is the most frequent, while other subtypes, such as angioimmuno- 
blastic and anaplastic large cell lymphoma (ALCL) are less common. 
Less than 40 cases of ALCL have been reported in HIV-infected 
patients.\textsuperscript{3,7}

ALCL was first characterised by Stein, who described a new type 
of lymphoma consisting of large anaplastic lymphoid cells with a 
strong expression of CD30, and a tendency to grow cohesively and 
invade lymph node sinuses.\textsuperscript{8} As in our case the common type is 
characterised by sheets of large lymphoid cells with horseshoe-
shaped nuclei containing multiple nucleoli. Tumour cells have an 
abundant cytoplasm with vacuoles and an increased Golgi region.
Most cases of ALCL express T-cell markers. The CD3 complex (TCR) 
is one of the most commonly expressed T-cell antigens, whereas 
unlike that of our patient CD4 or CD8 expression is less common.\textsuperscript{9}
Some ALCLs are associated with a 2;5 chromosomal translocation 
encoding the tyrosine kinase anaplastic lymphoma kinase (ALK).\textsuperscript{10}
It is assumed that both CD30 and ALK are involved in the growth 
and replication of the tumour cells.\textsuperscript{7}

ALCL in HIV-infected patients has a distinct course, being much 
more aggressive than in immunocompetent patients. Although it 
is usually associated with extranodal involvement and systemic 
symptoms,\textsuperscript{5} presentation with rapidly appearing painful subcuta-
neous nodes, as in our patient, is very rare. Two clinical forms of 
ALCL have been described, systemic and cutaneous.\textsuperscript{7} Although the 
skin may be involved in both forms, in systemic cases the hypo-
dermis is affected, but characteristically the dermis is preserved.
This was the pattern in the case reported here. As in this case, ALCL 
tends to affect patients with severe immunodepression, and con-
trary to cases in non-infected population, rarely expresses ALK, 
which is associated with better responses to chemotherapy.\textsuperscript{4,9}
Immune reconstitution by HAART is crucial. Anti-neoplastic regi-
mens are frequently considered, but the prognosis is poor, with a 
median survival of 5 months.\textsuperscript{5,10}

Although uncommon, clinicians caring for patients with HIV 
infected should be aware of this tumour, especially in patients pre-
senting with swollen lymph nodes, or subcutaneous nodes. Since it 
affects patients with severe immunodeficiency, and has an ominous 
prognosis, good control of HIV infection and subsequent immuno-
depression is the best preventive strategy.

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Are HIV-infected patients a high-risk population for hepatitis E virus infection in Spain?

¿Son los pacientes VIH positivos un grupo de riesgo para la infección por virus de la hepatitis E en España?

To the Editors,

We read the article by Rodriguez-Frias et al.\textsuperscript{1} with interest. The authors reported a seroprevalence of anti-HEV antibodies (IgG anti-HEV) between 2.2% and 7% in Spain. However, the prevalence of anti-HEV antibodies varies according to the population included in the study, and is even much higher in HIV infected patients. Data on the frequency of anti-HEV antibodies in these patients in Spain are scarce, and it is a controversial issue in other countries, such as England where Feane et al.\textsuperscript{2} reported a similar seroprevalence in controls and patients with HIV infection.

Therefore, we tested 178 plasma samples from 178 HIV-infected patients who attended our Infectious Disease Department for moni-
toring of HAART therapy between December 2011 and January 2012. Among them, 140 (78.65%) were males with a mean age of 
46 years (range: 20–78). IgG anti-HEV antibodies were detected in 
serum by a commercial enzyme immunoassay (EIA) kit (HEV Ab, 
DiaPro Diagnostic Bioprobos, Milan, Italy) following the manufac-
turer's instructions. All positive samples were studied further for 
the presence of IgM anti-HEV antibodies (HEV IgM, DiaPro Diagnostic 
Bioprobos, Milan, Italy) following the manufac-
turer's instructions. All positive samples were studied further for 
The seroprevalence of HEV infection has been studied in other 
probable risk groups, such as immigrants in Madrid\textsuperscript{4} (Table 1). Our 
results showed similar frequencies of detection of IgG anti-HEV
antibodies in all the population tested, with the exception of pig handlers\(^5\) (18.6%) and HIV-infected patients (10.1%). In blood donors and pregnant women, the prevalence is 2.8% and 3.6%, respectively,\(^6\) significantly lower than in the HIV infected population, 10.1% (\(p < .01\)). Our data are similar to those reported by Jardi et al. in Catalonia,\(^8\) Spain. They found a prevalence of 9% among 238 HIV-infected patients. However, it is interesting that in healthy adults the prevalence is much higher in Catalonia\(^9\) than in Madrid,\(^5\) 7% and 2.8%, respectively. This difference may be due to epidemiological characteristics of the patients studied (rural or urban areas, gender, age, profession), or methodology. The geographical situation of Madrid inside the country may also have a role, since a very high prevalence has been reported in southwest France.\(^10\)

In summary, our results show a high seroprevalence of HEV infection in HIV positive patients different to that observed in blood donors, pregnant women, and other considered high risk groups (except pig handlers, as hepatitis E is a zoonosis and its reservoir is swine). The normal values of ALT and absence of clinical symptoms recorded in all the patients suggests that asymptomatic infection could have taken place frequently in the past in these patients, and they can be considered as a risk group for HEV infection.

### Bibliografía


### Influenza A (H1N1) complicated by invasive aspergillosis in non-severely immunocompromised patients

### Influenza A (H1N1) complicada en pacientes sin inmunocompromiso severo: coinfección con Aspergilosis pulmonar

### Introduction

Pulmonary aspergillosis (PA) is a disease which usually occurs in immunocompromised hosts with an overall mortality around 60%.\(^1\) There have been some reports in the literature of invasive PA after pandemic influenza A (H1N1) infection.\(^2,3\) We present two cases of invasive aspergillosis after influenza A (H1N1) infection in patients without classical predisposing factors.

### Case report

The first patient is a 43-year-old diabetic male, who was admitted to the intensive care unit (ICU) due to diabetic ketoacidosis, pneumococcal pneumonia and influenza A (H1N1). He received levofloxacin, ceftriaxone, oseltamivir and methylprednisolone (80 mg/day)/1wk. On day 12, fever and respiratory failure reappeared, invasive mechanical ventilation was required. The chest computed tomography (CT) scan showed a cavity of 6 cm \(\times\) 5 cm. *Aspergillus fumigatus* grew in a sputum sample and the galactomannan antigen (AGA) tested positive in BAL fluid. Intravenous voriconazole was started as well as corticosteroids due to respiratory distress syndrome. He was discharged after three months of hospitalization. The second case is a 56-year-old diabetic man with alcoholic liver cirrhosis admitted to ICU due to alcoholic hepatitis, a methicillin sensitive *Staphylococcus aureus* bacteraemic pneumonia and influenza A (H1N1). He was started with oseltamivir, cloxacillin, meropenem and methylprednisolone (60 mg/day)/1 wk). On day 14, the patient developed right hemiparesis. Magnetic resonance imaging showed various parenchymatous lesions suggestive of brain abscesses. A chest CT had bilateral cavitated nodules. *A. fumigatus* grew in BAL fluid. Treatment was switched to voriconazole, anidulafungin and cloxacillin. The patient died on hospitalization day 21.

### Discussion

We present two cases of influenza A (H1N1) complicated by invasive aspergillosis. These patients had none of the risk factors.