evidence that the patient had an acute infection. However, observations that the patient had no manifestation of encephalitis during a previous episode of neutropenia and that she had an acute febrile illness associated with neurologic signs of encephalitis point to an acute infection. The figure, in which WNV copy numbers are correlated with leukocyte count, is not intended to pinpoint the time of infection. However, as stated in the paper, this figure did show that the virus was rapidly cleared after resolution of neutropenia.

A report by Camenga et al. (5) demonstrated that mice, infected with WNV develop only an inapparent infection. These mice will invariably die of fulminant encephalitis if only a single dose of cyclophosphamide is given. However, mice treated with one dose of cyclophosphamide demonstrate inflammatory changes in the brain. If a second dose of the drug is administered 5 days after infection, inflammation is completely suppressed in mice. Although mice are immunologically different from humans, this work, done almost 30 years ago, supports the argument for an acute infection in the current case report. If the patient in our study was a chronic carrier, she should have had manifestations of acute West Nile encephalitis immediately following the first course of combination chemotherapy, which was much more immunosuppressive than cyclophosphamide alone. This fact reemphasizes our major point in the article that patients who are immunocompromized and undergoing chemotherapy, which may cause neutropenia, should take extra precautions against being exposed to WNV.

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Instructions for Infectious Disease Authors

Letters

This section includes letters that present preliminary data or comment on published articles. Letters (500–1,000 words) should not be divided into sections, nor should they contain figures or tables. References (not more than 10) may be included.

Correction Vol. 9, No. 4

In the article, "Antimicrobial Drug Prescriptions in Ambulatory Care Settings, United States, 1992–2000" by Linda F. McCaig et al. errors occurred on pages 432, 434, and 446. On page 432, the correct affiliations are as follows: Linda F. McCaig, National Center for Health Statistics, Centers for Disease Control and Prevention (CDC), Hyattsville, Maryland, USA; Richard E. Besser and James M. Hughes, National Center for Infectious Diseases, CDC, Atlanta, Georgia, USA. In the abstract, the change in antimicrobial prescribing rate for amoxicillin/clavulanate is +69%. On page 434, second paragraph, Results section, the correct first sentence appears below:

During the study period, the antimicrobial prescribing rate at all ambulatory care visits declined for amoxicillin and ampicillin (–43%; $p<0.001$), cephalosporins (–28%; $p<0.001$), and erythromycin (–76%; $p<0.001$) (Figure 5); the prescribing rate rose for azithromycin and clarithromycin (+388%; $p<0.001$), quinolones among persons ≥15 years (+78%; $p<0.001$), and amoxicillin/clavulanate (+69%; $p=0.004$) (Figure 6).

On page 436, the correct caption to Figure 6 appears below:

Trends in increasing annual antimicrobial prescribing rates by drug class—United States, 1992–2000. Note: trend for amoxicillin/clavulanate $p<0.001$; for quinolones among persons ≥15 years, $p<0.001$; for azithromycin and clarithromycin among all ages, $p<0.001$.

The corrected article appears online at http://www.cdc.gov/ncidod/EID/vol9no4/02-0268.htm.

We regret any confusion these errors may have caused.