Implications of High Antifungal Susceptibility on *Schizophyllum commune*-Associated Allergy in Clinical Practice

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Chowdhary et al. reported that *Schizophyllum commune* is the predominant causative antigen of allergic bronchopulmonary mycosis (ABPM) (1). In a series of studies regarding *Schizophyllum* allergy in respiratory disease, they successfully demonstrated the *in vitro* profiles of the antifungal susceptibility of *S. commune* (2). Those studies raise questions regarding how the antifungal susceptibility should influence *Schizophyllum* allergy (3) in clinical practice.

(i) Would the high antifungal susceptibility of *S. commune* provide information for decision making with regard to the use of antifungal drugs for *S. commune* infection (4) or *Schizophyllum* allergy? The successful treatment of ABPM caused by *S. commune* (5) is assumed to consist of 4 strategies: (a) prevention and eradication of fungal colonization in the airway, (b) control of eosinophilic bronchitis caused by fungal exposure, (c) removal of any mucus plugs from the airway, and (d) effective management of environmental fungi. This management process is applicable to various types of *Schizophyllum* allergies in respiratory disease (6). However, further investigations are required to clarify whether full doses of antifungal drugs are actually necessary to eradicate fungal colonization in the airways under such conditions. On the other hand, how should we plan antifungal therapy in patients with severe asthma with fungal sensitization (7) or in patients with *S. commune* infection?

(ii) Does the high antifungal susceptibility of *S. commune* have advantages with regard to the recurrence of ABPM caused by this fungus? Chowdhary et al. discussed the outcomes of antifungal treatment in 11 cases. In addition, they reported that the 5 of 8 cases of ABPM treated with itraconazole (ITCZ) showed no recrudescence after 6 to 24 months of follow-up. Dealing with this fungus as a spore and considering the ecology and life cycle of this fungus growing in the forest may provide insights into how to prevent disease recrudescence. A search of the literature (2) did not reveal any peculiar seasonality of either disease onset or the first visit to the hospital. However, the occurrences of disease recrudescence seemed to be concentrated from September to November (6 of 8 [75%] patients described this as the time of relapse). It remains to be determined whether this trend can be explained by the coincidence of the fungal overgrowth season in the field.

Chowdhary et al. cited our case report of ABPM caused by *S. commune*; in this case, disease recurrence was considered to be influenced by the presence of antigen in the patient's environment (5). Here, we would like to add further information. After two episodes of recrudescence, we began to conduct periodic surveys of pharyngeal swabs and environmental samples for *S. commune*, especially in the fall season, because spores were a possible antigen in this case. When *S. commune* was cultured from pharyngeal swabs, the patient received a low dose of ITCZ therapy for 14 days. Disease recrudescence in this case has been successfully prevented for 4 years.

The results of the study of Chowdhary et al. encourage future work by clinicians dealing with *S. commune* allergy (8–10). Periodic surveys of *S. commune* and the appropriate use of antifungal drugs may be useful for establishing strategies to prevent disease recurrence.

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We declare that we have no competing interests that might be perceived to influence the results and discussion reported in the present paper.

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