

and have noted that solicitation may increase the chances of the exchange of money, goods, or favors between the donor and recipient. And I agree with Rady and colleagues that informed consent is required for donation and must include full disclosure, understanding, voluntariness, competence, and consent. All organ-procurement coordinators are trained to provide donor families with information about the donation process, as well as its potential benefits, without coercion. The goal is, of course, consent for donation, because of the well-recognized benefits to the donor or donor's family and to the transplant recipient. Rady et al. argue that the Web sites of organ-procurement organizations may not provide adequate information about donation while advocating for donor registration.<sup>5</sup> Now that honoring donors' wishes is the law in several states, it is incumbent on the entire transplantation community to work

toward creating better mechanisms for ensuring that potential donors are signing their donor cards after becoming fully informed.

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## Into the Woods

**TO THE EDITOR:** The Clinical Problem-Solving article by Safdar et al. (March 1 issue)<sup>1</sup> concerns an immunocompromised woman who received the diagnosis of pulmonary nocardiosis. The authors recommended that if the patient still required immunosuppression after completion of therapy, prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX) should be given. A role of TMP-SMX prophylaxis has been well established for *Pneumocystis carinii* pneumonia, but there is no clear evidence that it will prevent patients from acquiring nocardia infections. In two case series, TMP-SMX prophylaxis did not show a benefit in immunocompromised patients with nocardia infection.<sup>2,3</sup> In our experience with lung-transplant recipients, all patients with nocardia infection were receiving TMP-SMX prophylaxis. The only data supporting a role for TMP-SMX prophylaxis in nocardia infections comes from a case series of patients with human immunodeficiency virus infection.<sup>4</sup> It would be extremely difficult to make an assumption that TMP-SMX prophylaxis in doses that are routinely prescribed will prevent the development of nocardia infection. The possibility of either using a higher dose for prophylaxis or increasing the frequency of administration of the drug needs to be elucidated.

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**THE AUTHORS REPLY:** We agree with Khan and Gubina that breakthrough nocardia infections have been reported in patients receiving TMP-SMX prophylaxis for pneumocystis pneumonia. However, a single-center review of the incidence of nocardia infections in heart-transplant recipients showed an association between the use of TMP-SMX for pneumocystis pneumonia prophylaxis and a reduction in the number of nocardia infections.<sup>1</sup> Many clinicians continue secondary prophylaxis with

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

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## Intraaortic Vegetations and Infective Endocarditis

**TO THE EDITOR:** The mobile aortic thrombus described by Adam et al. (Feb. 22 issue)<sup>1</sup> as suggestive of intraaortic endocarditis does not even warrant a diagnosis of possible endocarditis, according to the Duke criteria.<sup>2</sup> 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.

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**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.<sup>1</sup> 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.

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