the prevalence of HIV positivity among our patients is unknown, a pre-
liminary study from Yangon shows that the prevalence of drug-resistant TB among HIV-seropositive and -
seronegative patients is the same (pers. comm., Myanmar national TB
programs). To our knowledge, this report is the first to describe drug-
resistant patterns in *M. tuberculosis* isolates from Myanmar.

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**Pneumocystis carinii vs. Pneumocystis jiroveci: Another Misnomer**

*(Response to Stringer et al.)*

To the Editor: The proposal by Stringer et al. to change the name of *Pneumocystis carinii* found in humans to *Pneumocystis jiroveci* requires critical consideration (1). First, their ratio-
nale for the choice of Jirovec is not compelling. Principle III of the Inter-
national Code of Botanical Nomenclature
(ICBN) states: “the nomenclature of a
taxonomic group is based upon priority of publication” (2). Jirovec’s
publication in 1952 was not the first to report *P. carinii* infection in human
lungs. In 1942, two Dutch investiga-
tors, van der Meer and Brug, described *P. carinii* as the infecting
organism in a 3-month-old infant with
congenital heart disease and in 2 of
104 autopsy cases (a 4-month-old
infant and a 21-year-old adult) (3).
Their description, photomicrographs,
and drawings of *P. carinii* are
unequivocal. They also described the
typical “honeycomb” patterns in alve-
oli. In 1951, Dr. Josef Vanek at Karls-
Universität in Praha, Czechoslovakia,
reported his study of lung sections from
16 children with interstitial pneumonia
and demonstrated that the disease was caused by *P. carinii* (4).
Vanek notes in his report, “In man the
parasite was for the first time estab-
lished as a cause of pneumonia in a
child by G. Meer and S. L. Brug
(1942).” In 1952, Jirovec reported *P. carinii* as the cause of interstitial plas-
macellular pneumonia in neonates (5).
A year later, in a coauthored publica-
tion, Vanek, Jirovec, and J. Lukes
acknowledged and referenced the ear-
lier reports of van der Meer and Brug
and Vanek (6). If principle III is to be
followed, as well as fairness to the
investigators, both van der Meer and
Brug and Vanek hold priority over
Jirovec, assuming the designation of
the species name should be based on
the name of the first person to dis-
cover *P. carinii* in humans.

The nomenclature of *P. carinii* has
actually been fraught with errors from
the beginning. In the earliest publica-
tions, Carlos Chagas and Antonio Car-
ini mistook the organism for stages in
the life cycle of trypanosomes. Chagas
placed it in a new genus, *Schizotry-
panum* (7,8). In 1912, Delanoë and
Delanoë at the Pasteur Institute in
Paris published the first description of
the organism as a new entity unrelated
to trypanosomes (9). They proposed
the name “Pneumocystis carinii” as a
tribute to Carini. The Delanoë paper
has remained unchallenged as the
original description of *P. carinii*. Both
Chagas and Carini later acknowledged
their errors and the validity of the Del-
anoës’ conclusion. By current ICBN
principles, *P. carinii* is acceptable
nomenclature because the authors of
the first publication proposed the
name of Carini, rather than their own.

In addition, changing the name to
*P. jiroveci* will create confusion in
clinical medicine where the name *P.
carinii* has served physicians and
microbiologists well for over half a
Memphis, Tennessee, USA

*St. Jude Children’s Research Hospital, edgeable oncologist asking for ter because of a call from a knowl-

century. I was moved to write this let-

a report by Stringer et al (1).

AIDS patients are well informed about P. carinii pneumonia and avidly monitor medical news about their dis-

case. Without doubt, the name change will cause confusion and undue anxiety among the many thousands of HIV-infected patients who attend clin-

careers. Health-care workers will have an added burden of explaining why the name was changed, but the organism and infection are unchanged. Also, versions of the pronunciation of jiroveci (yee row yet zee) by American patients, physicians, and health-
care workers will be interesting to hear.

The tone of the article by Stringer et al. implies that the change of P. carinii to P. jiroveci is final, which is not the case. The nomenclature of fungi is governed by ICBN under the auspices of the International Botanical Congress and is not based solely on molecular genetics. Neither P. carinii nor P. jiroveci have been submitted for ICBN scrutiny. In another paper, Stringer et al. outline the mechanics for submission, but indicate that no application has been submitted for their proposal (10). In fact, P. carinii has not been acknowledged as a fungus by ICBN or any other authoritative taxonomic system. Only when nomenclature is registered in ICBN, can a name be referred to as “formally accepted.” In the meantime, the work-
able terminology proposed earlier by Stringer et al. in 1994 (11) will suffice for clinical use.

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LETTERS

A New Name (Pneumocystis jiroveci) for Pneumocystis from Humans (Response to Hughes)

Reply to W.T. Hughes: We appre-

ciate Dr. Hughes’ letter of concern regarding our article endorsing the name Pneumocystis jiroveci (1). When working with well-known disease agents and syndromes, these types of changes are more difficult to adopt on the effect they have on daily communication, patient care, record keeping, and other important routines of health-care providers. However, in this case, new information and understanding dictate that a change be made.

For some time, scientists have known that humans are infected by a particular species of Pneumocystis and that this species does not infect other host species. In recognition of these facts, Frenkel named the human pathogen Pneumocystis jiroveci, using the procedure prescribed by the International Code of Botanical Nomenclature (ICBN) (2). Although Dr. Hughes raised a number of issues, none justifies rejecting the new, valid name.

Dr. Hughes suggested that the name P. jiroveci is incorrect on the basis of principal III of ICBN, which holds that “the nomenclature of a taxo-
nomic group is based upon priority of publication.” He indicated that Jirovec was not the first investigator to report Pneumocystis in humans. Although this situation may be the case, principal III has not been vio-

lated because “priority of publication” refers to the time when a name is validly published, not to the time when an organism is first described. The name P. jiroveci was validly published in 1999, and this name therefore has priority. To be valid, all of the fol-

AIDS patients are well informed about P. carinii pneumonia and avidly monitor medical news about their disease. Without doubt, the name change will cause confusion and undue anxiety among the many thousands of HIV-infected patients who attend clinics. Health-care workers will have an added burden of explaining why the name was changed, but the organism and infection are unchanged. Also, versions of the pronunciation of jiroveci (yee row yet zee) by American patients, physicians, and health-care workers will be interesting to hear.

The tone of the article by Stringer et al. implies that the change of P. carinii to P. jiroveci is final, which is not the case. The nomenclature of fungi is governed by ICBN under the auspices of the International Botanical Congress and is not based solely on molecular genetics. Neither P. carinii nor P. jiroveci have been submitted for ICBN scrutiny. In another paper, Stringer et al. outline the mechanics for submission, but indicate that no application has been submitted for their proposal (10). In fact, P. carinii has not been acknowledged as a fungus by ICBN or any other authoritative taxonomic system. Only when nomenclature is registered in ICBN, can a name be referred to as “formally accepted.” In the meantime, the workable terminology proposed earlier by Stringer et al. in 1994 (11) will suffice for clinical use.

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