MATTERS ARISING

Non tuberculous cavitary disease in a West African man with AIDS

We read with great interest the recent two case reports by Mabey DCW et al describing cavitating pulmonary nocardiosis in a West African man with AIDS associated with other opportunistic infections.1 We observed a similar case (but non-cavitary) of pulmonary nocardiosis in a homosexual caucasian of UK origin, as the first major opportunistic infection. In the past nocardiosis appeared to be more common in Africa than in Europe and America.2

A 36 year old Englishman, who has been known to be HIV positive for one year presented with a 2 month history of persistent fever, watery intermittent diarrhoea, sore throat, night sweats, mild splenomegaly, weight loss, white cell count of 3-7 x 10⁹/l neutrophil count of 0-5 x 10⁹/l and CD4 count of 50/mm³.

In the past apart from oral thrush and perianal herpes he did not have any other symptomatic opportunistic infections. One year ago he was commenced on zidovudine 250 mg twice daily and prophylactic dose of co-trimoxazol. Subsequently this had to be discontinued as he developed cotrimoxazol related Steven-Johnson syndrome and he was commenced on nebulised pentamidine prophylaxis.

Chest radiograph and CT of chest revealed evidence of upper lobe consolidation (fig). Several induced sputum samples for acid fast bacilli, pneumocystis and gram stain were negative. Subsequently he had two diagnostic bronchoscopies but broncho-alveolar lavage did not reveal any evidence of opportunistic pathogens. A transbronchial biopsy was abandoned as he could not tolerate this procedure and he was commenced on empirical quadruple anti-tuberculous therapy in view of the persistent upper lobe consolidation. As he did not improve on anti-tuberculous therapy an ultrasound guided percutaneous lung biopsy was carried out and this showed histopathological evidence of nocardia.

Speciation could not be done as there was not enough tissue sample for culture. Serum LDH 484 IU/l (normal range), and toxoplasma serology <32, multiple blood and mycobacterium avium intracellulare (MAI) cultures (Bacillin and plastic embedded material. Cal Mol Biol 1987;33:711-23.


BOOK REVIEWS


Not being a radiologist I was somewhat apprehensive about my ability to review this book and do it justice. Fortunately due to the clarity of the text and accompanying investigations I have been guided easily through a very comprehensive tour of HIV radiology. I thought, however, that the title should be changed from AIDS to HIV to avoid confusion as several non-AIDS conditions are discussed.

The book takes the reader through the systems from chest to genitourinary and finishes with paediatrics. The format consists of individual cases with a brief clinical history, questions and relevant investigation. Overleaf a standard answer is given with alternative investigations, differential diagnosis and epidemiological data.

It is unfortunate and probably a reflection on the time taken to produce this book that none of the references are later than 1990. This means that the epidemiological data cited regarding AIDS cases are out of date and may also explain why progressive multifocal leucoencephalopathy is not mentioned. I would strongly recommend that this be rectified in the next edition. The series editor clearly states that therapeutic information has not been included.

On the whole the pictures are clear and text is easy to understand. The author is to be congratulated on assembling such a comprehensive collection. I was particularly pleased to see sexually transmitted infections other than HIV included in the discussions. Overall I had few very criticisms of the text. A comment on the use of induced sputum and/or bronchoscopy for investigating chest infections should be included.

There is an overwhelming focus on barium investigations, in most centres these have been superseded by endoscopy but would be useful to see MRI scans and how they compare with CT scans for the diagnosis of cerebral toxoplasmosis/lymphoma. The fact that


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