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Book Review
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Title Index, 2007

Author Index, 2007

Scientific Reviewers, 2007
to the uninitiated eye and the arrow pointing to this would greatly improve the quality of this publication. The “numerous” microconidia mentioned in the text is not evident in the figure that has been published.

References


Authors’ Reply
Dear Editor,

The case report of disseminated histoplasmosis in a patient with AIDS was published with the idea of increasing awareness of this condition and we are happy with the response we have received. Acute disseminated histoplasmosis is considered an AIDS indicator disease and yet reports from this country are very few. This is in spite of the fact that India is one of the major foci of the AIDS pandemic. One of the reasons for this as aptly brought out by Goswami et al.1 is that Histoplasma culture is difficult unless the appropriate sample is collected and there is a high index of suspicion by the microbiologist. Though the disease is more commonly reported from the Eastern parts of India, it is by no means restricted to these parts of the country as amply demonstrated by the article by Subramaniam et al.2 and an earlier review by Randhawa et al.3 Increased travel within the country has made the prevalence of the disease more widespread than it was previously believed to be and is at present still under-reported.

Though our culture showed abundant microconidia, the picture published with the article attempted to demonstrate the macroconidia as these are more characteristic of the organism. The photograph also shows many macroconidia without the characteristic tubercles and one in which these tubercles are just appearing. This has been aptly brought out in the comments by Goswami et al.,1 who have described that typical macroconidia may sometime appear late and most of these may be initially without tuberculated processes. An arrow was placed in the photograph pointing to the yeast phase of the organism.

By the time this article was submitted for publication, the series of Subramaniam et al.2 mentioned above had not been published. However, in spite of an extensive review of available literature, we missed the single culture positive case in the study by Goswami et al.1 Therefore, the credit for the first culture of Histoplasma from a patient with disseminated histoplasmosis in an AIDS patient must go to them.

References

Microwave Disinfection of Gauze Contaminated with Bacteria and Fungi
Dear Editor,

Commercial radiation has been used to sterilize medical products for more than 40 years.1,2 Evidence from the literature clearly demonstrates that domestic microwave energy can be used for sterilization.3,4 The equipment in routine use for the sterilization of surgical materials is moist heat sterilizer, i.e., autoclave. The main purpose for using
microwave for sterilization is to save time. In this study, we verified whether microwave energy is able to disinfect gauze pieces colonized with *Pseudomonas aeruginosa* ATCC 27853, *Escherichia coli* ATCC 25922, *Staphylococcus aureus* ATCC 25923 or *Candida albicans* ATCC 10231 and compared this method to autoclave.

The microorganism concentration was adjusted to 0.5 in McFarland opacity scale. This solution was added to gauze pieces and submitted to microwave oven treatment at 1000 W from 10 to 60 seconds. Control samples were not submitted to this treatment. The gauze pieces were then inoculated in blood agar or brain heart infusion medium and incubated at 37 °C for 24 hours. Our results showed that exposure to microwave energy for 30 seconds was able to inhibit the growth of microorganisms (Figure). When compared to humid heat sterilizer (temperature of 121 °C at 1.1 atmospheric pressure for a minimum of 20-30 minutes), similar results were found (data not shown).

In this work, we demonstrated that a domestic microwave oven could disinfect gauze pieces colonized with microorganisms. The material may be disinfected with exposure to microwave energy at 1000 W for 30 seconds.

**References**


VH Cardoso, DL Gonçalves, E Angioletto, F Dal-Pizzol, *EL Streck*

Laboratory of Experimental Pathophysiology (VHC, FDP, ELS), University of the Far South Catarinense, 88806 - 000 Criciúma, SC, Brazil; Laboratory and Development of Antimicrobial Biomaterials and Materials (DLG, EA), University of the Far South Catarinense, 88806 - 000 Criciúma, SC, Brazil

*Corresponding author (email: <emiliostreck@terra.com.br>)
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**Endoscope Reprocessing: Stand up and Take Notice!**

Dear Editor,

Endoscopy is a very frequently performed diagnostic and therapeutic interventional modality. Recently, it has been reported that up to 270,000 infections (in 2.7% of procedures) are transmitted annually by flexible endoscopes in the USA.¹ There have been >500 reports of infections due to use of contaminated endoscopes, commonly by *Pseudomonas aeruginosa*, *Salmonella* spp., *Mycobacterium tuberculosis* and atypical mycobacteria. Recommendations for reprocessing of endoscopes have been established worldwide, but lack of compliance is rampant in 20-70% of centres in Europe, Australia and Asia.²,³ Compliance is also very poor in Japan, India (only 1/3 of 133 centres practiced minimum disinfection), Western Europe (inadequate disinfection in ≥30% centres) and USA (inadequate disinfection of 23.9% of endoscopes).⁴

International recommendations for endoscope reprocessing is a stepwise process; pre-cleaning, leak testing, cleaning, rinsing, high level disinfection (HLD)/sterilization, rinsing, drying and storage. Cleaning is extremely important, resulting in $2-6 \log_{10}$ (mean 3 log$_{10}$) reduction in bacterial load and