correlations between IFN-α and the other parameters showed that IFN-α levels correlated positively with high levels of triglycerides \( (P = 0.004) \) and with the wasting syndrome \( (P = 0.002) \), and correlated negatively with an elevated hematocrit \( (P = 0.04) \). Moreover, 6 (75%) of the 8 patients with wasting but only 18 (25%) of the 71 patients without wasting had detectable levels of IFN-α \( (P = 0.01) \). The mean \( (±SD) \) levels of IFN-α were \( 3.6 ± 6.8 \text{ pg/mL} \) and \( 1.6 ± 6.4 \text{ pg/mL} \), respectively, in patients with and without active opportunistic infections at the time of sampling \( (P = NS) \).

Grunfeld and colleagues [3] also found high levels of IFN-α in HIV-infected patients and a strong correlation between IFN-α and hypertriglyceridemia in these patients. This is the first report, to our knowledge, of a correlation between IFN-α and the wasting syndrome. Interferon has been shown to induce anorexia [4], and it might play an important role in the wasting syndrome of HIV-infected patients. In our study TNF-α does not appear to be strongly implicated in AIDS-related wasting. Moreover, repeated administration of TNF-α in animals does not induce cachexia [5]. It is interesting that only eight of our patients had a wasting syndrome. Studies of the role of cytokines in the wasting syndrome should be conducted in greater numbers of HIV-infected patients. Patients should be matched to controls according to other factors such as opportunistic infections or CD4 lymphocyte count, and levels of both TNF-α and IFN-α should be measured.

Active Human Herpesvirus 6 Infection in an Adolescent Male

Sir—Active infection with human herpes virus 6 (HHV-6) in immunocompetent adolescents and adults may be more common than is generally believed [1]. We describe a case of active HHV-6 infection in a healthy adolescent.

A 17-year-old male was admitted to Saint Jozef Hospital (Kerkrade, the Netherlands) for a high recurrent fever (spikes to \( 39.5°C \)) and a generalized erythematous skin rash. Physical examination revealed bilateral conjunctivitis, tonsillar pharyngitis, and cervical lymphadenitis. Jaundice and mild hepatomegaly were also noted. The hemoglobin level was 14.1 g/dL. The following hematologic alterations that were associated with toxicity and that were consistent with the presence of an infectious disease were noted. The erythrocyte sedimentation rate was elevated (\( 38 \text{ mm/h} \)). The WBC count was \( 15,600/\text{mm}^3 \) (8% band forms; 76% neutrophils, with Döhle's bodies and toxic granulation [both found in \( ∼30\% \) of neutrophils]; and 3% lymphocytes). The platelet count was \( 130,000/\text{mm}^2 \). Hepatic dysfunction was evidenced by the significant increase in the levels of bilirubin and liver enzymes. Other clinical findings were normal, and the results of hematologic and biochemical tests were within normal range.

The patient's rash subsided during the week after admission, but with gradual desquamation, especially on the palms of his hands and the bottoms of his feet. The patient recovered unexpectedly. Because of the patient's symptoms, the differential diagnosis included a variety of infectious diseases. The patient did not have a history of travel outside of his hometown and the surrounding regions. Histologic examination of a biopsy specimen of a cervical gland revealed a nonspecific inflammatory process. Histochemical staining of the biopsy specimen was not performed. Appropriate microbiological cultures and paired serological tests were performed for detection of the following agents or diseases: Streptococcus pyogenes; Q fever; Brucella species; Leptospira species; Mycoplasma pneumoniae; Chlamydia species; Toxoplasma gondii; adenovirus; measles virus; parainfluenzae virus; parvovirus B19; rubella virus; hepatitis A, B, or C virus; and HIV. The results of these cultures and serological tests were uninformative or negative. ELISAs for cytomegalovirus (CMV) and Epstein-Barr virus were negative for IgM, but CMV IgA was detected on day 58 of hospitalization. Serum specimens were tested by indirect immunofluorescence [1], which showed a significant rise in the titer of HHV-6 IgG (the titer was 1:20 on day 9 of hospitalization and 1:640 on day 18). HHV-6 IgM was detected on day 18 of hospitalization (titer, 1:160) and day 58 (titer, 1:10), but it was not detected at a later date (table 1). Six months after the patient initially presented, an ELISA for detection of HIV antibodies was negative.

Despite the absence of lymphocytosis, our patient's clinical picture resembled a recently published description of an acute

References


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Teicoplanin Selects for Staphylococcus aureus That Is Resistant to Vancomycin

The resistant, but not the susceptible strain of Staphylococcus aureus expresses a new membrane protein of ~35 kD in molecular weight, that it shows increased expression of the two polypeptides of penicillin-binding protein (PBP2), and that it is more resistant to lysis by lysostaphin, an endopeptidase that is susceptible to vancomycin [7]. We have carried out a preliminary characterization of a susceptible strain of S. aureus and the teicoplanin-resistant derivative that emerged during teicoplanin therapy for endocarditis [8]. We showed that the resistant strain expresses a new membrane protein of ~35 kD in molecular weight, that it shows increased expression of the two polypeptides of penicillin-binding protein (PBP2), and that it is more susceptible to lysis by lysostaphin, an endopeptidase that

<table>
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<tr>
<th>Viral antibody</th>
<th>9</th>
<th>18</th>
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<tr>
<td>HHV-6 IgG</td>
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<td>1:1,280</td>
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<tr>
<td>HHV-6 IgM</td>
<td>&lt;1:10</td>
<td>1:160</td>
<td>10</td>
<td>&lt;1:10</td>
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<td>CMV IgG (AU)</td>
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<tr>
<td>EBV-VCA IgG/IgM</td>
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<td>&lt;1:8</td>
<td>&lt;1:8</td>
<td>&lt;1:8</td>
<td>&lt;1:8</td>
</tr>
</tbody>
</table>

NOTE. AU = arbitrary laboratory units; EBV-VCA = Epstein-Barr virus viral capsid antigen; = negative.

References