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Pulmonary Tuberculosis Due to M. bovis in a Human Immunodeficiency Virus–Infected Patient

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Reprin s or correspondence: Dr. Norber A. Foudraine, Depar men of Infec suscep ible o rifampin. Con ac racing showed ha hree immuno-supposed and ha clinicians in his case rea ed his pa ien for a long period in isola ion a grea ex pense as if he had pulmonary tuberculosis. Clinicians should consider a ypical presen a ions of infec ion due o non uberculous myco-

bacteria. When evalua ing cavi ary pulmonary lesions in HIV- posi ve pa ien s receiving aggressive herapy wi h an irre roiral medica ion.

In summary, MAC infec ion has been shown here o imi a e pulmonary M. tuberculosis infec ion in a pa ien wi h AIDS who was receiving herapy wi h pro case inhibi ors wi h a resul an low viral burden. The impor ance of his case rela es in par o he fac ha undiagnosed cavi ary pulmonary disease in his pa ien popula ion is a public heal h hrea and ha clinicians in his case rea ed his pa ien for a long period in isola ion a grea ex pense as if he had pulmonary tuberculosis. Clinicians should consider a ypical presen a ions of infec ion due o non uberculous myco-
bacteria. When evalua ing cavi ary pulmonary lesions in HIV-
posi ve pa ien s receiving aggressive herapy wi h an irre roiral medica ion. Recen ly, we described he microbiological iden ifica ion of M. bovis (which belongs o he M. tuberculosis complex), by using novel gene ic markers, in speci-

mens from four immunocompromised pa ien s [1]. Herein we de-

tal he clinical course of one of he four pa ien s who was HIV-1-infec ed. A 39-year-old, homosexua l, HIV-1-infec ed man was admi ed admi ed admi ed o he hospi al because of weigh loss, fever, and a flu-like syn-
drome. Six weeks before admission, he had developed nigh swea s wi h concurren weigh loss and in ermi en fever ( empera ure, ≤40°C) wi hou chills. A ha ime his CD4+ lymphocy e coun e was 20/mm 3 and his viral load was 140,000 copies/mL, despi e he had a nonproductive eough and dyspnea on exer ion, and he had heama usu e no vomi ing. His bowel movemen s were unremarkable. Physical examina ion a he ime of admission revealed a weigh of 78.5 kg (normal, 90 kg). There were no ches abnormali ies no ed. A sharp edge of he liver was palpable 3 cm below he righ cos al margin. Unchanged symme ric axillary and inguinal lymphadenopa hy was found.

Skin es ing (Mul i es CMI, Ins i u Mérie u , Beneluse, Brus-
sels, Belgium) including uberculin skin es ing indica ed comple e

energy. A ches radiograph revealed a small infil ra e in he lef lower lung lobe, and abdominal ul rasonography showed hepa o-

splenomegaly. Zeehl-Nielsen s aining of spu um and s ool speci-

mens remained nega ive for myco-
bacteria. A PCR assay performed on he spu um wi h primers specific for he IS6110 sequence of M. tuberculosis complex [2] was posi ve. For her analysis by use of spoligo yping, a echnique based on he mycobac erial s rain-dependen presence

of abor nonrepe i ve i spacer sequences ha in erspe he repe i i direc repea (DR) sequences, iden ified he species as M. bovis [3].

Therapy wi h e hambu ol, pyrazinamide, isoniazid, and rifabu in was ins i u ed. A follow-up af er 20 weeks, he clinical signs and sym-

poms of he mycobac erial infec ion had disappeared, bu spu um examina ion a he ime ed indica ed high numbers of curved AFB. A CT scan of he ches showed a persis en dense infil ra e and small cavi ies in he lower la eral region of he lef lung (figure 1). Conseuen ly, clari homycin and ofloxacin were added o he quadruple an imycob-

ac erial erapies. During he nex 2 mon hs when no AFB were observed in he spu um, herapy was changed o ha wi h he ini al quadruple erapies. However, 2 mon hs la er (9 mon hs af er diagno-

sis), AFB were again no ed in he spu um. The six-herapie upe i

regimen was resumed. The pa ien s clinical condi on did no de eri os of he lef hronchon-

ac infections wi h musculoskeletal fungal disease. The pa ien s clinical condi on did no de eri os of he lef lung infection has been reported in pa ien s wi h HIV infec ion. In addition, a case report of a pa ien wi h HIV infec ion and tuberculosis has been reported in a pa ien wi h HIV infec ion. In addition, a case report of a pa ien wi h HIV infec ion and tuberculosis has been reported in a pa ien wi h HIV infec ion.

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Therapy Evalua ion Cen re, Acade mic Medical Cen re Room F5-167, Meibergdreef 9, 1105 AZ. Ams erdam, P.O. Box 22700, he Ne herlands.
Bacteremia Due to Camp lobacter sputorum Biovar sputorum

Camp lobacter sputorum biovar sputorum can be found in he oral cavi y and he gas roin es inal rac of humans, bu i rarely causes disease. To our knowledge, only a few repor s have impli ed his organism in human infec ions [1–4].

In hee of hes repor s, he isola es were recovered from ab- susses [1–3], whereas in he four h repor [4] he organism was recovered from fecal samples of pa ien s wi h diareea. We de- scribe a case of C. sputorum biovar sputorum in a pa ien wi h bac ermia who presen ed wi h a knee abscess and a recen ches infec ion.

Figure 1. CT scan of he ches of a 39-year-old, HIV-1-infec ed man wi h pulmonary tuberculosis due o M cobacterium microti af er 5 mon hs of quadruple an imycobac erial herapy. A cavi y infil ra e is seen a he lef lower lung base.

A 56-year-old woman wi h non-insulin-dependen diae es mel- li us came o he hospi al because of a 1-day his ory of nausea, vomi ing, and chills. Four weeks earlier she had fallen a home, grazing he righ knee on he carpe . He righ-knee lesion had developed surrounding ery hema and had begun discharging mal- odorous fluid. A admission o he hospi al, he pa ien had a em- pera ure of 38.4°C. A 10-cm × 8-cm abscess cavi y wi h pu ren discharge and surrounding celluli is was no ed over he righ knee. Righ inguinal lymphadenopa hy was also no ed. In addi on, on auscul a he ion, he ha a few coarse crepi a ions a he lef lung base consis en wi h a recen ches infec ion. There was no evidence of an den al disease, and here was no his ory of recen den al procedures.

Labeled by evalua ion revealed a WBC coun of 23.4 × 10/L, (80% neu rophils) and an eleva ed C-reac ive proein level of 384 mg/L. The surface of he abscess cavi y was swabbed and blood was drawn for cul ures before commencing herapy wi h iv iacillin/ clavulana e 3.1 g q.i.d. The abscess was debrided on he following day and did no ex end in he underlying bone or join . Af er an addi ional 4 days of iv iacillin/clavulana e, herapy wi h oral ci- profloxacain, 750 mg b.i.d., was ins i u. he pa ien’s condi on gradually improved and she was discharged from he hospi al af er 3 days.