

Angiostrongyliasis in the Americas

To the Editor: We read with special interest the article by Hochberg et al. about angiostrongyliasis in Hawaii (1). *Angiostrongylus cantonensis* meningitis in the Americas was reported by Aguiar et al. in Cuba in 1981 (2), and we have studied this zoonosis during the ensuing 25 years. We agree with the authors about the difficulty in obtaining a specific immunoassay for detection of antibodies to *A. cantonensis* antigens. In Cuba, as in Hawaii, no other cause of eosinophilic meningitis was identified.

To improve accuracy of the diagnosis we investigated immunoglobulin (Ig) E intrathecal synthesis during the first diagnostic lumbar puncture. We also confirmed this synthesis as either a 2-class response (IgG + IgA) or a 3-class response (IgG + IgA + IgM) that appeared 8 days later in cerebrospinal fluid (3).

Since 1991, our records show that the major incidence of the disease is during the second quarter of the year. We detected 32% of the cases during the rainy season when rats come into houses in rural and semirural areas and snails and slugs appear more often in gardens and yards where children play. Ethnicity data show that 52% of those affected were Caucasian and 32% were African. The median interval from onset of symptoms to lumbar puncture was 1–3 days. Although no children died, 6 (23%) of 26 adult patients died. The clinical signs and symptoms of the Cuban patients are similar to those in Hawaii (4,5). We congratulate the authors for systematically determining incidence rates of *A. cantonensis* meningoencephalitis, a severe but preventable infection.

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Increase in Group G Streptococcal Infections in a Community Hospital, New York, USA

To the Editor: Identified in 1935 by Lancefield and Hare, group G streptococci (GGS) are part of the normal flora of the pharynx, gastrointestinal tract, genital tract, and skin (1–3). However, previous case reports have indicated that GGS also could cause complicated infections, including cellulitis, osteomyelitis, septic arthritis, meningitis, endocarditis, and bacteremia (3–6). Since the mid-1980s, several studies worldwide have reported an increasing incidence of GGS bacteremia (1,5–8), but no recent study has been conducted in the United States to determine the incidence of overall GGS infection.

We noticed that an increasing number of patients with GGS have been admitted to Long Island College Hospital in Brooklyn, New York, USA, during the past few years. To better understand the trend of GGS infection in our institution, we retrospectively reviewed charts of patients admitted from January 2003 through December 2007 who had microbiologically proven GGS infection. Inclusion criteria were clinically and microbiologically documented GGS infection in patients who received appropriate antimicrobial drugs and were ≥ 18 years of age. Lancefield GGS were identified in the laboratory by latex agglutination test; resistance profiles were not done for GGS.

A total of 73 persons with GGS were admitted to the hospital during the 5-year study period; the number of patients admitted increased yearly (Figure). Mean age of patients was 53 years; most (77%) were < 65 years of age; 52% were women, and most (61%) patients were African American. Thirty (41%) patients had polymicrobial infections; other identi-