Allergic Bronchopulmonary Aspergillosis Treated With Itraconazole

To the Editor:

The study reported by Drs. Mroueh and Spector1 in the January 1994 issue of Chest emphasizes the efficacy of corticosteroid therapy in allergic bronchopulmonary aspergillosis (ABPA), an unusual complication of cystic fibrosis. But patients who failed to respond could be treated with itraconazole, an orally administered triazole antifungal agent.

Mannes et al2 recently reported favorable results with itraconazole as adjunctive therapy for ABPA in twins with cystic fibrosis. Using the same drug, Denning et al3 found clinical improvements in biologic and respiratory functions in six patients with ABPA (three asthma, three cystic fibrosis), allowing a reduction in corticosteroid therapy. Our study confirms the advantage of associating itraconazole with corticosteroid therapy in six ABPA patients and the efficacy of itraconazole alone in six others.

We investigated seven women and five men (mean age 44 years, range 17 to 70), all of whom presented signs of ABPA as defined by the criteria of Ricketti et al.4 The disease had developed over 6 months to 5 years and was in an exacerbation phase. Nine had severe asthma, and there were no cases of underlying cystic fibrosis. Treatment was carried out during a developing episode of ABPA as defined by clinical and x-ray film signs and a rise in total IgE. Oral itraconazole (200 mg, once daily) was administered for 6 months in ten patients and for a longer period in two. Six patients were on continuous systemic prednisolone (mean dose 16 mg/d, range 10 to 30 mg/d) at the start of therapy, and three of these patients were inhaling corticosteroids.

Response was evaluated at 1, 3, 6, and 12 months. A patient was presumed to have responded to therapy when all clinical and x-ray film signs of exacerbation had disappeared, with a decrease of serum IgE and blood eosinophilia.

Eleven patients showed major improvement under itraconazole, whereas no change was noted in one taking itraconazole and corticosteroids. Prednisolone was discontinued in five to six patients 1 to 4 months after inclusion. In 11 of 12 cases, mean blood eosinophilia dropped from 983/mm³ (420 to 1,850) before the start of itraconazole therapy to 467/mm³ (150 to 1,100) at the end of treatment, whereas mean serum IgE for all 12 cases decreased from 2,239 IU/mL (250 to 14,600) to 677 IU/mL (10 to 1,650). Aspergillus specific IgE levels did not seem to reflect clinical response in most cases, and Aspergillus precipitins became negative again in seven cases. Five patients were in clinical relapse 2 to 5 months after therapy was stopped and two at 14 months. There were no adverse clinical or biologic effects.

The cases reported here and in the literature indicate that the use of itraconazole as adjunctive therapy generally allows reduction or discontinuance of corticosteroids, which are often administered over long periods in the treatment of ABPA. In six of our patients, remission from a developing episode of ABPA was achieved using itraconazole without corticosteroids. However, randomized studies are required to determine the role of this antifungal drug as an alternative when corticosteroids are contraindicated or during weaning from prolonged corticosteroid therapy or in association with corticosteroids during a developing episode of ABPA to shorten the treatment period.

REFERENCES

The Stomach Is Not a Source for Infection in ICU Patients

To the Editor:

The interesting study reported by Bonten et al1 may at first seem an important contribution to the debate over the pathogenesis of ventilator-associated pneumonia. Unfortunately, Bonten et al have not investigated the bacteriology of the oropharynx, stomach, and trachea with the same rigor as they established a diagnosis of pneumonia.

The frequency of specimen collection is critical in studies of bacterial ecology in ICU patients. It has been found that the qualitative and quantitative bacteriology of gastric contents can change several times in 24 h in these patients.1 Bonten et al are therefore right to question the validity of a sampling frequency of only twice per week. In one recent study of colonization of ventilated ICU patients, gastric contents were sampled every 8 h.2 In the same study, where tracheal secretions were