carnet. The major anxiety regarding their use is the
increased risk of infection. The organisms responsible are
predominantly staphylococci or fungi.2,3
We describe a case of recurrent episodes of enterococcal
bacteremia precipitated by infusion of ganciclovir
through a contaminated Hickman catheter. This organism,
which rarely infects this site, appears to have produced
rigors coinciding with ganciclovir infusion, leading to the belief
that the patient had developed allergy to the drug.
A 36 year old homosexual man with AIDS was
admitted with five rigors. Four of these episodes occurred
during or just after ganciclovir infusion through his
Hickman line. Six months prior to admission he was
diagnosed to have a Pneumocystis carinii pneumonia
(PCP) and concurrent CMV infection, the latter con-
formed with a lung biopsy. A Hickman line was subse-
sequently inserted. He received thrice weekly intravenous
ganciclovir at home in addition to low dose oral
zidovudine and fortnightly prophylactic nebulised pen-
tamidine isethionate.
On admission the patient who had suffered these
symptoms at home, was well and afebrile. The neutrophil
count was normal (3000/mm³).

Twenty-four hours following admission he experienced
two further episodes of fever (> 38.5°C) associated with
rigors. The first bout was unrelated to ganciclovir
infusion but the second occurred 5 minutes after com-
 mencement of one. During both episodes blood cultures
(peripheral as well as Hickman site) were taken. In view of
the temporal relation of the symptoms to the infusion of
the drug, the ganciclovir was discontinued as we
suspected allergic responses. At this juncture the first set of
blood cultures revealed growth of Proteus mirabilis. He
was treated successfully with ciprofloxacin. Further
investigations including urine cultures and intravenous
pyelography (both negative) failed to identify the focus
responsible for the Proteus bacteraemia. Three days
following discharge prolonged incubation of both blood
growths Enterococcus faecalis type 3.

In view of the presence of enterococcaemia associated
with the symptoms it was suspected that the Hickman line
was the probable source of sepsis. Two further Hickman
line blood cultures grew enterococci. He was not given
any further ganciclovir and remained well. Following
removal of the line, culture of the tip revealed growth of
enterococci and coagulase negative Staphylococcus
aureus (presumably a contaminant from removal).
P. mirabilis was not isolated here.
The above case illustrates how infusion of material
through an infected Hickman line may lead to clinically
significant episodes of bacteraemia in the absence of
bacteraemia at other times. These may be mistaken for an
allergic reaction to the infusate. Enterococcal infections
were previously looked upon as pathogens of low viru-
lence that may produce urinary tract infections or
endocarditis, but are now appreciated to be sometimes
more virulent.4 Furthermore these organisms which are
notoriously resistant to many antibiotics have shown
moderate in vitro activity against ciprofloxacin,5 though
this is not the agent of choice. Ampicillin and vancomycin
still remain the drugs of choice in the UK.

Dilip Nathwani,
Paul M.H. McWhinnie,
Anita Patel,
Stephen T. Green
Dermot H. Kennedy,
Department of Infection and Tropical Medicine,
Ruchill Hospital,
Glasgow G20 9NB, UK.

References
1. Jacobson, M.A. & Mills, J. Serious cytomegalovirus disease in
   the acquired immunodeficiency syndrome (AIDS): clinical
   findings, diagnosis and treatment. Ann Int Med 1988, 104:
   585 – 594.
2. Raviglione, M.C., Battan, R., Pablos-Mendez, A., Aceves-
   Casillas, P., Mullen, M.P. & Tarranta, A. Infections associated
   with Hickman catheters in patients with AIDS. Am J Med
3. Henry, K., Thurn, J.R. & Johnson, S. Experience with central
   venous catheters in patients with AIDS. N Engl J Med 1989,
   320: 1496.
5. Muranaka, K. & Greenwood, D. The response of Streptococ-
   cus faecalis to ciprofloxacin, norfloxacin and enoxacin. J
Pneumococcal bacteraemia: a late complication following endoscopic variceal sclerotherapy.
J. M. Aquado, J. Napal and M. J. Alsar

doi: 10.1136/pgmj.66.779.790

Updated information and services can be found at:
http://pmj.bmj.com/content/66/779/790.citation

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/