AUTHORS REPLY

Ref.: Mycophenolate mofetil may protect against *Pneumocystis carinii* pneumonia in renal transplanted patients. **Rev. Inst. Med. trop. S. Paulo, 47**(3): 143-145, 2005.

Dear Editor.

We read the Letter to the Editor submitted by Dr. Anne TOTET and co-workers reporting a case of *Pneumocystis jirovecii* in a transplanted patient six months after switching AZA for MMF. We recently observed, at our transplant unit, new cases of *Pneumocystis pneumonia* (PP). In one case the patient received MMF for 77 days and it was withdrew due to diarrhea and leucopenia; one month later PP developed. In another case the patient received MMF for only three days and sirolimus was introduced; 75 days later PP developed. A third patient, 19 years after receiving azathioprine and prednisone, developed PP one month after sirolimus was introduced due to chronic allograft nephropathy. A fourth patient received MMF for 50 days after transplantation and developed PP three years later. All patients had good outcome with trimethoprim-sulfamethoxazol treatment. Due to these observations we have now started PP prophylaxis always after MMF withdrawal. It is worth noting that OZ & HUGHES¹ reported also a protective role of sirolimus on PP in rats (only 30% of infected animals had signs of PP) what does not seem to be the case in two of our patients. Dr. TOTET *et. al.* suggested that MMF may kill MMF sensitive *Pneumocystis* strains while may have no effect on resistant strains that may grow after MMF withdrawal. Although, this may be considered a plausible explanation it does not jeopardize our hypothesis that MMF is protective against MMF² because the reported clinical case occurred only after switching MMF for AZA. The description of such a case supports our recent finding of no need for *Pneumocystis* prophylaxis when MMF treatment is interrupted.

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