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<th>Invasive Acremonium falciforme infection in a patient with severe combined immunodeficiency [7]</th>
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Invasive *Acremonium falciforme* Infection in a Patient with Severe Combined Immunodeficiency

SIR—We report the successful treatment of invasive gastrointestinal infection due to *Acremonium* species in an 11-month-old girl with severe combined immunodeficiency (SCID) who had received a haploidentical T cell–depleted bone marrow transplantation (BMT) from her father [1]. She had *Clostridium difficile* gastroenteritis, klebsiella urinary tract infection, methicillin-resistant *Staphylococcus aureus* sepsis, and acinetobacter pneumonia, as well as cutaneous graft-versus-host disease. Engraftment was documented by karyotyping on day +29 and day +114. The patient then had severe diarrhea, which necessitated prolonged parenteral nutrition and elemental diet through a nasogastric tube. Nine months after BMT, she developed fever and hepatosplenomegaly with increasing cholestatic jaundice, elevated levels of transaminases, and hypoalbuminemia. Laboratory values were as follows: peak bilirubin level, 763 μmol/L (direct bilirubin, 547 μmol/L); aspartate aminotransferase level, 692 U/L; alanine aminotransferase level, 236 U/L; γ-glutamyl transferase level, 3,174 U/L; hemoglobin level, 113 g/L; white blood cell count, 5.3 × 10^9/L (80% neutrophils, 15% lymphocytes, 4% monocytes, and 1% eosinophils); platelet count, 88 × 10^9/L. Despite treatment with various antibiotics, the patient’s clinical condition deteriorated; she developed upper gastrointestinal bleeding and disseminated intravascular coagulopathy.

Endoscopy of the patient’s upper gastrointestinal tract revealed diffuse gastric erosions with shallow ulcers. Direct potassium hydroxide (KOH) tests and gram staining of gastric biopsy specimens showed short, swollen hyphal elements. Subsequent culture of the biopsy specimens yielded *Acremonium falciforme*. After 3 days of incubation on Sabouraud dextrose agar, tufted white colonies could be seen on the specimen. Further incubation revealed a pale violet pigment on the reverse side. After 10 days, a Scotch tape preparation of the biopsy specimen was stained with lactophenol cotton blue (figure 1). Unbranched, tapering phialides (2–4 μm diameter) arising from hyaline hyphae were present along with single-cell, nonseptate, crescent-shaped conidia (these commonly form clusters on tips of phialides). Nodular budding was seen.

To determine the MICs of various antifungal agents, spectrophotometry was first used to standardize the inoculum equivalent to 10^5/mL of those spores (microconidia) that were harvested from a 5-day-old culture [2]. Yeast nitrogen base broth or agar was inoculated with the organisms. It was easier to read the endpoint at 48 hours when the agar dilution method was used than when the broth dilution method was used. The MICs were
Pancreatic Abscess Due to *Eikenella corrodens* in Association with Severe Ethanolism

Str—We read with interest the report by Stein et al. [1] regarding *Eikenella corrodens* as a rare cause of pancreatic abscess. The review was timely as we had just isolated *E. corrodens* in pure culture from an abscess that was presumed to be associated with pancreatitis.

A 47-year-old male with a history of seizure disorder that was probably related to severe ethanol abuse was admitted to the hospital after he had been found in an unresponsive state. His family reported a 3-week history of weight loss, anorexia, and abdominal pain associated with fever and chills. On admission he was febrile and unresponsive; he had nonspecific abdominal tenderness and leukocytosis with a left shift. Findings on a chest radiograph revealed a pneumonic infiltrate in the right lower lobe. Intravenous fluids were administered and empirical antibiotic therapy was initiated. A computed tomographic scan of the

therapy with other antifungal agents such as fluconazole and itraconazole [3] as well as GM-CSF is still only empirical.

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References