

CORRESPONDENCE



A New Arenavirus in Transplantation

TO THE EDITOR: We find the description of a “new arenavirus” by Palacios and colleagues (March 6 issue)¹ interesting, but we consider several of their conclusions to be unjustified or misleading. First, the characterized virus is simply lymphocytic choriomeningitis virus (LCMV), its nucleotide sequence lying well within the range of variability for the species as defined by the International Committee on Taxonomy of Viruses (ICTV) for this virus. Second, diagnostic tests for LCMV (polymerase chain reaction, serologic tests, or viral isolation) would undoubtedly have detected the agent, had these tests been used on initial screening. The omission of these tests from otherwise comprehensive testing was odd, given the clinical similarities to previously described clusters of post-transplantation LCMV infections.² Although the study correctly shows how ultra-high-throughput sequencing is a powerful tool for microbiology, it appears that the current study is

an example of its unnecessary use. Sequence diversity within a species is not the same thing as a “new virus.”

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1. Palacios G, Druce J, Du L, et al. A new arenavirus in a cluster of fatal transplant-associated diseases. *N Engl J Med* 2008;358:991-8. [Erratum, *N Engl J Med* 2008;358:1204.]

2. Fischer SA, Graham MB, Kuehnert MJ, et al. Transmission of lymphocytic choriomeningitis virus by organ transplantation. *N Engl J Med* 2006;354:2235-49.

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THE AUTHORS REPLY: We reported the sequence and genetic relationship of this virus to other arenaviruses and described it as being LCMV-like; however, formal classification must rest with the ICTV. There is no pathognomonic presentation for transplant-associated LCMV. Whereas our patients had encephalopathy without seizures, the report on the earlier series described four patients: two with seizures, two with no neurologic disease, and all four with other findings, including diarrhea, abdominal pain, incision tenderness, and pulmonary infiltrates. We investigated an unexplained outbreak, simultaneously screened approximately 100,000 sequences, and pursued a candidate pathogen using culture and electron-microscopical, immunohistochemical, molecular, and serologic methods. We predict that this example will be followed by many others as high-throughput sequencing becomes more affordable

and accessible to clinicians and public health agencies.

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Thrombus Aspiration during Primary Percutaneous Coronary Intervention

TO THE EDITOR: I do not agree with Svilaas and colleagues (Feb. 7 issue)¹ that thrombus aspiration during percutaneous coronary intervention (PCI) in patients who have myocardial infarction with ST-segment elevation improves clinical outcomes. In their intention-to-treat analysis, neither the incidence of death, reinfarction, or target-vessel revascularization nor a combination of these events was significantly different between the group with and the group without aspiration.

The authors' implication that aspiration thrombectomy is applicable "in a large majority" of patients who have myocardial infarction with ST-segment elevation is misleading. They suggest that since material was aspirated in almost three fourths of the patients, the myocardial blush grade and clinical outcomes were correlated across groups, and the blush grade was higher in the aspiration group than in the conventional-PCI group, then, ipso facto, aspiration is widely applicable for the improvement of clinical outcomes. A recent meta-analysis of randomized trials showed that distal-protection devices with PCI in patients who have myocardial infarction with ST-segment elevation improved the blush grade without improving the rate of death at 30 days.² The current study results are consistent with these data. Thus, I would suggest caution in recommending the use of aspiration thrombectomy without first showing improvement in clinical outcomes.

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1. Svilaas T, Vlaar PJ, van der Horst IC, et al. Thrombus aspiration during primary percutaneous coronary intervention. *N Engl J Med* 2008;358:557-67.

2. De Luca G, Suryapranata H, Stone GW, Antoniucci D, Neumann F-J, Chiariello M. Adjunctive mechanical devices to prevent distal embolization in patients undergoing mechanical revascu-

larization for acute myocardial infarction: a meta-analysis of randomized trials. *Am Heart J* 2007;153:343-53.

TO THE EDITOR: Svilaas and colleagues report on a large, randomized, controlled trial of thrombectomy in acute myocardial infarction. This single-center trial showed improvement in markers of myocardial reperfusion with thrombectomy. Meta-analyses of previous studies have reached the same conclusions.¹⁻³ Thus, we are concerned about the conclusion that thrombectomy improved clinical outcomes in the Thrombus Aspiration during Percutaneous Coronary Intervention in Acute Myocardial Infarction Study (TAPAS) trial. At 30 days, the confidence interval crossed the unity line for all studied outcomes — namely, death, reinfarction, target-vessel revascularization, and major adverse cardiac events. The authors show a gradient of improvement in clinical outcomes, with better indexes of myocardial reperfusion in a pooled analysis of data from patients in both the thrombectomy group and the control group. However, in the article, it is clear that there were no significant differences in clinical outcomes between the groups. The take-home message would be that improved reperfusion does not translate into fewer clinical events. Insufficient power to show a clinical benefit may explain this finding.

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