中文題目：以多處蝕骨性病變和縱隔淋巴結腫大為臨床表現之 Mycobacterium kansasii 感染

英文題目：Mycobacterium kansasii infection presented with multiple osteolytic bony destruction and mediastinal lymphadenopathy

作　　者：陳奕廷[1]，張雅婷[2]，楊志仁[3]

服務單位：[1.3]高雄醫學大學附設中和紀念醫院胸腔內科 ，[2]高雄醫學大學附設中和紀念醫院感染內科

Introduction:

Nontuberculous mycobacteria (NTM) can cause clinical syndromes in humans, such as pulmonary disease, disseminated disease, superficial lymphadenitis, and skin and soft tissue infection. Herein, we reported a patient with Mycobacterium kansasii infection presenting with multiple osteolytic bony destruction and mediastinal lymphadenopathy.

Case Presentation:

A 65-year-old female with underlying diseases of:

.Alzheimer's disease

.Allergic rhinitis

.Gastroesophageal reflux disease

Tracing back to her history, initially she presented with fever, upper respiratory tract symptoms, and acute right lower chest pain. She was admitted for intravenous antibiotic treatment due to still high C-Reactive Protein (CRP) level accompanied with chest X-ray showing right lower lung opacity and pleural effusion after oral Unasyn use. Sputum acid fast stain reported negative finding. Chest Computed Tomography (CT) after admission revealed enlargement of lymphadenopathy at the upper mediastinum and subcarinal region, Differential diagnosis: lymphoma and metastases. We performed endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) biopsy, however, pathology of mediastinum reported negative for malignancy.

Positron Emission Tomography (PET) scan for fever survey reported multiple bone/marrow avidity in the pelvis, sacrum/coccyx, sternum and rib cages, osteosclerosis majorly. Further bone scan showed multiple sites in the skeleton, metastatic bone disease, suspect disseminated. Repeated chest CT disclosed progression of skeletal metastases. (ribs, sternum and spine), and enlargement of lymphadenopathy at the bilateral supraclavicular regions, upper mediastinum, precarinal region and subcarinal region.

We consulted surgeon for chest wall tumor excision, of which tissue culture yielded Mycobacterium kansasii. Ciproxin, Ethambutol, and Clarithromycin were administered for disseminated NTM infection treatment. Both toxic sign and septic parameter were improving. Besides, chest CT after 3 months disclosed decrease of the size of the lymphadenopathy at the upper mediastinum.

Discussion:

For M. kansasii infection, disseminated infection is a rare complication that occurs in immunocompromised hosts such as those with HIV infection. However, in this case, she got no HIV infection and presented with multiple osteolytic bony destruction and mediastinal lymphadenopathy. Hence, disseminated infection of M. kansasii may occur in immunocompetent patient and may mimic clinical presentation of lung cancer should be considered for. With appropriate NTM treatment, disseminated infection of M. kansasii as mediastinal lymphadenopathy may also improve.

Conclusion:

Disseminated infection of M. kansasii may mimic clinical presentation of lung cancer as multiple osteolytic bony destruction and mediastinal lymphadenopathy.