CASE REPORT

Concurrent granulomatous *Pneumocystis carinii* and *Mycobacterium xenopi* pneumonia: an unusual manifestation of HIV immune reconstitution disease

F Chen, G Sethi, R Goldin, A R Wright, C J Lacey

This report of concurrent granulomatous *Pneumocystis carinii* pneumonia (GPCP) and *Mycobacterium xenopi* pneumonia (MXIP) in a patient with advanced HIV disease 3–5 weeks after commencing antiretroviral therapy (ART) fits the syndrome of HIV immune reconstitution/restoration disease (IRD). It may also be a unique window into the immunology of granulomatous inflammation.

A 35 year old white HIV positive man commenced antiretroviral therapy (ART) with zidovudine, lamivudine, and nelfinavir 7 years after diagnosis (CD4 count 20 cells/ml, viral load 154 000 copies/ml (Chiron III)). Prophylaxis for *Pneumocystis carinii* pneumonia (PCP) was with nebulised pentamidine. Three weeks after commencing ART, with no prior respiratory symptoms, he developed an unproductive cough. Despite 2 weeks of treatment with amoxicillin, his cough persisted and, although he was well, a chest radiograph 5 weeks after initiating ART showed bilateral apical consolidation (fig 1A). Arterial blood gas tensions on air were normal (PCO₂ 4.53 kPa, PO₂ 16.3 kPa, pH 7.468). Bronchoscopic examination after 3 days of treatment with high dose intravenous Septrin showed generalised mucosal inflammation, and the bronchoalveolar lavage (BAL) fluid had scanty *Candida albicans* but was negative for acid fast bacilli and *P carinii*. Ten days after PCP treatment the apical consolidation improved significantly (fig 1B) but the appearance of a new area of right mid-zone consolidation led to diagnostic biopsy to exclude a malignant process. A percutaneous computed tomographic (CT) guided lung biopsy (left apex, 3 × 20G tissue cores) was undertaken 13 days after admission. The CT scan showed consolidation (fig 1C and D) with multiple small and medium sized pulmonary nodules (many cavitated) in both upper and right middle lobes. Histological examination showed granulomatous PCP (fig 1E and F). Blood culture for *M avium* complex and polymerase chain reaction for *M tuberculosis* were both negative. *M xenopi* was isolated from the BAL fluid and three sputum specimens after 6 weeks but tissue culture was negative. The granuloma, a localised inflammatory process, can form part of the host’s immune protection response to infections or part of an autoimmune disease process. Patients with AIDS have T cell deficiency and consequently have difficulty in mounting a granulomatous reaction to infections. Despite this, our patient mounted a hyper-accentuated response weeks after commencing HAART.

Bondoc *et al* reported GPCP in three non-HIV patients with malignancy who shared similarities with our patient. GPCP occurred 2 weeks to 2 months after stopping corticosteroids compared with 3–8 weeks after receiving ART in our patient. All had minimal symptoms, a comparable time scale of immune reconstitution, and *P carinii* was not detected in the BAL fluid. These two reports seem to support recent evidence that the main pathway for T cell recruitment during granuloma formation is from the systemically activated T cell pool. Corticosteroid therapy suppresses peripheral circulating lymphocytes and its discontinuation leads to a rebound of peripheral lymphocytes, a process akin to the phase of memory T cell redistribution following ART.

The simultaneous occurrences of GPCP and MXIP are perhaps less surprising when viewed in the context of T memory cell (therefore diverse memory clone) redistribution. Recent evidence has shown that the T cell repertoire of granulomas in response to a primary pathogen is diverse.
Only 30–60% in a single granuloma are specific to the inducing antigen, and systemically activated T cells with no specificity to the granuloma also have access to it.\textsuperscript{9}

Cytokine gene polymorphisms\textsuperscript{11} and an abnormal cytokine profile\textsuperscript{12} have been associated with HIV IRD. This, together with a recent report of granulomatous pulmonary disease occurring in a patient following cessation of tumour necrosis factor (TNF)-\(\alpha\) antagonist treatment,\textsuperscript{13} implies that perturbation of the cytokine profile can trigger granulomatous inflammation.

Host and antigenic factors implicated in the pathogenesis of granulomatous lung diseases are also likely to influence the expression of GPCP; in addition, immune dysregulation (systemic T cell pool and cytokine perturbation) may also trigger granulomatous inflammation.

ACKNOWLEDGEMENTS

The authors thank Drs G Brook and M Murphy for their critical comments and suggestions.

Authors’ affiliations

F Chen, Department of Sexual Health, Whipps Goss University Hospital and Department of Infection and Immunity, St Bartholomew’s Hospital, London, UK (formerly Department of Genitourinary Medicine, St Mary’s Hospital, London, UK)

G Sethi, Department of Genitourinary Medicine, St Mary’s Hospital, London, UK

R Goldin, Department of Histopathology, St Mary’s Hospital, London, UK

A R Wright, Department of Radiology, St Mary’s Hospital, London, UK

C J Lacey, Reader in Infectious Diseases, Hull York Medical School, University of York, UK (formerly Imperial College London and Department of Genitourinary Medicine, St Mary’s Hospital, London, UK)

Correspondence to: Dr F Chen, C/O Andrewses Unit, St Bartholomew’s Hospital, London EC1A 7BE, UK; fchenff@msn.com

Received 29 July 2003
Accepted 10 December 2003

REFERENCES


---

**LUNG ALERT**

**Sildenafil and exercise capacity in hypoxic pulmonary hypertension**

This study examined the influence of oral sildenafil on pulmonary haemodynamics and exercise tolerance during hypoxia induced pulmonary hypertension in healthy mountaineers and trekkers who were not susceptible to high altitude pulmonary oedema. Fourteen healthy volunteers (12 men, median age 36.5 years) were enrolled and randomised in a double blind, placebo controlled, crossover design. Participants were assigned to receive placebo or one 50 mg dose of sildenafil. Systolic pulmonary artery pressure, cardiac output, and peripheral arterial oxygen saturation at rest and during assessment of maximum exercise capacity on cycle ergometry were measured, both while breathing a hypoxic gas mixture with 10% fraction of inspired oxygen at low altitude and then at the Mount Everest base camp (5400 m).

Sildenafil reduced hypoxic pulmonary hypertension at rest and with exercise, and increased maximum exercise capacity and cardiac output. The study did not examine the effects of sildenafil on normoxic exercise tolerance, and the authors cautioned about the unclear role of sildenafil in the management of acute mountain sickness. In addition, it is not known whether sildenafil increases exercise capacity in hypoxic pulmonary hypertension due to lung diseases such as COPD.

M M Mughal

The Cleveland Clinic Foundation, Cleveland, Ohio, USA; mughalm@ccf.org
Concurrent granulomatous *Pneumocystis carinii* and *Mycobacterium xenopi* pneumonia: an unusual manifestation of HIV immune reconstitution disease

F Chen, G Sethi, R Goldin, A R Wright and C J Lacey

*Thorax* 2004 59: 997-999
doi: 10.1136/thx.2003.012567

Updated information and services can be found at:
http://thorax.bmj.com/content/59/11/997

These include:

**References**
This article cites 13 articles, 6 of which you can access for free at:
http://thorax.bmj.com/content/59/11/997#BIBL

**Email alerting service**
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Topic Collections**
Articles on similar topics can be found in the following collections

- Drugs: infectious diseases (968)
- HIV/AIDS (194)
- Pneumonia (infectious disease) (579)
- Pneumonia (respiratory medicine) (562)
- TB and other respiratory infections (1273)
- Inflammation (1020)

**Notes**

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/