Valadas and Antunes also raise questions regarding the history of HIV-2 discovery, which we wish to clarify. HIV-2 was first identified in a group of healthy Senegalese commercial sex workers by Barin and colleagues in 1985 on the basis of serologic cross-reactivity to simian T-lymphotropic virus–3 with altered seroreactivity to human T-lymphotropic virus–3 [6]. As noted by Clavel and colleagues in 1986, serologic reagents from reactive Senegalese women were used to type the described isolates [7]. In 1987, a special WHO working group designated HIV-2 to accommodate the variety of virus names including lymphadenopathy-associated virus–2, SBL-6669, and human T-lymphotropic virus–4 [8]. The original Senegalese sex workers described in 1985 have been part of a 19-year prospective study of HIV-2 pathogenesis, immunity, and, more recently, antiretroviral treatment. In fact, the lowered transmission potential and decreased time to disease progression with HIV-2 infection was first described in this cohort of HIV-2 infected women, along with many other unique biological and clinically relevant features of HIV-2 infection [9–12]. We are in complete agreement with Valadas and Antunes on the need for further studies to determine the optimal course of treatment for HIV-2 infected individuals.

Acknowledgment


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References


Fluoroquinolone-Resistant Streptococcus pneumoniae, an Emerging but Unrecognized Public Health Concern: Is it Time to Resight the Goalposts?

Srn—In his recent editorial in the journal, McGowan [1] noted the emergent situation regarding antimicrobial resistance among bacteria in both the hospital and other patient care settings. He recognized that bacterial drug resistance has many consequences to patients and to society. Increased infection-associated morbidity and mortality, decreased utility of antimicrobial agents for future generations of infected patients, and the consequent eco-


Clinical Infectious Diseases 2004; 39:1553–4
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