Nontuberculous Mycobacteriosis (Different Faces of Two Most Common Nontuberculous Mycobacteriosis)

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Abstract

Nontuberculous mycobacteriosis are chronic granulomatous diseases caused by different types of mycobacteria. Plain chest X-ray and high resolution computed tomography are highly nonspecific but absolutely necessary in detection and follow-up of patients with pulmonary mycobacterial infection. Treatment of infection caused by Mycobacterium avium complex is often successful. However treatment is successful only in 55% of patients with pulmonary infection caused by Mycobacterium abscessus complex. The results of therapy is dependent on sensitivity to macrolides which are cornerstones of medical therapy. In our case series of four patients with cystic fibrosis show that results of therapy in patients with preexistent lung disease can be very different and is not dependent only on type of mycobacterial infection and sensitivity to antimicrobial treatment. In such cases, therapy of Mycobacterium avium complex infection can last even several years.

Keywords: Nontuberculous mycobacteriosis; Mycobacterium avium complex, Mycobacterium abscessus complex, Cystic fibrosis, Computed tomography

Introduction

Nontuberculous Mycobacteriosis (NTM) is chronic granulomatous inflammatory disease caused by a different types of mycobacteria. They are potentially pathogenic for people. NTM were isolated from water, soil, dust, flowers and animal hair and secretions [1]. Person to person transmission is rare, mostly by respiratory tract, in some cases by skin contact (skin abrasion) or ingestion. NTM infection is rare in healthy persons. Due to a different time of growth on culture media NTM can be divided into two groups – rapidly growing and slow growing. Rapidly growing NTM are Mycobacterium fortuitum, abscessus, chelonii, smegmati, mucogenicum, gondii a immunogenum. Slowly growing NTM are Mycobacterium avium complex (MAC), kansassi, marinum [2]. Rapidly growing NTM are typical for they rapid growth on culture media during a few days and their in vitro resistant to common antituberculosics. The most common NTM in the Czech Republic are Mycobacterium avium intracellulare and Mycobacterium kansassi [3]. NTM can be diagnosed either in imunocompetent or imunodeficient patient. The risk factors are previous lung disease as asthma bronchiale, chronic obstructive pulmonary disease, cystic fibrosis, bronchiectasis, lung infections, deformities of the chest (pectus excavatum) and immunosupression (inmodeficiency, human immunodeficiency virus HIV, patients after transplantations). NTM affects predominantly lungs and lymphatic nodules but it can affect only skin, soft tissues, joints, bones or urogenital tract. In immunodeficient patient NTM can be presented as disseminated form of disease with multiorgan impairment [4,5]. Clinical manifestation is nonspecific – fatigue, fever, weight loss, night sweating. Manifestation of lung infection is caught, which can be productive or hemoptysis. The typical example of immunocomponent patient preconditoned for NTM infection is older woman, smoker with some lung disease - called lady Windermere syndrom [6]. In imunodeficient patients with cystic fibrosis is in more than 50% NTM infection caused by Mycobacterium abscessus complex [7]. The diagnosis is based on all three conditions: 1 clinical symptoms, 2 radiological image, 3 culture media positivity (at least two times positive finding from sputum or one positive finding from bronchoalveolar lavage (BAL) or histological identification of granulomatous inflammation and one positive cultivation from BAL [8,9].

Radiological images are variable – thin wall cysts in apical and ventral segments of upper lung lobes, infiltrations of lung parenchyma, nodularities. More specific patterns are revealed by High Resolution Computed Tomography (HRCT). Peribronchial infiltrations, centrilobular nodules, bronchiectasis, consolidations and cavitations can be seen [10]. In differential diagnosis it is necessary to rule out Mycobacterium tuberculosis infection (in this case isolation of patient is necessary), other opportunistic infections, noninfectious granulomatous disease and bronchogenic carcinoma. Treatment is based on long terms aplication of antibiotics and antituberculosics. They are administered further 12 month after all negative cultivations. The surgical treatment is indicated in the case of isolated lung form of NTM infection or relapsing hemoptysis [9].

