Cavitating pulmonary cryptococcosis developing in an HIV antibody patient despite prior treatment with fluconazole

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Abstract
Disseminated cryptococcosis developed in an HIV antibody positive patient who was taking fluconazole for oral candidiasis. This case highlights the poor response to therapy that may be seen, and the severe pulmonary complications that may ensue. The use of fluconazole prior to the development of cryptococcosis did not confer protection.

Introduction
Cryptococcus neoformans is a rare but significant cause of pneumonia in patients infected with the human immunodeficiency virus (HIV). The spectrum of disease caused by the fungus varies considerably from asymptomatic pulmonary cryptococcosis to widespread disseminated disease including, commonly, meningitis. The drug of choice in the treatment of this disease is amphotericin B, but recently interest has focused on the role of the azoles, particularly fluconazole.

Case report
Four weeks prior to admission with headache, a 37 year old West Indian heterosexual was found to be HIV antibody positive after he presented with oral candidiasis. Serum cryptococcal antigen at this time was negative. He was started on fluconazole (50 mg/day).

On examination, at admission, he was pyrexial (38°C) with mild neck stiffness. A chest radiograph revealed soft shadowing in the left upper zone. Examination of the cerebrospinal fluid (CSF) showed budding yeast on India ink stain which was subsequently cultured and identified as Cryptococcus neoformans var. neoformans. Blood cultures and sputum cultures also grew C neoformans. The MIC to fluconazole of C neoformans isolated from the CSF sample was 25 mg/ml. He was hyponatraemic.

He was treated with amphotericin B (0-6 mg/kg/day) for three weeks but developed renal impairment (creatinine clearance falling to 28 ml/minute) and subsequently fluconazole (400 mg/day), and flucytosine (100 mg/kg/day) but he deteriorated and developed leucopenia (WBC count 0·7 x 10^3/l). Further chest radiographs (fig 1) and CT (fig 2) showed increasing consolidation with cavitation and scattered intrapulmonary nodules. Bronchoscopic examination with bronchoalveolar lavage confirmed pulmonary cryptococcosis. He was treated for a further month with liposomal amphotericin B (3 mg/kg/day) but continued to deteriorate and died two months after admission.

Postmortem examination revealed widespread involvement in both lungs by C neoformans. No other pathogens were detected.

Discussion
Cryptococcal infection occurs in 5–10% of all patients with the acquired immunodeficiency syndrome (AIDS) and is the fourth most common infection found in AIDS patients after Pneumocystis carinii, cytomegalovirus, and mycobacterial infections. Cryptococcosis is the initial manifestation of AIDS in 40% to 45% of such patients.

The lung is the usual site of entry of C neoformans and of those infected 50% to 80% are immunocompromised. Cryptococcal infection may be limited to the lungs in immunocompetent hosts, whereas disseminated disease and meningitis are more common in immunocompromised hosts. Pulmonary cryptococcosis is probably more common.
extrameningeal sources, as seen in this patient, indicate a poor prognosis, prior therapy with fluconazole may have reduced ergosterol levels and therefore have prevented full benefit from amphotericin B. Alternatively, use of fluconazole prior to the development of cryptococcosis may have selected an isolate with a high MIC to fluconazole and poor response to the higher dose subsequently given. However, the laboratory sensitivity of azole antifungal drugs is highly dependent on test conditions, and MICs for responsive strains that are higher than the concentration of the drug attained in the responsive patient may be seen.

Liposomal amphotericin B (Ambisome) has been used with success in the treatment of cryptococcal meningitis, pulmonary aspergillosis, and other systemic fungal infections. It appears to be less nephrotoxic than conventional amphotericin B, hence its use here, though its efficacy is still unknown. Results of clinical trials are awaited. Flucytosine may be effective but is limited by its considerable toxicity profile, as was the experience in this case. The current dosage recommendation of 150 mg/kg/day may be too high and 75–100 mg/kg/day is perhaps adequate.

Awareness that cryptococcal infections may occur despite patients already taking systemic antifungal drugs is important. Further studies are required to establish possible interactions between the azoles and amphotericin B. Though unusual, cavitation may be a feature of pulmonary cryptococcosis in AIDS.


