Pneumocystis and think a a
We think also that the study by K.M. and others may be a case of pleural involvement was reported by Dyner et al.3 Our
pathogenetic consideration is the conversion of a diffuse into a
peripherally localized smoldering infection because of an non-
homogeneous delivery of the topically administered drug.

Pneumothorax in AIDS is difficult to manage. In our
hemophiliac cohort with 97 patients on aerosolized pentamidine since
June 1989, five pneumothoraces could be observed. Two were coincidental with a breakthrough P carinii pneumonia, another
occurred without any apparent opportunistic infection during
secondary prophylaxis. Another case was the result of cavitating
Pseudomonas aeruginosa pneumonia; another pneumothorax
during primary prophylaxis could not be attributed to any
underlying pulmonary disease and was classified as spontaneous.
Although the pleura is a target of P carinii infection in the setting
of aerosolized pentamidine prophylaxis, other underlying
conditions must be taken into account. Yet recurrences of P car-
inii pneumonia appear treatable. We, therefore, now recommend
an aggressive diagnostic and therapeutic approach in HIV-
infect ed patients with pneumothorax during aerosolized pentam-
dine prophylaxis. This includes thoracoscopy with inspection of the
pleural surfaces, pleural biopsy in case of a dispeased aspect, and
eventually resection of cysts. As Schaumberg et al1 pointed out,
examination of pleural fluid including a stain for P carinii
may add further useful diagnostic information.

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Crossreactivity of Candida With
Pneumocystis

To the Editor:

Direct immunofluorescence monoclonal antibody (DFA) is one of
the preferred methods of detecting Pneumocystis carinii in
lower respiratory tract secretions.1 The DFA test has high spec-
ificity and sensitivity for the detection of P carinii.2 Like other
stain interpretations, however, results depend on user experience
and the concentration of organisms. According to the manufac-
turer of our test kit, Genetic Systems (Seattle), the test is not be-
lieved to crosreact with other organisms like yeasts. However, We
recently observed crossreactivity with Candida. This prompted us
to test the kit against 33 fresh cultures of clinical and stock yeast
strains, including 21 Candida albicans, 5 Candida glabrata, 4
Candida tropicalis, 2 Candida parapsilosis, and 1 Histoplasma
capsulatum. The H capsulatum was included because it was
closer in size to P carinii than Candida. No fluorescence was de-
tected in 16 strains, 9 had fluorescence limited to 1 to 10 percent
of all cells observed, while 5 strains (2 C parapsilosis and 6 C al-
bicans) exhibited fluorescence in 20 to 80 percent of the cells.

Diagnosis of Pneumocystis carinii
Infection in HIV-Seropositive Patients
By Identification of P carinii in Pleural Fluid

To the Editor:

We read with interest the report that appeared in the June 1993
issue of Chest by Schaumberg et al1 about the diagnosis of
Pneumocystis carinii by identification in pleural fluid in HIV-
infect ed patients on aerosolized pentamidine prophylaxis. We
think that involvement of the pleura is a main pattern of break-
through P carinii pneumonia that has largely been unrecognized.
We observed an HIV-infected hemophiliac patient presenting with a
double-sided pneumothorax; on thoracotomy, there appeared a
thickened visceral pleura, three bronchopleural fistulae,
and a cyst. Pleural biopsy revealed P carinii pleuritis.2 Another