

Clinical update no. 508

21 February 2017

Triage Category	Nurse Assess: FEVERS 3/52 BEEN TO GP ON PO ABS NO EFFECT. SORE THROAT STRUGGLING TO SWALLOW. CURRENTLY BEING INVESTIGATED FOR INFLUENZA. VOMITING PARACETAMOL AT 0300 TEMP: 38.7 STATS99% HR 115 NKA WEIGHT: 50KGS.
3	

46yr-F of Indian background, though had not left Australia for 9 years. Presented with difficult and painful swallowing, with marked cervical lymphadenopathy. She was admitted for investigation.



There was marked lymphadenopathy, with central necrosis consistent with *Mycobacterial* infection, later confirmed on biopsy.

SPECIMEN: FLUID
SITE: RIGHT CERVICAL LYMPH NODE
DESCRIPTION: 5mL of cloudy fluid

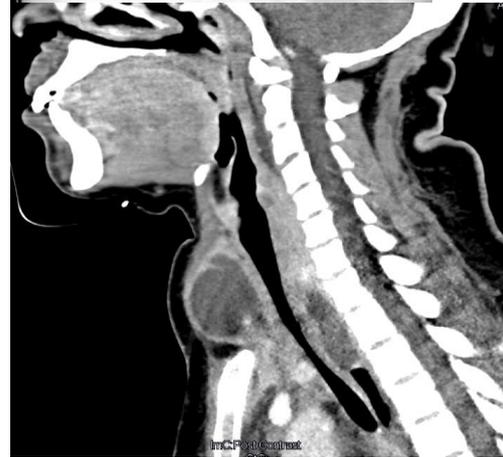
MICROSCOPY:
ACID FAST STAIN: + Acid Fast Bacilli SEEN

MYCOBACTERIUM PCR
Mycobacterium tuberculosis Complex: DETECTED
(From direct specimen)

There was no pulmonary involvement. She was commenced on Rifampicin, isoniazid/ pyridoxine, pyrazinamide and ethambutol.

The difficulty swallowing was due the mass of lymph nodes compressing the oesophagus.

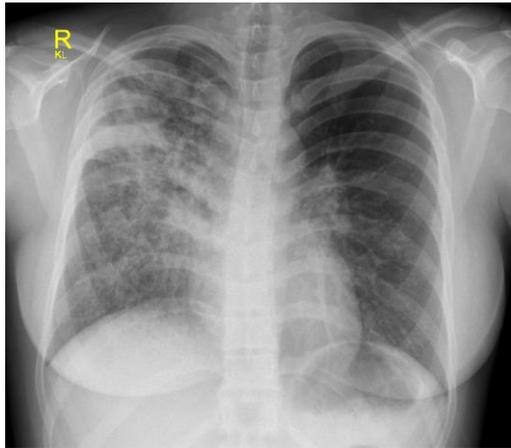
She presented 3 weeks later with worsening pain and difficulty swallowing, hoarse voice and stridor. The threat to her airway was the primary concern – how to approach?



Front of neck access might not be an option. Observed closely, and improved with steroids

21yr-F from South America presenting with 6 weeks of ongoing cough and fevers not responding to antibiotics from GP. CRP 110.

ALT	92H
ALKP	171H
New GGT	276H



Multilobar consolidation reported.

CULTURE:

1. *Mycobacterium tuberculosis*
isolated after 9 days incubation.

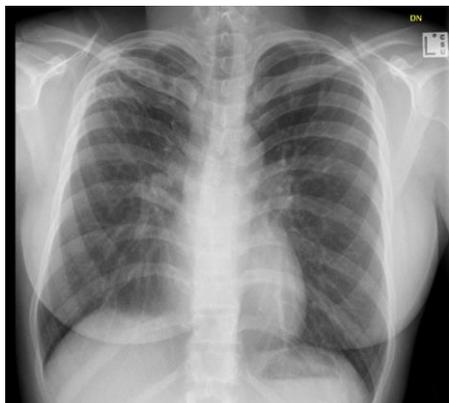
This organism is always pathogenic.

This patient should be urgently assessed for anti-tuberculosis treatment and appropriate public health management of contacts.

The cavitation was not initially reported, but noted to be “again present” on follow up films.

Liver/biliary ultrasound showed nil of note.

Always consider TB in risk groups, and don't rely on x-ray reports to tell you everything.



A good response to treatment at 9mth, though residual scarring.

77yr Chinese male referred by GP for ongoing chest infection not responding to antibiotics.



Reported as patchy infiltrates and non specific appearance. AFBs –ve, with non tuberculous *Mycobacterium fortuitum* on culture.

MICROSCOPY:

ACID FAST STAIN: Acid fast bacilli not seen.

CULTURE:

1. *Mycobacterium fortuitum* complex
isolated after 8 days incubation.

This organism does NOT cause tuberculosis in humans.

An Official ATS/IDSA Statement: Diagnosis, Treatment, and Prevention of Nontuberculous Mycobacterial Diseases

Am J Respir Crit Care Med Vol 175. pp 367–416, 2007

<https://www.thoracic.org/statements/resources/mtpi/nontuberculous-mycobacterial-diseases.pdf>

Mycobacterium, but not tuberculous.

It still causes disease which can be multiorgan as well as significance lung involvement.

CXR shows fibrosis and cavitation similar to TB, often with bronchiectasis and nodules. CXR and multiple sputum cultures for AFBs are usually adequate to diagnosis with CT and bronchoscopy reserved for select cases.

M. fortuitum is susceptible to multiple antibiotics including macrolides (clarithromycin; but risk of inducible resistance), quinolones (ciprofloxacin), doxycycline and sulfonamides.

Whether TB or not TB, *Mycobacterium* is fairly prevalent – think of it.