

Abstracts en français dans le secteur d'annonces Deutsche Abstracts im Anzeigenteil

The New England Journal of Medicine

Established in 1812 as THE NEW ENGLAND JOURNAL OF MEDICINE AND SURGERY

VOLUME 341

OCTOBER 14, 1999

NUMBER 16

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European edition published by the Massachusetts Medical Society and printed in England by St. Ives (Andover) Ltd., West Portway, Andover, SP10 3SF, U.K. Registered as a newspaper at the Post Office. ISSN 0028-4793. of peripheral-blood mononuclear cell DNA for the quantitation of HHV-8 DNA in peripheral-blood mononuclear cells (unpublished data). We found no relation between the titer of antibodies against the latent nuclear antigen of HHV-8 and the amount of HHV-8 DNA in plasma or peripheral-blood mononuclear cells (P=0.93 and P=0.49, respectively, by Spearman's rank correlation) (Fig. 1, previous page). Although the results of this preliminary analysis of a small group of HHV-8-infected patients does not exclude the possibility that in some settings there is a relation between the titer of antibodies against HHV-8 and the peripheral-blood HHV-8 viral load, our findings provide evidence that the titer of antibodies against the latent nuclear antigen of HHV-8 is not a marker of the peripheralblood HHV-8 viral load in persons with AIDS-related Kaposi's sarcoma.

THOMAS B. CAMPBELL, M.D.

University of Colorado Health Sciences Center Denver, CO 80262

> MARGARET BOROK, M.B., CH.B. LOVEMORE GWANZURA, PH.M.

University of Zimbabwe School of Medicine Harare, Zimbabwe

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The authors and a colleague reply:

To the Editor: Campbell and colleagues investigated the correlation between titers of anti-HHV-8 antibodies and the viral load in a small group of HIV-infected patients with Kaposi's sarcoma. In other studies of HIV-positive patients, HHV-8 was more readily detected by PCR in peripheral-blood cells from patients with Kaposi's sarcoma than in peripheral-blood cells from those without Kaposi's sarcoma,¹ suggesting that the patients with Kaposi's sarcoma had an increased HHV-8 viral load. Titers of anti-HHV-8 antibodies are also higher in HIV-positive patients with Kaposi's sarcoma.² Therefore, there appears to be an association between the viral load and the antibody titer.

Anti-HHV-8 antibodies are detectable in a higher percentage of patients with classic Kaposi's sarcoma (those without HIV infection) than patients with AIDS-related Kaposi's sarcoma,^{3,4} suggesting that some patients with Kaposi's sarcoma and AIDS have reduced or undetectable antibody responses against the latent nuclear antigen of HHV-8. Furthermore, patients with classic Kaposi's sarcoma have higher titers of anti-HHV-8 antibodies than patients with AIDS and Kaposi's sarcoma.⁴ Antiretroviral and antiherpesviral drugs used in HIV-infected patients may directly or indirectly (through the restoration of cellular immunity) influence the HHV-8 load, the titer of anti-HHV-8 antibodies, or both, although it is unlikely that these drugs would be readily accessible in Zimbabwe. The correlation between the titer of anti-HHV-8 antibodies and HHV-8 load may therefore not be apparent in small groups of HIV-infected patients with Kaposi's sarcoma, especially if they have been ill with HIV infection and Kaposi's sarcoma for unspecified periods.

In the study of mother-to-child transmission,⁵ all the subjects were mothers and children who were attending a paternity-dispute clinic but whose HIV status was unknown. Whether there is a direct correlation between the titer and the viral load in HIV-negative persons, as we hypothesized, still needs to be determined.

DIMITRA BOURBOULIA, M.SC. CHRIS BOSHOFF, M.R.C.P., PH.D. University College London London W1P 6BT, United Kingdom

FREDDY SITAS, D.PHIL.

South African Institute for Medical Research Johannesburg 2000, South Africa

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Interventional Sialendoscopy

To the Editor: Obstruction of the salivary ducts is one of the main causes of sialadenitis. The principal diagnostic tool for disorders of the salivary duct is sialography, a procedure requiring high doses of radiation. Interventional sialendoscopy is a new procedure for visualizing the salivary ducts and treating their abnormalities. Attempts have been made to visualize salivary stones¹ and to destroy them by internal² or external³ lithotripsy. These techniques required many sessions, and stone fragments were removed blindly.

Progress in fiberoptic technology and miniaturization now allows the endoscopist to obtain high-quality images. We have developed a rigid endoscope that is 1.3 mm in diameter and that has a working channel and several miniature wire baskets for retrieving objects. A sialolith is removed under direct endoscopic control⁴ by introducing the sialendoscope into Stensen's or Wharton's duct. Small sialoliths can be extracted with the wire baskets (Fig. 1, facing page), whereas larger stones must first be fragmented. Removal of the obstruction results in immediate relief of symptoms. Preservation of the salivary glands is therefore





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Figure 1. Removal of a Salivary Stone (Panel A) with a Wire Basket (Arrow in Panel B) during Endoscopy.

possible in a majority of patients, who previously would have had to undergo surgical extirpation of the glands.

> FRANCIS MARCHAL, M.D. PAVEL DULGUEROV, M.D. WILLY LEHMANN, M.D. Geneva University Hospital 1211 Geneva 14, Switzerland

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