Case 1

Patient with cystic fibrosis and pulmonary infection Mycobacterium abscessus complex (MABSC) subspecies bolleti

Twenty year old patient with cystic fibrosis and bronchiectasis, with normal lung functional tests, with pancreatic insufficiency, gastroesophageal reflux and Body Mass Index (BMI) 18,6 had chronically colonization of airways with Staphylococcus aureus. The first detection of MABSC in sputum was when he was nineteen, in that time he was asymptomatic. On HRCT images were stationary changes due to cystic fibrosis (cylindric bronchiectasis mainly in midle lobe and in lingula), bronchial wall thickening, no consolidations, no mucous plugs (Figure 1). Control test on Bacillus Kochii(BK) in sputum was negative. Five month after the first positivity of MABSC in sputum was spuam again positive. In that time clinical symptoms appeared – fatigue, weakness, green sputum production without hemoptysis. On HRCT images (Figure 2) was seen progression of pattern – tree in bud patterns bilaterally (more in the left lung - in lingula and apical segment of left lower lobe), lymphadenopathy in mediastinum. All diagnostic

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recommendations combined therapy – amicacin, linezolid, tigecyclin i.v. and azitromycin per os was administered. After three months of therapy patient is oligosymptomatic (limited daily production of green sputum) but sputum cultures on MABSC are still positive. There is only partial regression of consolidations and ground glass opacities on HRCT images (Figure 4). For future combined therapy was recommended – inhalational amicacin, tetracyclin and moxifloxacin per os for one year. Regular controls of sputum cultures and controls of unwanted effects of therapy is needed – due to toxic effects of aminoglycosides. If the clinical symptoms become worse, intravenous therapy will be administered again.

**Case 2**

**Patient with cystic fibrosis and lung infection** Mycobacterium abscessus complex (MABSC) subspecies abscessus

Eighteen year old man with cystic fibrosis. On chest X-ray he had bronchiectasis, bronchial wall thickening. Some of the bronchiectasis in the right upper lung field were filled with mucous plaques (Figure 5). He had chronic colonization of airways by Staphylococcus aureus and Pseudomonas aeruginosa, short bowel syndrome (after resection due to impairment with cystic fibrosis) what resulted in long lasting parenteral nutrition. BMI at the time of diagnosis of NTM was 19. Fever and pathological breathing phenomena appeared during scheduled hospitalization. On chest X-ray there was new consolidation in the right lower lung field and lymphadenopathy in the right hilum (Figure 6). On HRCT images cylindrical bronchiectasis in both lower lung lobes, some lung consolidations with affection of adjacent pleura mainly in apical segments of lower lobes (predilection to the right) and mediastinal lymphadenopathy could be seen (Figure 7). Specific antibiotic
treatment was without any effect so HRCT navigated bronchoscopy with BAL was performed. In BAL were found acidoresistant bacteria. Sputum was for several times positive for MABSC. In accordance to short bowel syndrom per os monotherapy with claritromycin was started. As a part of regular antipseudomonade treatment amicain intravenously for fourteen days every three month was aplicated. During this therapy, clinical symptoms and consolidation on chest X ray partially resolved very quickly (Figure 8). Sputum cultivation was negative in two months. On HRCT images in one year (Figure 9) was well-marked regression with only small residual reticulations and small consolidation in the right lower lobe. After the first negative sputum cultivation claritromycin monotherapy was stopped.

Figure 6: Chest Xray - consolidation in the right lower lung field and lymphadenopathy in the right hilum.

Figure 7: HRCT of the lung - cylindric bronchiectasis in both lower lung lobes, lung consolidations with affection of adjacent pleura mainly in apical segments of right lower lobe.

Figure 8: Chest Xray – partial regression of consolidation in the right lower lung field.

Figure 9: HRCT of the lung - small residual reticulations and small consolidation in the right lower lobe.

Figure 10: HRCT of the lung – bronchiectasis in the left lower lobe, consolidation with ground glass opacities and tree in bud patterns.

