China were due to genotype 4 HEV [4], yet 4 major HEV were genotypes identified in Asia [7]. A study in Spain showed that HEV infection negatively affects the survival and prognosis in patients with chronic liver disease. Nevertheless, this association differed among continents with different HEV genotypes or subtypes [8]. We echo the suggestion by Sun et al [1] that genetic variation in HEV genotypes may play a role and agree that further studies are needed to explore this issue.

Note

Potential conflicts of interest. V. W. S. W. reports personal fees from AbbVie, Allergan, Echosens, Gilead Sciences, Janssen, Perspectum Diagnostics, Pfizer, Terns, Bristol-Myers Squibb, and Merck, during the conduct of the study. G. L. H. W. reports personal fees from Gilead Sciences, Abbott, AbbVie, Bristol-Myers Squibb, Echosens, Furui, Janssen, and Roche, during the conduct of the study. J. C. T. L. reports no potential conflicts. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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Clinical Infectious Diseases® 2020;70(12):2748–9

DOI: 10.1093/cid/ciz725

Influenza-like Illness Definition Pertaining to Clinical Practice Guidelines on the Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza

To the Editor—We read with great interest the recent publication of clinical practice guidelines on the diagnosis, treatment, chemoprophylaxis, and institutional outbreak management of seasonal influenza in the March 15, 2019, issue of *Clinical Infections Diseases* [1]. In that paper, Uyeki et al cited our paper as evidence to support recommendations addressing the recognition of influenza in immunocompromised hosts [2]. However, the authors stated that only 7% of patients in our study met the Centers for Disease Control and Prevention's influenza-like illness definition (ILI). We reported in the abstract, the main body, and the tables in our paper that 7 patients (23%) met ILI definition and not 7% stated by the authors. We think this was merely an oversight by the authors. Our findings are also corroborated in a later publication by Claus et al who reported numbers similar to ours [3]. We hope to provide this clarification to ensure an appropriate estimation of the risks associated with dependence on signs and symptoms for diagnosis of influenza in immunocompromised patients. Once again we commend the authors for doing this work.

Note

Potential conflicts to interest. Both authors have no potential conflicts to disclose. Both authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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Clinical Infectious Diseases® 2020;70(12):2749

DOI: 10.1093/cid/ciz766

Response to Apewokin and Onyishi

To the Editor—We thank Apewokin and Onyishi [1] for allowing us to correct an error in the Infectious Diseases Society of America's clinical practice guidelines on influenza [2]. In their study, they reported that 7 of 31 (23%) of hematopoietic stem cell transplant recipients with influenza met the case definition of influenzalike illness, not 7%, as we cited. Their work and the work of others clearly demonstrate that immunocompromised patients with influenza frequently present with atypical clinical features and are at higher risk of complications from influenza, including death [3–5].

It is therefore critical that clinicians maintain a high index of suspicion for influenza in severely immunocompromised patients during influenza season. Nucleic acid amplification tests for influenza should be used for testing. In immunocompromised or critically ill patients with evidence of pneumonia but with negative results of influenza testing in the upper respiratory tract, tracheal aspirates

or bronchoalveolar lavage fluid should be tested for influenza and other respiratory viruses [2, 6]. Antiviral therapy should be started promptly in those with suspected or laboratory-confirmed influenza, ideally as soon after illness onset as possible. Treatment should not be delayed during the wait for laboratory results.

Notes

Disclaimer. The views expressed are those of the authors and do not necessarily reflect the official position of the Centers for Disease Control and Prevention.

Potential conflicts of interest. A. T. P. reports grants from BioFire Diagnostics, royalties from Antimicrobial Therapy, and personal fees from WebMD and Genentech, outside the submitted work. M. G. I. reports grants from Emergent BioScience, grants and personal fees from Genentech/Roche and Janssen, and personal fees from Celltrion, Shionogi, and VirBio, during the conduct of the study, as well as grants from AiCuris, Chimerix, and Gilead, and personal fees from Viracor Eurofins, outside the submitted work. All other authors report no potential conflicts. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

Andrew T. Pavia,[1] Michael G. Ison,[2] Cameron R. Wolfe,[3] and Timothy M. Uyeki[4]; for the Infectious Diseases Society of America Panel on Clinical Practice Guidelines: 2018 Update on Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza

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Clinical Infectious Diseases® 2020;70(12):2749–50

DOI: 10.1093/cid/ciz839

The Safety of Eravacycline in the Treatment of Acute Bacterial Infection

To the Editor—We read with great interest the report of the evaluating the clinical efficacy and safety of eravacycline versus meropenem in the treatment of complicated intra-abdominal infections (cIAIs) in a randomized controlled trial [1]. In this study, Solomkin et al [1] demonstrated that eravacycline had relative low rates of adverse events (AE) for a drug of this class but had higher incidence of treatment-emergent AEs (TEAEs) than meropenem. Therefore, we have one serious concern about the safety issue of eravacycline and conducted this meta-analysis to provide an updated evidence on the safety of eravacycline.

Four randomized controlled trials [1–4] were identified through a systematic review of the literature in PubMed, Embase, ClinicalTrials.gov, and Cochrane databases until May 2019. Three studies [1, 3, 4] compared the use of eravacycline with carbapenem (2: ertapenem; 1: meropenem) in the treatment of cIAI, and 1 study [2] compared eravacycline with levofloxacin in the treatment of complicated urinary tract infection. Figure 1 showed the comparison between eravacycline and comparator in terms of AEs. In the pooled analysis of 3 studies reporting TEAE, we found that eravacycline was associated with higher risk of TEAE than comparators (odds ratio [OR], 1.55; 95% confidence interval [CI], 1.21–1.99; I^2 = 0%). Nausea (11.3%, 123/1084) and vomiting (5.3%, 57/1084) were the most common AEs of eravacycline, and their incidences were higher than the comparators (for nausea, OR, 5.70; 95% CI, 2.17–14.97; I^2 = 53%; for vomiting, OR, 2.40; 95% CI, 1.02–5.65; I^2 = 53%). However, no significant differences were found between eravacycline and comparators for the incidence of serious AEs (OR, 1.05; 95% CI, 0.67–1.65; I^2 = 0%), and all-cause mortality (OR, 1.17; 95% CI, 0.39–3.48; I^2 = 5%).

In conclusion, eravacycline is associated with higher risk of TEAE and 2 of the most common AEs (nausea and vomiting) than the comparator in the treatment of acute bacterial infection, but the incidence of serious AEs and mortality are similar between eravacycline and comparator.

Note

Potential conflicts of interest. Both authors: No reported conflicts of interest. Both authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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