Multidrug resistant tuberculosis

We read with interest the report by White and Moore-Gillon on the resource implications of multidrug resistant tuberculosis (MDR-TB) in the UK. We studied the outcome of 44 HIV negative patients with MDR-TB admitted to two tertiary care tuberculosis units in the Netherlands between 1985 and 1998. Most (38 patients) had pulmonary tuberculosis. The mean admission period was 164 days and all patients received an individually tailored combination of antituberculosis drugs for a mean period of 608 days. We estimated the cost of treatment per patient to be US$60 000 which included admission fee, costs for outpatient visits, and the cost of drug provision. Although we did not include cost of toxicity monitoring and additional procedures, our costs compare favourably with those of White et al (mean £60 000) and Mahmoud (mean US$180 000).

In the Netherlands the number of patients with tuberculosis resistant to any antituberculous drugs is limited to 11%, and only 0.6% of the bacilli are MDR. Between 1993 and 1997 only 43 cases of MDR-TB were identified, of which 28% had received previous treatment for tuberculosis (Index Tuberculosis 1998, Royal Netherlands Tuberculosis Association, The Hague, 2000). This suggests that transmission of MDR bacilli rather than inadequate treatment contributes to the resistance problem in the Netherlands.

In poor resource countries, directly observed short course chemotherapy of tuberculosis is generally recommended to prevent the occurrence of MDR-TB. We feel that new rapid molecular methods for detecting resistance should be developed to limit the period of contagiousness (nosocomial and community) transmission of MDR bacilli and thus prevent the emergence of MDR-TB. Such tests should then be made available to poor resource countries at an affordable price.

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We thank Professor Lipworth for his interest in our paper. The main hypothesis being tested was a comparison of the total cortisol metabolite levels after 7 days of treatment with fluticasone propionate and budesonide between healthy and asthmatic subjects. Although we were interested in the plasma levels of the two drugs, limitations in the assays available prevented us from studying plasma cortisol levels in subjects with asthma compared with healthy controls, and we now have data confirming that budesonide plasma levels are identical in healthy and asthmatic subjects.

We accept that part of the explanation for the difference between fluticasone and budesonide may have resulted from differences in the inhalers used. We used dry powder inhalers because we wanted to reduce the effects of inhaler technique and because dry powder inhalers had been used in a number of studies comparing fluticasone and budesonide in healthy subjects. It is also worth noting that Brutsche et al[1] studied metered dose inhalers, which have a large volume spacer and produced similar results to ours.

We are grateful to Professor Lipworth for bringing our attention to his letter reporting a study in subjects with mild asthma. This agrees to the same as a later publication that we had referenced in which the osteocalcin data were omitted. The reduction in osteocalcin concentrations with budesonide but not fluticasone at microgram equivalent doses was an unexpected finding and we did state that confirmation of this finding was required.

Finally, we have major reservations about the meta-analysis published by Lipworth, not only because it combined studies performed in healthy and asthmatic subjects but because it included a number of studies which did not compare fluticasone and budesonide, so it does not satisfy the methodology for a meta-analysis.

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Pulmonary infiltrates in non-HIV patients

We read with interest the article by Rano et al in the May edition of Thorax. This group showed that, by using non-invasive methods (blood cultures, sputum cultures, nasopharyngeal washes and tracheobronchial aspirates), they were able to make a positive diagnosis in 41% of 200 non-HIV immunocompromised patients with pulmonary infiltrates.

We have looked at a similar group of patients treated in the Leukaemia and Lymphoma Units at the Royal Marsden Hospital who needed investigation for pulmonary infiltrates and found a low diagnostic yield from bronchoscopy with neither a positive result (36%) nor a change in management (28%) making any impact on survival. Like Rano et al, we are therefore keen to explore the use of non-invasive investigations.

