

Letter to the Editor

Nystatin Prophylaxis

In their review of nosocomial fungal infections, Fridkin and Jarvis (3) appear to have misunderstood our report concerning seriously burned patients treated with prophylactic topical nystatin (2).

Contrary to their assertion, we reported that 15 of the 21 fungemias in patients receiving nystatin prophylaxis were caused by *Candida rugosa*, compared to none of 18 fungemias that occurred during the period prior to nystatin use ($P = .002$). As the burn unit isolates had a common pattern of antifungal drug susceptibility that was different from that of *C. rugosa* isolates from other sources, we judged that a single strain was likely responsible for the cluster. Although we were unable to identify a common single source for these cross-infections, *C. rugosa* was isolated from a glucose monitor used on multiple patients in the unit (2).

Further analysis of isolates from our burn unit (including isolates from patients and the isolate from the glucose monitor) using pulsed-field gel electrophoresis (1) and repetitive sequence-based PCR (4) have demonstrated genetic relatedness of the isolates from our original study (2). Taken together, these results suggest that clonal strain transmission of *C. rugosa* can occur and that serious invasive infection due to *C. rugosa* is an important clinical consequence of topical nystatin prophylaxis.

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Michael P. Dubé

Peter N. R. Heseltine

Department of Medicine and Division of Infectious Diseases
University of Southern California School of Medicine
Los Angeles, California 90033

Michael G. Rinaldi

Fungus Testing Laboratory

Department of Pathology

University of Texas Health Sciences Center
San Antonio, Texas 78284-7750

Authors' Reply

We appreciate the letter of Dubé and colleagues, in which they clarify their findings of *C. rugosa* fungemia in burn unit patients during a time when nystatin prophylaxis was used (1). We reported that wound colonization by *C. rugosa* was associated with the routine use of topical nystatin in wound dressing (2). However, in their study, not only did colonization occur, but fungemia as well. We agree with Dubé and colleagues that the significant increase in *C. rugosa* fungemia and the probable cross-infection of this pathogen underscore the caution which should be embraced in the routine use of prophylactic antifungal agents.

As the incidence of invasive fungal infections becomes more common in hospitalized patients, the use of prophylactic antifungal agents may become more common. However, this use must be conjoined with ongoing surveillance and prospective studies evaluating the effects these antimicrobial agents have on the host flora and associated disease and the potential for this altered flora to be transmitted from patient to patient. In addition, hospital laboratorians need to be aware that such practice may be occurring, as the pathogens isolated from clinical specimens may change concomitant with changes in clinical practice, necessitating the isolation and identification of previously underappreciated human pathogens.

REFERENCES

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Scott K. Fridkin

William R. Jarvis

Hospital Infections Program
Centers for Disease Control and Prevention
Atlanta, Georgia 30333