



CORRESPONDENCE

Pulmonary tuberculosis in the differential diagnosis of community-acquired pneumonia

To the Editors:

Especially in view of the need to maintain a high index of suspicion for tuberculosis (TB) in elderly patients and in patients with HIV infection, I would like to add to the reservations expressed about the guidelines for the management of adults lower respiratory tract infections [1, 2] by voicing concern about another aspect of the guidelines. In this instance, I would like to draw attention to the omission of any mention of the role of *Mycobacterium tuberculosis* either as an alternative aetiology for radiographic and clinical stigmata simulating community-acquired pneumonia (CAP) [3, 4] or as a co-pathogen even when *Streptococcus pneumoniae* is the acknowledged bacterial aetiological agent [5, 6].

In the former context, “failure to respond to antimicrobial agents for common bacterial pneumonias should prompt concern that TB is a possible cause”, as was the case in a 25-yr-old febrile patient who was referred for presumed pneumonia unresponsive to antibiotics, and in whom pulmonary TB proved to be the underlying cause of right lower lobe consolidation [3]. A high index of suspicion for *M. tuberculosis* as an alternative diagnosis should also prevail in the elderly [4], given the fact that there is an age-related increase in the prevalence of *M. tuberculosis*-related lower-lobe disease, and in view of the fact that “frequency of cavitation in the TB group showed a negative correlation with age” in a study by PEREZ-GUZMAN *et al.* [4]. The role of *M. tuberculosis* as a co-pathogen was exemplified by 11 patients belonging to a subgroup of 222 with CAP characterised by typical respiratory symptoms and positive chest radiography associated with an identifiable respiratory pathogen. In those 11 patients, *S. pneumoniae* CAP coexisted with sputum-positive pulmonary TB [5]. In yet another study, nine patients were reported with bacteraemic *S. pneumoniae* CAP and concomitant pulmonary TB. These patients were admitted with brief history of respiratory symptoms and fever, and none was previously diagnosed with HIV infection. Chest radiographs all showed lobar or multilobar consolidation, and blood cultures were positive for *S. pneumoniae*. Although symptoms and pyrexia initially abated after antibiotics, all nine patients subsequently experienced recurrence of symptoms and pyrexia associated with non-resolution of radiographic stigmata. Co-existing *M. tuberculosis* was subsequently diagnosed by sputum smear in five instances, by mycobacterial culture of bronchial washings in two patients, by mycobacterial culture of a transbronchial specimen in one patient and, in one case, by mycobacterial

blood culture. All nine patients also subsequently tested positive for HIV infection [6]. In view of these examples, TB should also feature in the differential diagnosis of unresolved pneumonia, and guidelines should, arguably, also specify which patients should have post-discharge clinical and radiological review.

These reservations aside, the guidelines are well researched and well balanced. Above all, they reinforce good practice by stressing the primacy of identifying the culprit pathogen so that antibiotic therapy can be more targeted, thereby mitigating the risk of side-effects from inappropriate medication with broad-spectrum antibiotics.

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