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1. Toxoplasma gondii

Post-transplantation period is risky to many opportunistic infections due to chronic therapy with immunosuppressive agents such as cyclosporine and tacrolimus which impairs cellular immunity. *T. gondii* is one of the common opportunistic pathogens in this group of patients, and it can cause various clinical syndromes. In solid organ transplant (SOT) recipients including renal transpantation[1,2], toxoplasmosis is mainly caused by the transmission of the protozoa latent within the transplanted organ of a *Toxoplasma*-seropositive donor to a *Toxoplasma*-seronegative recipient.[2] Toxoplasmosis usually occurs within the first 3 months after transplantation, and usually includes febrile myocarditis, encephalitis, pneumonitis, and disseminated infection. A diagnosis of toxoplasmosis is based on the demonstration of parasites or parasitic DNA in the blood, bone marrow, cerebrospinal fluid, bronchoalveolar lavage fluid, or other biopsy specimens. Serological tests are not useful for the diagnosis due to high rate of false negative and positive results.

2. For prevention of toxoplasmosis, serological screening of donors and recipients before transplantation allows the identification of patients at higher risk of toxoplasmosis, i.e. seropositive hemopoietic stem cell transplant (HSCT) recipients and mismatched (seropositive donor/seronegative recipients) SOT recipients.[3] Co-trimoxazole (trimetroprim/sulfamethoxazole) is still the drug of choice for primary chemoprophylaxis of toxoplasmosis.[4] For treatment, cotrimoxazole is recommended for 4-6 weeks and usually followed with secondary prophylaxis until there is a recovery of immune status.

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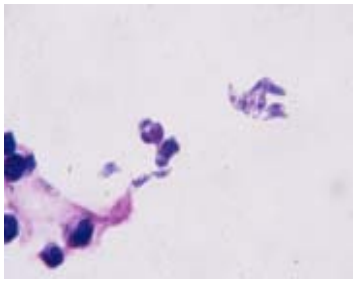

Figure. Wright's stain of bronchoalveolar lavage.

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Received for publication: July 16, 2007.