Systemic *Pneumocystis carinii* pneumonia prophylaxis with dapsone and pyrimethamine fails to protect against extrapulmonary pneumocystosis

E M Carlin, R J Coker, R D Goldin, J R W Harris

Abstract
Extrapulmonary pneumocystosis is a feature of severe immunosuppression which earlier reports have suggested is limited to patients receiving either no prophylaxis or aerosolised pentamidine. We report a case of disseminated pneumocystosis which developed in an HIV positive homosexual man despite systemic primary *Pneumocystis carinii* pneumonia prophylaxis.

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Introduction
*Pneumocystis carinii* pneumonia (PCP) is the commonest severe opportunistic infection seen in patients infected with the human immunodeficiency virus (HIV).1 This is despite effective prophylaxis which is now recommended for all patients with the acquired immunodeficiency syndrome (AIDS), those with CD4 count <200/mm3, and those with symptomatic HIV disease.2 Patients with AIDS are now surviving longer3 and the complications of more severe immunosuppression are being seen. Amongst these is disseminated pneumocystosis. This report is the first, to our knowledge, to show that disseminated pneumocystosis can occur in patients receiving systemic PCP prophylaxis.

Case report
A 34 year old homosexual was admitted in his final illness with a one month history of a fever, dyspnoea and a cough productive of clear sputum which had failed to respond to amoxycillin. He had been diagnosed seropositive for the human immunodeficiency virus (HIV) four years earlier. The acquired immunodeficiency syndrome (AIDS) was diagnosed when cytomegalovirus retinitis occurred 14 months prior to his final presentation. He was treated with ganciclovir via a portacath. However, 6 months later his retinitis relapsed, reinduction with foscarnet was complicated by renal failure and ganciclovir was reintroduced as maintenance therapy. His renal function improved but he was left with some residual renal insufficiency. Three months prior to admission he had a brief episode of fever, examination was normal but the chest radiograph showed bilateral hilar lymphadenopathy. He declined further investigation.

Primary *Pneumocystis carinii* pneumonia (PCP) prophylaxis was started 18 months prior to his last admission, initially as fortnightly aerosolised pentamidine (300 mg via Respigrad II nebuliser) and then, after 11 months, changed to dapsone (100 mg twice weekly) and pyrimethamine (25 mg twice weekly). He claimed to be compliant with all medication. He had taken zidovudine for 1 year 3 years earlier but this had been stopped because of anaemia. On examination he was pyrexial (40°C). Bilateral basal crepitations were audible in the chest and extensive inactive retinitis was present in the right fundus with reduced acuity to hand movements only. Cardiovascular, neurological and abdominal examinations were normal.

Investigations showed haemoglobin 11.8 g/l, white cell count 2.7 × 10⁹/l, neutrophils 1.2 × 10⁹/l, platelets 69 × 10⁹/l, CD4 count 10/mm³.¹ Serum creatinine 245 μmol/l, creatinine clearance 29.5 ml/min, AST 127 U/l, ALT 95 U/l, alkaline phosphatase 290 U/l, bilirubin 6 μmol/l. Chest radiography (fig 1) showed bilateral hilar lymphadenopathy, lower zone interstitial infiltrates, and small bilateral pleural effusions. Abdominal CT showed a single prominent...
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and pneumocysts were seen on staining with Grocott's methenamine silver stain. The tracheo-bronchial, coeliac axis and para-aortic lymph nodes were enlarged and showed haemorrhage and necrosis. Histological examination of lymph nodes from all of these sites showed an eosinophilic granular exudate in which Pneumocystis carinii cysts could be demonstrated on staining with Grocott's methenamine silver stain (fig 2).

Discussion
Extrapulmonary pneumocystosis occurs in up to 2.5% of AIDS patients, and several studies have shown that the diagnosis is often made post mortem. Earlier reports have suggested that systemic PCP prophylaxis confers protection.

In this case it may be that subclinical PCP was present prior to the introduction of systemic prophylaxis 7 months before his death. However, the lack of symptoms prior to this period suggest this is unlikely, particularly as primary prophylaxis with aerosolised pentamidine is effective. However, the effect of pentamidine in the severely immunocompromised with low CD4 counts has been questioned. Earlier reports have suggested that dapsone 100 mg and pyrimethamine 25 mg twice weekly are also effective in preventing PCP but recently at this dose dapsone and pyrimethamine have been shown to be less efficacious in preventing PCP than pentamidine or co-trimoxazole. Our experience would agree with this and we are currently studying data from our own unit.

Compliance in patients is a problem which is difficult to evaluate long term patient acceptability is important and is known to be higher with pentamidine than co-trimoxazole.

Extrapulmonary pneumocystosis is a problem among long-term survivors with AIDS. As the survival of patients with AIDS increases the frequency of disseminated pneumocystosis can be expected to increase. Both clinicians and pathologists are becoming increasingly aware of disseminated pneumocystosis. As a result of earlier cases at both St. Mary's and Middlesex Hospitals we routinely look for evidence of pneumocysts in all clinical material from patients with HIV.

In conclusion, systemic prophylaxis with dapsone and pyrimethamine, a regimen now known to be less effective than co-trimoxazole in a patient with uncertain compliance, does not confer protection against the development of extrapulmonary PCP. We suggest that clinicians should be alert to this condition as early intervention may improve prognosis.

8 Smith DE, Hills DA, Gazzard BG. Patient tolerance of nebulised pentamidine or co-trimoxazole as secondary prophylaxis for Pneumocystis carinii pneumonia. AIDS 1992;6:1044-5.
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