From our literature review we found many groups advocating the use of high resolution CT scanning (HRCT) of the chest. It has found particular use in those patients with a normal chest radiograph but respiratory symptoms and fever, having a negative predictive value after bone marrow transplantation of 97%. The HRCT scan has characteristic appearances in aspergillosis, Pneumocystis carinii pneumonia (PCP), and cytomegalovirus (CMV) infection. One group has compared HRCT and bronchoalveolar lavage (BAL) in the diagnosis of fungal pneumonia and found the former to be superior. From these data we believe that such characteristic appearances on CT scanning could obviate the need for bronchoscopy.

The paper by Rano et al isolates (15%) of A fumigatus and four (2%) were of PCP. Do the authors feel that these patients might have been diagnosed by HRCT scanning and thus have avoided bronchoscopy altogether?

Antifungal treatment was only instigated after 4–5 days if there was no improvement or positive microbiology. With such a policy the mortality rate in those with Aspergillus infections was 67%. Other groups recommend early introduction of antifungal treatment due to its high prevalence, particularly in haematological malignancies. In the light of these results and the potential of early HRCT scanning, have the group considered their practice to include early use of antifungal treatment?

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REFERENCES

AUTHORS’ REPLY We appreciate the valuable comments by Drs Murray and O’Brien regarding our study on immunocompromised patients. In our study the diagnostic yield of non-invasive methods was 41%. The good results obtained with these techniques, as well as their availability and relatively low cost, make them very useful in the clinical management of immunocompromised patients. In this sense, HRCT scanning, as Drs Murray and O’Brien point out, has a demonstrated role in the diagnosis of some pulmonary complications, particularly Aspergillus pneumonia, and can be included in the diagnostic strategies of non-invasive diagnostic techniques. Whether or not an HRCT scan might facilitate the early start of antifungal treatment and improve the mortality from Aspergillus pneumonia will need to be evaluated in properly designed studies.

Although non-invasive techniques must be considered as a first step in the clinical management of immunocompromised patients, their use cannot justify any delay in performing a bronchoscopic exploration. In this sense, contrary to the experience reported by Drs Murray and O’Brien, the systematic use of endoscopic techniques allowed us to increase the diagnostic yield up to 81%. We believe that obtaining an early diagnosis in immunocompromised patients is of paramount importance. In fact, the low diagnostic yield of the 25 bronchoscopies performed in the series by Murray et al and the lack of impact on survival, also reported by other groups, may well be due to the fact that the endoscopic techniques are performed too late in the evolution of the disease when the possibilities of influencing the outcome are very few.

Replacing bronchoscopic techniques by HRCT scanning carries the risk of misdiagnosing polymicrobial lung infectious and non-infectious pulmonary complications in which bronchoalveolar lavage and bronchial aspirates have a known diagnostic role. Remarkably, in 11 of the 15 polymicrobial infections reported in our series, both Aspergillus and/or cytomegalovirus (CMV) were involved. In these cases the use of HRCT scanning instead of bronchoscopy would probably have missed one of the other co-existent pathogens. We therefore do not believe that HRCT scanning of the chest can replace bronchoscopy in the clinical management of immunocompromised patients with pulmonary infiltrates.

Severe bullous emphysema associated with cocaine smoking

Pulmonary emphysema is characterised by permanent enlargement of airspaces distal to the terminal bronchiole accompanied by destruction of alveolar walls. The loss of elastic tissue contained in the interalveolar septa is caused by an imbalance between proteolytic and antiproteinase activity, most commonly caused by cigarette smoking. Congenital deficiency of α1-antitrypsin, the most well known antiproteinase, is an important risk factor for the development of premature emphysema. In addition, various other causes have been reported including intravenous drug abuse, particularly Ritalin. More recently, Johnson et al reported four cases of bullous emphysema associated with marijuana smoking. We want to report an additional case of severe premature bullous emphysema in a man with a longstanding history of cocaine smoking. To the best of our knowledge, this relationship has only once been reported in the Spanish medical literature.

