中文題目：HIV 病患全身淋巴腫又高燒不退，這咁是壞東西？
英文題目：Diffuse lymphadenopathy in a patient under HIV treatment: Is it lymphoma?
作　　者：鄭坤霖[1]，江建昌[1]，顧文瑋[2]
服務單位：
[1]台北市立聯合醫院仁愛院區內科部一般內科
[2]台北市立聯合醫院仁愛院區內科部感染科

Background

Immune reconstitution inflammatory syndrome (IRIS) is associated with increased morbidity and mortality in human immunodeficiency virus (HIV)-infected patients who initiate antiretroviral therapy (ART), especially in those with low CD4 count. Diagnosis and management of IRIS can be challenging in such patients with disseminated mycobacterial infections, with protean clinical manifestations such as prolonged fever and generalized lymphadenopathy (LAP). We presented here a case with disseminated *Mycobacterium avium* complex (MAC) infection mimicking lymphoma.

Case presentation

A 29-year-old man was first admitted with diagnosis of untreated HIV infection , *Pneumocystis jiroveci* pneumonia, and disseminated herpes zoster. The nadir CD4 count was 40/cumm. He was treated for his opportunistic infections, and ART with abacavir/lamivudine/dolutegravir were initiated on day 10, along with cotrimoxazole and clarithromycin prophylaxis. He was discharged uneventfully on day 14.

He experienced fever, nausea, vomiting, and abdominal fullness and was admitted again due to dehydration-related acute kidney injury on day 27. Sputum culture and stool culture yielded *Mycobacterium intracellulare* and ethambutol and rifabutin were added to clarithromycin as treatment for MAC infection. However, the patient still had persisted spiking fever with progressive dyspnea. Laboratory exams found elevated liver function tests (ALT: 54 U/L, AST: 103 U/L), ferritin (3502 ng/mL) and LDH (565 U/L) levels, and bicytopenia (hemoglobin: 7.9 g/dL, platelet count: 117,000/cumm). Abdomen CT and later PET-CT scan revealed wide-spreading LAP, with involvement on both sides of the diaphragm, hepatosplenomegaly and diffuse reticulonodular opacities in the both lungs. Under the suspicion HIV-associated multicentric Castleman disease and lymphoma, bone marrow aspiration was arranged but failed to present hemophagocytosis or lymphoma. Thus, we performed excisional biopsy of left supraclavicular lymph node. Pathology report revealed many acid-fast bacilli with no evidence of high-grade lymphoma, and tuberculosis

polymerase chain reaction (TB-PCR) was negative. Unmasked disseminated *Mycobacterium intracellulare* infection with IRIS was confirmed. We started prednisolone (20 mg/day) on day 56 and his condition improves gradually. He was discharged with ART, anti-MAC treatment, and steroid on day 68 and has been followed as outpatient stably.

Conclusion

Disseminated MAC infection and associated immune reconstitution inflammatory syndrome can present with prolonged fever and diffuse lymphadenopathy mimicking other AIDS-related lymphoma in HIV-infected patients with low CD4 count who initiated ART. Early excisional lymph node biopsy may facilitate diagnosis and improve prognosis with timely use of steroid.

Key Word: human immunodeficiency virus, immune reconstitution inflammatory syndrome, Mycobacterium avium complex infection, non-Hodgkin's lymphoma