Infectious Disease eConsult

50-year-old male with h/o chronic cough with RUL consolidation (ruled out active TB), treated for possible PNA with augmentin +doxy. Repeat CT diffusely abnormal. AFB neg but +Mycobacterium fortuitum.

What management would you recommend?

If a patient like this presented to me, these would be my general thoughts: Thanks for the consultation. Pulmonary mycobacteriosis is sometimes a hard disease to rule in. The guidance from ATS is that patient should have a suggestive x-ray or CT scan plus positive culture results, preferably more than 1 specimen the corroborates the type of microorganism. There is important since a lot of the mycobacterial flora can be simply contaminants in the process of generating the specimen. The description of pneumonia without improvement with therapy, cavitation in conjunction with the Mycobacterium isolated most certainly points to the direction that M fortuitum would be responsible here.

I would gather more AFB sputum and also sent the isolate for susceptibility testing. We want to use at least 2 agents to treat pulmonary disease and I would argue here with cavitary disease to rather start off with 3 agents. The choice can be empiric if susceptibilities are not conducted, but since therapy is usually lengthy, I would highly recommend to obtain susceptibilities and noted to start treatment until those have resulted. Pulmonary disease related to mycobacteriosis is never acute, but always chronic. As such, I believe there is no reason to rush therapy and you can make it well thought out decision once susceptibilities are back. Commonly used agents including amikacin, fluoroquinolones, doxycycline and macrolides. It is hard to say what the impact has been with the patient having received single therapy essentially with doxycycline recently been given.

**PCP case and specialist response are presented as summaries*