our case report and quoted two additional cases of the NMS which responded to amantidine.

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Crohn's colitis and sarcoidosis

Sir,
The similarities between Crohn's disease and sarcoidosis were emphasized in the case reported by Dr McCormick and his colleagues.¹ Cases of Crohn's disease sometimes show positive Kveim tests,² and the disorder is, at times, indistinguishable from ulcerative colitis.³ BCG inoculation may also conceivably account for the apparent increase in its incidence.⁴ The difference between Crohn's disease and sarcoidosis is slight, and it is probably due to slightly different transmissible agents. Sarcoidosis is possibly due to an attenuated human mycobacterium, while Crohn's disease may be caused by a bovine and attenuated mycobacterium.

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Fansidar – a treatment for AIDS-related pneumocystis?

Sir,
The standard treatment of acquired immune deficiency syndrome (AIDS) associated *Pneumocystis carinii* pneumonia (PCP) is high dose co-trimoxazole (trimethoprim and sulphamethoxazole).¹ This drug results in a severe

hypersensitivity reaction in more than 50% of patients. Pentamidine is an established alternative, but poor patient tolerance is common and the intramuscular route is contraindicated in thrombocytopenia. Low dose Fansidar (one tablet weekly of pyrimethamine 25 mg, sulfadoxine 500 mg) has been used as an alternative agent to co-trimoxazole in prophylaxis against recurrence of AIDS-related PCP.² We describe here the apparently successful use of high dose Fansidar (three tablets weekly) in the treatment of PCP in three patients intolerant of co-trimoxazole.

Comparative details of the three patients are given in Table I. All patients were human immunodeficiency virus (HIV) antibody positive and PCP was confirmed using trans-bronchial biopsy or lavage. All patients were treated initially with co-trimoxazole. In each case, a hypersensitivity rash appeared between 5 and 12 days following introduction of the drug. Patient 1 also received trimethoprim, which again resulted in a hypersensitivity rash. None of the patients received post-PCP prophylaxis or folic acid supplements.

None of our patients treated with Fansidar has suffered a relapse of their PCP over a period of at least 3 months in spite of not receiving prophylaxis. This is surprising in a disease exhibiting a median survival time of 9 months but may partly reflect the long half-life of Fansidar (130 hours).

Fansidar is not without side effects. These include elevation of liver enzymes and occasionally hepatitis; the former we saw in patient 1, who had the longest period of treatment. Marrow suppression may also occur, resulting in agranulocytosis, perhaps related to changes in folic acid metabolism. Patients 1 and 3 had falls in cell counts. Close monitoring of chemistry and haematological parameters is recommended.

Cutaneous adverse reactions, including Stevens-Johnson syndrome, have also been reported.³ However, in limited and cautious use, 75% of patients reacting to co-trimoxazole could tolerate Fansidar.⁴ This observation and the reaction of our patient 1 to trimethoprim suggest that the constituent sulphonamides are not always the problem and that some AIDS patients may be specifically intolerant of trimethoprim.

It can be argued that the clinical improvements seen in our patients were a delayed response to prior therapy. However, the symptomatic improvement (and radiological clearing in patients 1 and 3) seen only after starting Fansidar may be significant. Certainly a controlled comparative trial of co-trimoxazole and Fansidar is warranted. Until then we consider that Fansidar is worth trying in the treatment of life-threatening PCP, particularly in patients sensitive to or intolerant of co-trimoxazole and pentamidine.

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