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Mycophenolate-Associated Bronchiectasis

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Brill et al. [1] report on the potential utility of mycophenolate mofetil (MMF) as a steroid-sparing agent in chronic pulmonary sarcoidosis in 10 patients with some success in the reduction of systemic steroids while preserving lung function and clinical stability. Although this provides a welcome possible alternative to other steroid-sparing agents that might have more adverse events, such as methotrexate or azathioprine, MMF has been more recently associated [2, 3] with the development of bronchiectasis (in addition to its well-known problems of gastrointestinal disturbance and leucopenia).

Brill et al. [1] report several self-limiting upper airway infections and two mild pneumonic episodes but no particular mention of more serious chest infections. It would be interesting to know whether any of the 10 patients developed hypogammaglobulinaemia on MMF or chronic sputum production. In two adult case series of 12 patients with MMF-associated bronchiectasis, this occurred after less than 12 months of therapy in 7/12 cases (58%), albeit in only a small proportion (<3%) of patients but 25% of the

total number who had severe respiratory infections [2]. The mechanism for bronchiectasis is uncertain but most likely thought to relate to MMF-induced hypogammaglobulinaemia; indeed in one of the case series, all patients with MMF-associated bronchiectasis had low IgG levels [2]. It is suggested, therefore, that clinicians using MMF should be vigilant for signs of possible bronchiectasis and check immunoglobulins when using MMF. Differentiating the cause of increased respiratory infection will be more challenging when the underlying clinical indication for MMF is primary lung disease, but the time course of MMF therapy, presence/absence of hypogammaglobulinaemia and/or bronchiectasis may help give clarity.

Financial Disclosure and Conflict of Interest

The author has no conflicts of interest to declare.

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