Patient 1: 22 y/o F, at 3 months post-transplant, after receiving enhanced immunosuppression for high-grade acute rejection, presented with surgical sternal wound abscess, mediastinitis, and *M. abscessus* mycobacteremia. Long-term treatment (7.5 years) with cefoxitin, azithromycin, and amikacin was required and resulted in a complete eradication of the organism. The patient survived 90 months after the diagnosis. Prior to lung transplantation, the patient had long-term, periodic *M. abscessus* isolated from her airway and received aggressive long-term treatment (48 months) for *M. abscessus*; but her sputum had remained heavily smear and culture positive immediately prior to transplantation.

Patient 2: 32 y/o M, at 3 months post-transplant, *M. abscessus* was cultured from surgical sternal wound abscess and empyema. The abscess was surgically drained. He was treated with clarithromycin, amikacin and cefoxitin for 19 months with complete resolution. He continued to have normal graft function (BOS stage 0) for the following 27 months of follow-up. Prior to lung transplantation, the patient had *M. abscessus* pulmonary disease but failed treatment regimens due to medication intolerance.

Patient 3: 22 y/o F with underlying severe BOS (BOS stage 3) at 38 months post-transplant, developed an acute upper lobe infiltrates. After other infections were excluded, the bronchoalveolar lavage fluid grew *M. avium*-complex and *M. szulgai*. It was her wish not to receive aggressive therapy and succumbed to progressive hypercapnic respiratory failure from BOS. Prior to lung transplantation, the patient grew and was treated for *M. avium*-complex.

Patient 4: 29 y/o M with no BOS (BOS stage) presented with an acute fever, dyspnea, and a decline in lung function. Chest radiograph showed a right lower lobe infiltrate and BAL fluid
grew *M. kansasii*. He was treated with INH, ciprofloxacin, rifabutin, and ethambutol. His symptoms and chest radiograph abnormalities significantly improved after 2 months of therapy. He continued to have normal graft function (BOS stage 0) at 11 months of follow-up. Prior to transplantation, his sputum cultured an unidentifiable NTM species at one occasion. He did not receive any treatment for NTM before transplant.

**Patient 39:** 29 y/o M, with underlying BOS 3 at 57 months post-transplant, in the setting of enhanced immunosuppression for chronic rejection, presented with lung abscess (7x5x5 cm) and diffuse mediastinal lymphadenopathy. *M. abscessus* was cultured from sputa and BAL. The patient was treated with clarithromycin, cefoxitin and ofloxacin for 18 months. The lung abscess was eradicated and his bronchial washing and bronchoalveolar lavage fluids became sterile. His lung function ceased to decline and was stable for the following 11 months. He subsequently died from disseminated mucormycosis. NTM culture was negative at the time of transplant.