TMP-SMX indefinitely in immunosuppressed patients with nocardia, but we agree that there is little evidence to support this approach.

Nasia Safdar, M.D.
University of Wisconsin Medical School
Madison, WI 53792
ns2@medicine.wisc.edu

Daniel Kaul, M.D.
University of Michigan Medical School
Ann Arbor, MI 48109

Sanjay Saint, M.D., M.P.H.
Ann Arbor Veterans Affairs Medical Center
Ann Arbor, MI 48105

1. Montoya JG, Giraldo LF, Efron B. Infectious complications among 620 consecutive heart transplant patients at Stanford University Medical Center. Clin Infect Dis 2001;33:629-40.

Intraaortic Vegetations and Infective Endocarditis

TO THE EDITOR: The mobile aortic thrombus described by Adam et al. (Feb. 22 issue)[1] as suggestive of intraaortic endocarditis does not even warrant a diagnosis of possible endocarditis, according to the Duke criteria.[2] At admission, the patient had definite enterococcal endocarditis, meeting two major criteria: echocardiographic evidence of vegetations and the presence of a typical endocarditis pathogen. The fever initially responded to antibiotics but then relapsed. This is common during treatment of endocarditis, for numerous reasons. The suggestion that the relapse was due to a second pathogen seems unlikely. For unexplained reasons, the supposed aortic vegetation was not examined microscopically during the operation, making it impossible to diagnose it definitively as a mural vegetation. The finding of a mixture of coagulase-negative staphylococci casts further doubt on the conclusion that these bacteria were causing the infection. Mixtures of such bacteria, even from operative sites, usually indicate contamination from skin. The reporting of highly speculative cases serves only to confuse the clinical picture of endocarditis.

James Greig, M.R.C.Path.
Plymouth Hospitals National Health Service Trust
Plymouth PL6 8DH, United Kingdom
james.greig@phnt.swest.nhs.uk

1. Adam O, Kramm T, Klein HH, Schäfers H-J. Intraaortic vegetations as a manifestation of infective endocarditis. N Engl J Med 2007;356:874-5.
2. Baddour LM, Wilson WR, Bayer AS, et al. Infective endocarditis: diagnosis, antimicrobial therapy, and management of complications: a statement for healthcare professionals from the Committee on Rheumatic Fever, Endocarditis, and Kawasaki Disease, Council on Cardiovascular Disease in the Young, and the Councils on Clinical Cardiology, Stroke, and Cardiovascular Surgery and Anesthesia, American Heart Association: endorsed by the Infectious Diseases Society of America. Circulation 2005;111(23):e394-e434. [Errata, Circulation 2005;112:2373, 2007;115:e408.]

TO THE EDITOR: Adam et al. report a case of intraaortic vegetations as a manifestation of infective endocarditis. Although they reference the 1998 guidelines of the American College of Cardiology and the American Heart Association for the care of patients with valvular heart disease, their chosen treatment does not conform to current recommendations of the American Heart Association and the Infectious Diseases Society of America with regard to diagnosis and management of infective endocarditis.[1] The patient initially received piperacillin and ciprofloxacin. (Minimum inhibitory concentrations of gentamicin and streptomycin for the isolated *Enterococcus faecalis* are not reported.) The failure of this combination would not be unexpected. The subsequent switch to imipenem monotherapy is not advocated by the guidelines either. Failure with this antibiotic would not be unexpected.

From the standpoint of a microbiologic diagnosis, Adam et al. report that the patient had *E. faecalis* endocarditis but then also report that the valve and aortic material were infected with two types of coagulase-negative staphylococci (i.e., mixed staphylococci). Either the case represents *E. faecalis* infective endocarditis plus infection with coagulase-negative staphylococci or, more likely, contamination of the aortic-tissue specimen (and perhaps the valve-tissue specimen) by coagulase-negative staphylococci after excision — raising the question of whether the "floating" aortic lesion was infected at all. Histologic examination of the excised material might resolve the matter.

Cathal E. O'Sullivan, M.B.
Barts and the London National Health Service Trust
London E1 2ES, United Kingdom
osullivan.ce@gmail.com

The New England Journal of Medicine
Downloaded from nejm.org on May 24, 2012. For personal use only. No other uses without permission.
Copyright © 2007 Massachusetts Medical Society. All rights reserved.

