Letters to the Editor

A Small Outbreak of Spontaneous Abortion in Four Patients From Two Households

To the Editor:

Two sisters, Patient K (age 36) and Patient S (age 38) lived in the same household and shared all foods prepared in their home. Patient K was pregnant, and her sister, Patient S, became pregnant two months later. Patient K suffered a sudden, spontaneous abortion; two months later, Patient S also suffered a spontaneous abortion.

Two sisters-in-law, Patient L (age 33) and Patient Z (age 27), resided in the same household and shared all meals. About two months after Patient Z became pregnant, Patient L also became pregnant. Patient Z's pregnancy ended in spontaneous abortion, and two months later, Patient L also suffered a spontaneous abortion.

All four patients had positive indirect hemagglutination (IHA) tests for toxoplasmosis.

Over a five-year period, 139 pregnant women visiting the Mother and Child Care Center in Risafa, Iraq, tested IHA-positive for toxoplasmosis infection; however, only four women (two pairs of women, each pair sharing households) had spontaneous abortions. Women with serological evidence of toxoplasmosis infection prior to pregnancy do not infect their neonate; the fetus may be at risk only when primary infection is acquired during pregnancy.' Toxoplasmosis is transmitted to the fetus in utero during a pregnancy only as a result of parasitemia.[1,2]

The modes of transmission of toxoplasmosis in our culture, and especially in our four patients, have not been definitively established. Cooked meat cannot be considered a vehicle for infection in Iraq. However, direct contamination by flies[3] and cockroaches[4] serving as the mechanical carriers for the oecyst from cat feces is possible. There is a close association between the prevalence of toxoplasmosis in humans and the presence of toxoplasmosis in domestic cats.[5,6]

Toxoplasmosis infection is a preventable disease, and, even when primary infection occurs during pregnancy, early diagnosis and treatment can reduce the frequency and severity of disease in the neonate.[7]

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REFERENCES

1. Whitefield VR. Toxoplasmosis. In: Dewhurst, ed. *Obstretrics and Gynecology for Postgraduates.* 4th ed. 1988:331.
2. Jawetz E. Toxoplasmosis. In: ***Review of Medical Microbiology.*** 7th ed. Norwalk, Conn: Appleton and Lange; 1987:555.
3. Wallace GD. Experimental transmission of ***Toxoplasma gondii*** by flies. ***Am J Trop Med Hyg.*** 1971;20:411-413.
4. Wallace GD. Experimental transmission of ***Toxoplasma gondii*** by cockroaches. ***J Infect Dis.*** 1972;126:544-547.
5. Feldman H. Toxoplasmosis. In: Stein JH, ed. ***Internal Medicine.*** Boston, Mass: Little, Brown & Co.; 1986.
6. Kwates W. Toxoplasmosis. In: Weatherall DJ, ed. *Oxford Textbook of Medicine.* 2nd ed. New-York, NY: Oxford University Press Inc.; 1987.
7. Wilson GB, Remington JS. What can be done to prevent congenital toxoplasmosis? ***Am J Obstet*** Gynecol. 1980;138:357-367.

Parenteral Versus Oral Antimicrobials

To the Editor:

I read with great interest the recent report by Ehrenkranz et al.[1] However, I had several questions. The study was undertaken to promote a change from parenteral to oral antimicrobials with equivalent therapeutic actions. However, intervention also was regarded as successful if antimicrobial treatment was discontinued; this is not consistent with the study question. The rate of treatments that were discontinued rather than changed to an oral regimen should be reported. No sample size determinations were reported in this clinical trial. Because similar outcomes of mortality and secondary infections were observed, the power of the study should be stated to allow the reader to assess the probability of Type II error.[2]

Student's *t* tests and Fisher's exact tests were used to analyze the data. In Table 2, multiple com-

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