A 40 year old man was admitted with progressive dyspnoea, cough, and fever. According to his relatives he had been smoking cocaine (so called “free basing”) for the past 17 years. A reliable history of tobacco smoking could not be obtained because of his respiratory distress and poor level of consciousness. His medical history consisted of recurrent respiratory tract infections. Chest
Side effects of antituberculous treatment

Combined antimycobacterial chemotherapy has been shown to be very effective in the treatment of Mycobacterium tuberculosis hominis (MTH) pulmonary infections with a cure rate of >85% for short term (6 month) courses.1 Recent WHO initiatives have been launched and are aimed at eradicating pulmonary tuberculosis by intensive adoption of directly observed treatment (DOT) strategies in countries in which the incidence is high.

A new drug formulation has recently been produced which provides the three main first line drugs in the same tablet in a fixed ratio (rifampin (RIF) 120 mg, isoniazid (INH) 50 mg, and pyrazinamide (PZM) 300 mg).2 This formulation is likely to be extremely useful, particularly in developing countries where it can provide reliable simultaneous administration of all the drugs needed on bi-weekly or tri-weekly DOT programmes.3 However, it is not intended to substitute any (or all) of the single components in countries where they are already available and marketed.

In a recent WHO report, of all the industrialised European countries, Italy reported the highest prevalence of multidrug resistance among previously treated cases of tuberculosis (33.9%, 95% CI 23.9 to 42.7), with any drug resistance accounting for up to 60.6% of the strains.4 In addition, there was a high prevalence of resistance in new cases of tuberculosis with 12.3% resistance to any drug.2

In Italy the distribution and marketing of PZM ceased as a single drug formulation between 15 June 2000 and early 2001. This abrupt policy change temporarily introduced a new and interesting challenge to the treatment of MTH, and possibly increased risks of toxicity and decreased treatment efficiency for some patients.

Over the last 2 years we have treated 26 patients with pulmonary tuberculosis using the standard four drug regimens administered as single drugs and have recorded a relatively high rate of hepatotoxicity (35%) compared with studies in North American and European analyses (11%).3,4 In eight of the nine patients with hepatotoxicity the substitution of INH led to normalisation of liver function. This incidence of side effects approaches the incidence of side effects (26%) reported in a European study of similar design on 519 patients of similar mean age.

In our 26 patients we estimated that, if a fixed dose formulation had been used to maintain the dose of RIF at 10 mg/kg/day, a significantly increased dose of PZM (not correlated to the one that was actually given) would have been administered. Thus, it is reasonable to suggest that the already high rate of toxicity could increase in incidence and severity when PZM is administered daily as a fixed dose formulation. When considered in the context of the unavailability of PZM single drug formulations, two additional considerations are warranted.

Firstly, there is a limited choice of first line regimens which exclude INH for patients with INH related hepatotoxicity (for example, RIF+STM+EMB but not RIF+PZM+STM). Side effects in hospital treated patients usually lead to withdrawal of one of the basic drugs and replacement by other drugs such as ethambutol or streptomycin. This may lead to more prolonged treatment and to decreased adherence.5 However, these negative consequences would be considerably enhanced if single drug formulations of PZM are not available since withdrawal of at least two first line drugs would be needed (PZM + INH).

Secondly, the treatment of patients with chronic tuberculosis who are infected with the most frequent INH or RIF resistant MTH (43.3% and 44.9%, respectively)5 or with multidrug resistant MTH could lead to the drug being acquired from abroad at high cost, and sometimes to interruptions in the supply with dangerous consequences for the patient’s health. In fact, most tuberculosis units in our area acquired PZM as a single drug formulation from neighbouring countries during the time when it was not available.

Thus, available data do not support the use of fixed dose formulations as the only treatment choice in developed countries. This could be particularly dangerous where there is a high prevalence of multiple drug resistant MTH, including developing countries.


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