

gesting a large load of this organism. No other organisms were isolated despite prolonged incubation of cultures, and the patient recovered after specific treatment directed at *Nocardia* spp. Furthermore, he remained well with no further treatment at 18-month follow-up, with near-normal hepatic function and no new abnormalities.

We conclude that *N. asteroides* infection can present as a fulminant community-acquired pneumonia with bacteraemia in the absence of immunosuppression or coexistent infection. Our case illustrates the potential hepatic sequelae of *Nocardia* bacteraemia.

**Competing interests:** None identified.

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## Rhabdomyolysis secondary to interaction of fusidic acid and simvastatin

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**TO THE EDITOR:** A 71-year-old man was admitted to hospital in 2002 with nausea, abdominal discomfort and myalgia. He was dehydrated and had mild right upper quadrant tenderness. No muscle tenderness was noted.

Five weeks previously, an infected right femoropopliteal gortex graft had been surgically removed. Methicillin-resistant *Staphylococcus aureus* was present on culture. Therapy with fusidic acid (250 mg three times daily) and rifampicin (600 mg daily) had been commenced, and the patient's condition improved. Fusidic acid therapy was continued because of unsatisfactory wound healing. On presentation he had been taking fusidic acid for 4 weeks. He had been taking simvastatin (40 mg nightly) for 8 years.

The patient had a history of generalised vascular disease and multiple

bypass procedures. He had a background of paroxysmal atrial fibrillation, myocardial infarction, left ventricular failure, hypertension, hypercholesterolaemia and chronic airways limitation. His other medications were metoprolol, irbesartan, frusemide, warfarin, paracetamol and narcotic analgesics.

Test results showed the following biochemical concentrations: aspartate transaminase, 1618 U/L (normal range, <40 U/L); alanine transaminase 657 U/L (normal range [NR], <35 U/L); alkaline phosphatase 133 U/L (NR, 25-100 U/L); total bilirubin, 29 µmol/L (NR, <20 µmol/L); γ-glutamyltransferase, 37 U/L (NR, <50 U/L); urea, 24.7 mmol/L (NR, 3.0-8.0 mmol/L); creatinine, 0.35 mmol/L (compared with previous creatinine concentration of 0.11 mmol/L [NR, 0.06-0.12 mmol/L]).

Drug hepatitis, secondary to fusidic acid was suspected, and therapy with this drug was ceased.

The following day, the patient's clinical status declined, with generalised muscle pains and weakness, significantly impairing his mobility. The serum creatine kinase concentration was elevated at 66 710 U/L (normal range, 60-220 U/L), with a normal troponin I concentration. Myoglobinuria (567 200 ng/mL) was detected.

Simvastatin therapy was ceased, and there was prompt clinical improvement, with recovery of renal function and a gradual fall in the concentration of serum creatine kinase. On discharge 14 days after admission, his serum creatine kinase concentration was 1153 U/L and creatinine concentration was 0.12 mmol/L. Transaminase concentration readings fell rapidly in line with the creatine kinase concentration, suggesting they were of muscular rather than hepatic origin.

Three other cases of rhabdomyolysis have been reported as a result of interaction between an HMG CoA-reductase inhibitor and fusidic acid,<sup>1-3</sup> but there have been no previous reports from Australia.

Fusidic acid, like simvastatin, undergoes extensive first-pass metabolism in the liver (over 98%). Simvastatin is metabolised via the cytochrome P3A4 enzyme system. It is known that, if given concomitantly with inhibitors of this system (eg, macrolides and azole deriv-

atives), statin concentrations can become elevated and lead to an increased likelihood of adverse effects.<sup>4</sup> Fusidic acid is not known to be an inhibitor of this system (Peter Hobbs, Manager of Medical Affairs, CSL Limited [manufacturers of fucidin], personal communication), although our case is suggestive of such an interaction.

This case demonstrates the interaction of fusidic acid with simvastatin resulting in rhabdomyolysis. The extensive use of statin therapy in patients with vascular disease makes it important for doctors to be aware of this interaction when prescribing fusidic acid.

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## Influenza outbreak related to air travel

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**TO THE EDITOR:** Modern air travel lends itself to aerosol transmission of viral infection. Infected individuals in modern aircraft represent a significant risk for other travellers during long journeys.

In September 1999, a person with an influenza-like illness joined other workers returning by aircraft to an isolated mine in north-western Australia. He was identified as unwell by a mine supervisor in the airport lounge but was allowed to board the BAe 146 aircraft (a 75-seat passenger jet aircraft). The flight lasted 3 hours 20 minutes. On landing in the evening, most workers were transported to their quarters in a 10-minute bus trip, but some, including the affected worker, travelled independently. They then went to their individual rooms.

The next day, the affected worker reported sick immediately on going to his work site and did not work for 4 days. The other workers undertook 12-