Nocardiosis in Renal Transplant Patients

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Six (1.7%) nocardia infections were diagnosed between 1.1.1987 and 1.7.1995.

Table 1. Presenting symptoms, signs, chest X-ray findings, involved sites, suspected predisposing factors and outcome of the patients with nocardiosis.

Case Presenting symptoms Chest X-ray findings Involved sites Suspected predisposing factors Outcome

Cough, fever, left crural abscess Three nodules in the Lung, left upper, middle and skin right middle zones Hepatitis B virus infection Complete cure with TMP/SMX
among 334 patients in our transplantation center. Their ages were between 30 and 48. Five of them were male; 3 had living related, 1 living unrelated, 2 cadaveric donor kidneys. The presenting symptoms, signs, chest X-ray findings, involved sites, suspected predisposing factors and outcome are summarized in table 1. All but 1 of the patients had pulmonary involvement. Two patients had cerebral abscess. Three cutaneous abscess forms were encountered. Diagnosis was made by ultrasonography-guided aspiration biopsy from a lung nodule, bronchoalveolar lavage, cutaneous abscess aspiration, open lung biopsy, cerebral biopsy and hemoculture. In 1 patient the diagnosis was made at the postmortem period. In all patients high doses of trimethoprim-sulfoximethoxasole were used, in 1 patient with cerebral abscess cefotaxime additionally. All diagnosed patients fully recovered. As can be seen from table 1, predisposing factors were found to be CMV disease, posttransplant diabetes mellitus, pulse methylprednisolone treatment. While in our renal transplant population anti-HCV positivity was 34.7% and HBsAg positivity was 7.4%, 4 patients were anti-HCV positive and 1 was HBsAg positive in our 6 patients with nocardiosis. All patients with anti-HCV or HBsAg positivity had fluctuating ALT levels compatible with biochemical chronic active hepatitis. Two of them had biopsy-proven chronic active hepatitis in the posttransplant period. Interestingly, in the patient group who had anti-HCV and/or HBsAg positivity the prevalence of nocardiosis was 3.1% compared to 0.4% in the population with both anti-HCV and HBsAg negativity. We conclude that HCV and HBV infections may increase the predisposition of renal transplant recipients to nocardiosis.

References

Announcement
The Massry Prize in Nephrology, Physiology and Related Fields
The 1997 Massry Prize will be awarded by the Meira and Shaul G. Massry Foundation to an eminent scientist who has made extraordinary and meritorious contributions in the field of ‘Cytokines, Chemokines or Growth Factors’.

Nominations
Nominations may come from any country and must be made in writing. Seven copies of the nomination package should be mailed before Friday, May 23, 1997 to the Meira and Shaul G. Massry Foundation, 1140 Benedict Canyon Drive, Beverly Hills, CA 90210 (USA). Only one nomination may be made by: (a) the deans of medical schools; (b) members of national academies of sciences; (c) Nobel Prize Laureates in physiology and medicine; (d) Massry Prize Laureates, and (e) eminent scientists who may be selected by the board of directors of the foundation. Self-nomination is not acceptable. The nomination package should include the curriculum vitae of the nominee, five of her/his most important publications, names of four referees with their telephone and fax numbers, and a letter
providing in detail the scientific contributions of the nominee, the impact of her/his work on the scientific community and the relevance of her/his work to the advancement of health. The nominations will be reviewed by a special independent selection committee which will choose the winner. The prize is the Massry Gold Medal and a substantial monetary award. The winner of the Massry Prize must appear in person to receive the prize in Los Angeles.

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