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Abstract text

1.Background
Toxoplasmosis in recipients of allogeneic stem cell transplants (HSCT) is a severe infectious complication and occurs mainly through reactivation of latent Toxoplasma gondii cysts. Monitoring of T.gondii DNA in peripheral blood (PB) by polymerase chain reaction (PCR) has been shown to be an appropriate tool to detect reactivation.
2. Aim
To monitor recipients of allogeneic HSCT for T.gondii reactivation by PCR and to identify risk factors for T. gondii reactivation. We also designed this study to evaluate the effectiveness of preemptive treatment before the onset of organ involvement.
3. Methods
From November 2001 until December 2008, we prospectively monitored all patients undergoing allogeneic HSCT in our institution that were seropositive (IgG) for T.gondii or from which the donor was seropositive. Patients did not receive trimethoprim-sulfamethoxazole prophylaxis but were monitored with qualitative PCR for T.gondii DNA in PB, weekly until D+100, thereafter two-weekly until 1 year post-transplant. Toxoplasmosis infection (TI) was defined as two positive PCRs in PB without clinical, radiologic or microbiologic evidence of invasive infection. Patients with TI were preemptively treated with pyrimethamine and clindamycine until PCR results were negative in two consecutive samples.
4. Results
Two-hundred and eight patients were prospectively monitored. Eighteen patients had toxoplasmosis reactivation (8.7%) and the median time after transplantation was 62 days (range 25-166). One third (6/18) had evidence of invasive disease at first diagnosis (5 central nervous system, 1 cardiac involvement). Three of these patients with invasive toxoplasmosis died, but in only one patient toxoplasmosis was the direct cause of death (two also had concomitant severe invasive pulmonary aspergillosis). Twelve patients (67%) had TI at first diagnosis. Only one of these 12 patients who were preemptively treated, subsequently developed invasive infection but this was only 11 months later (chorioretinitis). Overall, 5 patients had a second reactivation of toxoplasmosis with a median time of 33 days (range 10-318) between termination of treatment and relapse. All but one reactivation occurred in seropositive recipients.
The incidence of toxoplasmosis infection/disease was significantly higher in patients conditioned with a myeloablative regimen including total body irradiation (p
5. Conclusions
This study represents the largest prospective study on the incidence of toxoplasmosis after allogeneic HSCT. Toxoplasmosis is common with an incidence of 8.7%. All reactivations occurred within the first 6 months after transplantation, except in patients with previous toxoplasmosis reactivation. The majority of reactivations occurred before reconstitution of CD4 T lymphocytes. We demonstrate that myeloablative regimens containing TBI predispose to toxoplasmosis reactivation. Seropositivity of the donor coincided with a lower incidence of toxoplasmosis reactivation in the recipient.

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