1. Baddour LM, Wilson WR, Bayer AS, et al. Infective endocarditis: diagnosis, antimicrobial therapy, and management of complications: a statement for healthcare professionals from the Committee on Rheumatic Fever, Endocarditis, and Kawasaki Disease, Council on Cardiovascular Disease in the Young, and the Councils on Clinical Cardiology, Stroke, and Cardiovascular Surgery and Anesthesia, American Heart Association: endorsed by the Infectious Diseases Society of America. Circulation 2005;111(23):e394-e434. [Errata, Circulation 2005;112:2373, 2007;115:e408.]

THE AUTHORS REPLY: Greig and O'Sullivan question the infectious nature of the intraaortic vegetation and apparently the diagnosis of endocarditis as well. We do not agree.

Since the patient had fever, valve destruction, valve vegetations, and microbiologic proof of the presence of pathogens, the standard criteria for infectious endocarditis were fulfilled. On initial transesophageal echocardiography, the aorta was normal, and 6 weeks later, the intraaortic vegetation was visible. Microscopical examination of the intraaortic mass showed neutrophils and gram-positive staphylococci. Two types of staphylococci, with identical susceptibility patterns, were found on mitral valve, aortic valve, and intraaortic vegetation. These facts make the probability of contamination negligible. Although there is a small but residual degree of uncertainty regarding differentiation between an infected intraaortic thrombus and a primary vegetation, the presence of 2 cm^3 of infected material seems clinically relevant. We believe that it is important for the practicing clinician to consider unusual presentations of life-threatening diseases, even if they are not part of a standard classification.

Oliver Adam, M.D.
University Hospital Homburg
66421 Homburg, Germany

Hermann Hubert Klein, M.D., Ph.D.
Municipal Hospital
55743 Idar-Oberstein, Germany

Hans-Joachim Schäfers, M.D., Ph.D.
University Hospital Homburg
66421 Homburg, Germany

Acute Wiiitis

TO THE EDITOR: A healthy 29-year-old medical resident awoke one Sunday morning with intense pain in the right shoulder. He did not recall any recent injuries or trauma and had not participated in any sports or physical exercise recently. He consulted a rheumatology colleague. The Patte's test was positive, consistent with acute tendonitis isolated to the right infraspinatus.

After further review of his activities during the previous 24 hours, the patient recalled that he had bought a new Nintendo Wii (pronounced "wee") video-game system and had spent several hours playing the tennis video game. With the Wii system, the player faces a video screen and moves a handheld controller (approximately 14.5 cm by 3.0 cm by 3.0 cm, with a weight of approximately 200 g) containing solid-state accelerometers and gyroscopes that sense three-dimensional spatial movements. In the tennis video game, the player makes the same arm movements as in a real game of tennis. If a player gets too engrossed, he may "play tennis" on the video screen for many hours. Unlike in the real sport, physical strength and endurance are not limiting factors.

The final diagnosis for the isolated right shoulder pain was Nintendinitis. However, the variant in this patient can be labeled more specifically as "Wiiitis." The treatment consisted of ibuprofen for 1 week, as well as complete abstinence from playing Wii video games. The patient recovered fully. Nintendinitis was first described in 1990,[1] and there have been many case reports of injuries related to intensive use of recreational technologies, mainly in children and mainly from intensive use of the extensor tendon of the thumb.[2-5]

With the growing use of this new video-game system, the risk of the Wiiitis variant may be higher than that of Nintendinitis reported in the literature, especially among adults. The available games for the Wii system already include golf, boxing, baseball, and bowling. Future games could involve different and unexpected groups of muscles. Physicians should be aware that there may be multiple, possibly puzzling presentations of Wiiitis.

Julio Bonis, M.D.
Instituto Municipal de Investigación Médica
E-08003 Barcelona, Spain
drbonis@gmail.com

The New England Journal of Medicine
Downloaded from nejm.org on May 24, 2012. For personal use only. No other uses without permission.
Copyright © 2007 Massachusetts Medical Society. All rights reserved.