Pulmonary tuberculosis due to mycobacterium microti in an human immunodeficiency virus-infected patient
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infected will con inue to occur but may resemble more closely
hose clinical lesions a ions seen in pa ien s wi hou HIV infec ion.
In 1997, Connors e al. [7] quan ified an igen-specific CD4+ cell
recep ors in HIV-posi ve pa ien s before and af er rea men wi h
he pro ease inhibi or or in dizivir. Th e o al CD4+ cell coun was
reso red, bu CD4+ cell clones wi h ac ivi y agains less commo
an igen were irrevo cably los ed, leaving gaps in immune surveil-
ance. Th us, we espec ula e ha our pa ien had par i al ra her han
comple e hos de nse agains MAC infec ion. If his hypo hesis
proves correc , more pa ien s wi h HIV/AIDS who are recei ving he ra-
th wi h pro ease inhibi ors wi h no res is a result an low
viral burden. The impor ance of his case rela es in par o he
fac ha undi agnosis cavi ary pulmonar y disease in his pa ien
popula ion is a public he al hrea and he ca clinicians in his case
rea ed his pa ien for a long period in isola ion a grea expense as
he had pulmonar y tuberculosis. Clinicians should consider a
ypical presen a ions of infec ion due o non uberculous myco-
bac era when evalua ing cavi ary pulmonary lesions in HIV-
posi ve pa ien s recei ving aggres sive he ra with an ire roviral
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 recei ving he ra wi h pro ease inhibi ors wi h no res is a result an low
viral burden. The impor ance of his case rela es in par o he
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Pulmonary Tuberculosis Due to M. c協bo c协议etum microti in
a Human Immunodeficiency Virus–Infected Patient
Joseph M. Alisk and Larr Schlesinger

Recen ly, we described he microbiological iden ifica ion of M c協bo c协议etum microti (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-
tail he clinical course of one of he four pa ien s who was HIV-
1-infec ed.

A 39-year-old, homoseual, HIV-1-infec ed man was admi ed o he hos pi al be cause of weigh loss, fever, and a flu-like syn-
drome. Six weeks before admiss ion, he had developed nigh swea s wi h conurren weigh loss and in ermi en fever ( empera ure,
≤40°C) wi hou chills. A ha ime his CD4+ lymphocy e coun e coun
was 20/mm 3 and his viral load was 140,000 copies/mL, despi e
an ir roviral riple he ra. He had a nonproduc ive cough and
dyspnea on exer ion, and he had he ausea bu no vomi ing. His
bowel movemen s were unremarkable. Physical examina ion a he
ime of admiss ion revealed a weigh of 78.5 kg (normal, 90 kg).
There were no chez 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 Mérieu , Beneluse, Brus-
sels, Belgium) including uberculin skin es ing indica ed comple e

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Bacteremia Due to \textit{Campobacter sputorum} Biovar \textit{sputorum}

\textit{Campobacter sputorum} biovar \textit{sputorum} can be found in he oral cavity and he gas roin es inal rac of humans, bu i rarely causes disease. To our knowledge, onl y a few repor s have implic ed his organism in human infec ions [1–4].

In hee of he se repor s, he isolas es were recovered from ab- scesses [1–3], whereas in he four he repor [4] he organism was recovered from fecal samples of pa ien s wi h diarrhea. We de- scribe a case of \textit{C. sputorum} biovar \textit{sputorum} in a pa ien wi h bac eria who presen ed wi h a knee abscess and a recen cheres infec ion.

A 56-year-old woman wi h non-insulin-dependen diahe 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 he she had fallen a home, grazing he righ knee on he carpe . The righ-knee lesion had developed surrounding eryhema 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 puuren discharge and surrounding celluli is was no ed over he righ kne. Righ inguinal lymphadenopa hy was also no ed. In addion, on auscul a he ion, he she had a few crore crepi a ions a he lef lung base consis en wi h a recen ches infec ion. There was no evidence of any den al disease, and here was no his ory of recen den al procedures.

Lhory evalua ion revealed a WBC coun of 2.3 × 10^9/L, (80% neurophils) and an eleva ed C-reactive pro e in level of 384 mg/L. The surface of he abscess cavi y was swabbed and blood was drawn for cul ure before commence ing herapy wi h iv iacillin/ci- valulana 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 addion al 4 days of iv iacillin/clavulana e, herapy wi h oral ci- profloxacin, 750 mg b.i.d., was ins i u ed. The pa ien ’s condi ion gradually improved and she was discharged from he hospi al 3 days

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