the epigastrium. Blood tests revealed leukocytosis (WBC count, 8.29 × 10^9 cells/L, with 78.2% polymorphonuclear leukocytes) and an elevated C-reactive protein level (6.47 mg/dL). The biliary enzyme levels were within the normal limits (alkaline phosphatase, 226 U/L; γ-glutamyl transpeptidase, 203 U/L). Urinary tract infection was the tentative diagnosis, and treatment with cephalosporin and gentamicin was started.

Abdominal ultrasonography revealed a lobulated, hypoechoic, cystic lesion in the lateral segment of the left hepatic lobe. The abdominal CT showed a 5-cm heterogeneous, septated, nodular lesion with marginal enhancement, a finding compatible with pyogenic liver abscess. However, a linear radiopaque density within the lesion was also noted (figure 1, top, arrow). The antibiotic therapy was changed to cefotiam and metronidazole. The fever became low-grade, and the antibiotic therapy was changed to ampicillin-sulbactam because of suspected bowel perforation that was successfully treated without removal of the foreign body. We thus recommend that medical approaches could be attempted first in such cases, especially when contraindications for surgery exist.

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Fluconazole Prophylaxis for Critically Ill Patients at High Risk for Candida Infection

Sir—I have read with interest the article by Wenzel and Gennings [1] recently published in a supplement of the journal. In this article, the authors comment on the strategy followed at the Johns Hopkins University Hospital for patients in critical care units who are at particularly high risk for Candida infection, which is to give prophylactic anti-Candida antibiotics to all patients expected to be in an intensive care unit for ≥3 days. This strategy has been shown to reduce the overall rate of candidal infections in a study that examined all anatomic sites, but it did not reduce mortality in a surgical intensive care unit at Johns Hopkins University Hospital [2]. However, only 1 patient receiving fluconazole developed a candidal bloodstream infection, and 2 patients receiving placebo developed infection of the blood and the peritoneum [1].

Figure 1. Distribution of Candida albicans and non-albicans species of Candida(C. non-albicans) before and after the study.
In a study conducted in our institution that involved critically ill patients at high risk for development of candidal infections, patients were randomly assigned to receive fluconazole at a dosage of 100 mg daily \( (n = 103) \) or placebo \( (n = 101) \) [3]. Candidal infections occurred less frequently in the fluconazole group than in the placebo group (5.8% vs. 16% of patients; rate ratio, 0.35; 95% CI, 0.11–0.94). Approximately 90% of candidemia episodes occurred in the placebo group (rate ratio for fluconazole use, 0.10; 95% CI, 0.02–0.74). The crude mortality rate in both groups was similar. In conclusion, our results demonstrate that, for selected critically ill patients at high risk, fluconazole prophylaxis decreases the incidence of candidal infection, and of candidemia, in particular.

We did not observe changes in the patterns of distribution of infection due to *Candida albicans* and infection due to non- *albicans* species of *Candida* when we compared the species distribution before and after the study [4] (figure 1). Nevertheless, we would recommend close surveillance for the emergence of antifungal resistance.

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**References**