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Zanamivir Treatment Is Equally Effective for Both Influenza A and Influenza B

TO THE EDITOR—We previously reported that oseltamivir was less effective against influenza B than it was against influenza A in a study of the 2002–2003 influenza season; these findings were similar to those in a report in 2007 by Sugaya et al. [1–3]. However, the effectiveness of another neuraminidase inhibitor, zanamivir, has not been compared between influenza A and influenza B. Therefore, we performed a preliminary study of the effectiveness of zanamivir for the treatment of 67 patients with influenza A and 100 patients with influenza B (with influenza being diagnosed using commercial antigen detection kits) [3, 4] during the 2001–2002, 2002–2003, 2003–2004, 2004–2005, and 2005–2006 seasons (table 1). The percentage of patients who were afebrile at 24 h or 48 h after the first inhalation of zanamivir was analyzed as a parameter of the effectiveness of zanamivir treatment. There was no significant difference between patients with influenza A and patients with influenza B with respect to the percentage of patients who were afebrile at 24 h (49.3% vs. 36%) or at 48 h (79.1% vs. 80%).

Table 1. The percentage of afebrile patients at 24 h and 48 h after the first inhalation of zanamivir.

Type of influenza	No. of female patients	No. of male patients	Age, mean years \pm SD	No. (%) of afebrile patients	
				At 24 h	At 48 h
A ($n = 67$)	42	25	37.9 \pm 17.5	33 (49.3)	53 (79.1)
B ($n = 100$)	61	39	31.6 \pm 18.2	36 (36.0)	80 (80.0)

In our previous study, the mean duration of fever (\pm SD) in patients with influenza A and patients with influenza B was 31.2 ± 23.7 h and 47.1 ± 30.8 h, respectively, after the first dose of oseltamivir and 47.9 ± 26.0 h and 65.4 ± 32.8 h, respectively, after the onset of fever [3]. In addition, the mean duration of fever (\pm SD) after onset of fever was 82.4 ± 36.0 h and 78.3 ± 41.9 h in patients with influenza A and patients with influenza B, respectively, who were not treated with anti-influenza drugs [3].

Studies of in vitro antiviral activity of oseltamivir or zanamivir against laboratory strains of influenza virus that used culture and enzymatic assays have suggested that influenza B virus is less susceptible than influenza A virus to oseltamivir and zanamivir [5]. However, the reported difference of the mean inhibitory concentration of 50% between influenza A and B viruses was less for zanamivir (2.09 nM vs. 4.15 nM) than it was for oseltamivir (0.73 nM vs. 11.53 nM). These findings may explain our results in a clinical context, showing that oseltamivir is less effective against influenza B than it is against influenza A and that zanamivir is equally effective against both. We are now studying the effectiveness of zanamivir against influenza A and influenza B among a large number of patients identified during the 2006–2007 season. In conclusion, zanamivir is more effective than oseltamivir for the treatment of influenza B.

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Halo Sign and Improved Outcome

TO THE EDITOR—Greene et al. [1] described baseline chest CT imaging findings from 235 patients with invasive pulmonary aspergillosis who participated in a

previously published clinical trial that compared the efficacy of voriconazole therapy with that of amphotericin B therapy [2]. The “typical” CT images associated with invasive fungal disease are the halo sign and the air-crescent sign, which were present in 60.9% and 10.2% of patients, respectively [1]. The authors described 13 other image appearances that are considered to be less specific for invasive fungal disease. Interestingly, the presence of a halo sign at baseline was associated with a significantly higher global response rate and better survival. This difference in outcome was not explained by other factors, such as neutropenic status or underlying disease [1].

Caillot et al. [3, 4] noted that the halo sign was the earliest radiological manifestation of invasive pulmonary aspergillosis in neutropenic patients and that nonspecific images and the air-crescent sign became more prevalent later in the course of the disease (figure 1). Thus, the improved outcome experienced among patients with a halo sign observed by Greene et al. [1] could have been a result of the earlier initiation of antifungal therapy in the course of the fungal disease. This would also explain why improved outcome was observed regardless of whether patients were treated with voriconazole or amphotericin B.

Timing is crucial for successful therapy of invasive *Candida* infections [5], because the survival rate of patients treated immediately after blood cultures were obtained was better than that of patients in whom administration of antifungal therapy was delayed. There is no reason to assume that the management of other invasive fungal diseases would be any different. These observations underscore the importance of reducing the delay in the administration of effective treatment for patients with invasive fungal infection.

As indicated in figure 1, the frequencies of the halo sign and the air-crescent sign encountered in the study by Greene et al. [1] can be superimposed on the figure based on the study by Caillot et al. [4] and

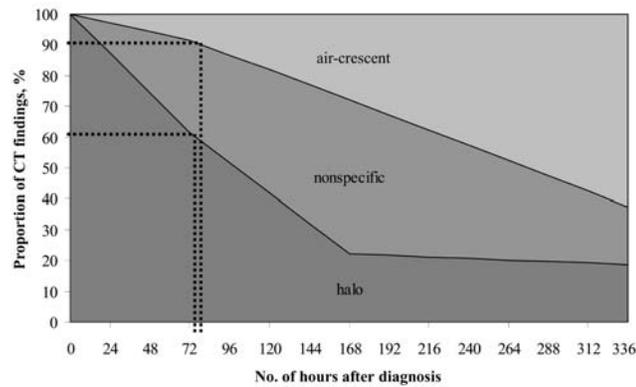


Figure 1. The evolution of CT images of invasive pulmonary aspergillosis in sequential CT scans of the thorax, adapted from Caillot et al. [4]. The observed frequencies of the halo sign and the air-crescent sign in a study by Greene et al. [1] are superimposed on the figure based on the study by Caillot et al. [4].

likely correspond with a delay in diagnosis of ~72 h. Caillot et al. [4] obtained prompt CT imaging of patients in whom invasive aspergillosis was suspected, whereas the current clinical practice is more in line with the study by Greene et al. [1], in which a delay of several days before a CT was performed was not uncommon. Given the importance of early initiation of antifungal therapy, we should no longer accept a delay in obtaining the diagnostic information necessary for the optimum treatment of patients with suspected invasive fungal disease.

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Reply to Verweij et al.

TO THE EDITOR—Our thanks to Verweij et al. [1] for their cogent comments. Although data from our study [2] were not sufficient to independently establish that the patients in whom we identified a halo