Case 3

Patient with cystic fibrosis and Mycobacterium avium complex lung infection

Next example of unsuccessful treatment is case of forty-four year old woman. The diagnosis of cystic fibrosis was made when she was thirty-eight years old due to recurrent pneumonias in the left lower lobe (LLL). HRCT of the lung was indicated. On HRCT images were extensive bronchiectasis in the right upper lobe, left lower lobe, less in in the left upper lobe, lymphadenopathy in the left hilum (Figure 10). In the left lower lobe were several consolidations. Volume of left lower lobe was reduced. Her lung functions were normal, her airways were without chronic colonisations, pancreatic functions were sufficient, her BMI index was 20,3. In the year 2009 the diagnosis of lung infection Mycobacterium Avium Complex (MAC) was made due to clinical symptoms and repeatedly positive sputum and BAL cultivation for MAC and HRCT images – peribronchial infiltrations and tree in bud patterns in both lower lobes, small consolidations in all lung lobes. There was significant progression of extent of bronchiectasis to cystic form in the left lower lobe (Figures 11 and 12). Up to date patient is permanently treated in according to ATS – three months intravenous amicacin, rifampicin, etambutol and claritromycin per os initially. After this the treatment continued without amicacin. Regarding to permanent positive cultivation for MAC repeatedly therapy in accordance to actual susceptibility for antituberculotics was indicated. However sputum was positive. On HRCT images (Figures 13 and 14) are still signs of activity of illness – peribronchial infiltrations,
tree in bud patterns, consolidations of lung are in progression. Patient is oligosymptomatic, lung functions are in limits. Due to changes in the left lower lobe – carnification of the lobe, surgical resection of the left lower lobe was indicated because it at be origin of hemoptysis and infection complications. Patient this surgical treatment refused.

**Case 4**

**Patient with cystic fibrosis and *Mycobacterium avium* complex lung infection**

Twenty-six year old woman with cystic fibrosis and chronic colonization of airway with *Burkholderia cepacia*. In the time of MAC diagnosis her lung functions were limited, pancreatic functions were insufficient. She had another risk factor – inherited deformation of thorax – pectus excavatum. She was cachectic with BMI 13.3. Diagnosis of MAC was based on positive cultivation (two times from sputum, one positivity from BAL), radiological images and clinical symptoms (reduce of weight 10 kilograms in two months). On chest X-ray were changes typical for cystic fibrosis and consolidations with air bronchogram in the left lung and a lot of small consolidations in the right lung (Figure 15). On HRCT images were peribronchial infiltrations and tree in bud patterns mainly in both lower lobes (Figure 16). Medical therapy in accordance to ATS as in case No. 3 was started. During this therapy rapid partially regression of consolidations mainly in the left lung was achieved (Figure 17). Sputum cultivations were quickly negative and they are negative up today. Chest X-ray is without new pathology. The therapy will be finished after the first negativity of sputum cultivation.

**Discussion**

Incidence of nontuberculous mycobacteriosis is worldwide growing [9] mainly in patients with chronic lung diseases. Human transmission was confirmed by genotyping only in patient with cystic fibrosis – transmission of *Mycobacterium abscessus* subspecies massiliense [10]. Transmission of different types on mycobacteria or human transmission in patients without cystic fibrosis was never confirmed [9]. *Mycobacterium abscessus* complex is rapidly growing mycobacteria with subspecies *Mycobacterium abscessus massiliense, bolleti, abscessus*. Identification of subspecies is absolutely necessary for medical therapy. Cell wall of MABSC express erm(41) gene which
on the right site without cavitations. Bronchiectases were mainly in apical segments of upper lobes but in literature they are described dominantly in middle lobe and in lingula. So these HRCT images were nonspecific. In both cases was seen mediastinal lymphadenopathy. In both patients with MABSC was proved in vivo resistence to macrolides. In the first case therapy was not curative even after eight month in the second case therapy was curative quite quickly even the therapy was much vigorous. The reason is probably due to intravenous application of amicacin due to chronic pseudomonas infection. In the third case was indicated surgical resection of carcinficated lower lobe after six years intensive therapy because it can be potentional cause of hemodynamic hemoptysis or infection complication (but it is probable that this could not be the only cause of MAC infection due to bronchiectases and bronchiolitis in the right lung). In the last case the treatment was curative after three month and her cultivations are still negative [12,13].

**Conclusion**

Diagnosis and treatment of NTM infection is very complicated. Therapy must be also often modified due to unwanted effect of medications. These cases show how important is to keep in mind this diagnosis mainly in long time nonspecific clinical symptoms in patients with predispose lung disease. In differential diagnosis is necessary to exclude *Mycobacterium tuberculosis* or other pathogens. To the right diagnosis is absolutely necessary cooperation of pneumologist, radiologist and microbiologist. Radiologist is often the first who turns attention to suspicion of NTM infection. Also the role in navigation for BAL is irreplaceable.

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