THE KOREAN SOCIETY OF NEPHROLOGY
APCN & KSN 2024
June 13(Thu) - 16(Sun), 2024 Coex, Seoul, Korea
APSN
Promoting Sustainable Kidney Health: The Asia-Pacific and Beyond

Abstract Submission No.: A-0045

A CASE REPORT OF EARLY SEVERE PNEUMONIA FOLLOWING LIVING DONOR KIDNEY TRANSPLANTATION

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Case Study : Opportunistic infections such as pneumocystis jirovecii, mycobacterium tuberculosis, herpesvirus infection (CMV, HSV, VZV, EBV), HCV, HBV and endemic mycoses are likely to occur 1-6 months after transplantation and often are caused by reactivation of latent infections. Data about opportunistic infection in this population in Indonesia is sparse. We report a case of early severe pneumonia caused by presumptive pneumocystis jirovecii concurrent infection with pulmonary tuberculosis clinically symptoms in a 24-year-old woman, who previously underwent successful living donor kidney transplantation and suffered from Hepatitis C and CMV latent. She did not receive tuberculosis, CMV or pneumocystis jirovecii pneumonia prophylaxis treatment. Six months after kidney transplantation, the patient had low grade fever for seven days followed by nonproductive cough, chest tightness, and shortness of breath 4 days before admitted to hospital. Laboratory results showed increased procalcitonin (2.59 ng/mL), TB sputum test, TB LAM Ag test and IGRA MTB test results were all negative, sputum culture result was staphylococcus epidermidis, decreased absolute lymphocyte count (700/ml), normal CD 4 (39.72%), decreased absolute CD 4 count (278/ml), Ig G anti CMV reactive (572 U/ml), non-reactive Ig M anti CMV (0.245), high CMV Ig G avidity test (72.7%) with negative CMV antigenemia and chest radiographic features show bilateral, symmetrical perihilar interstitial infiltrates with pleural effusion, lymphadenopathy and increased involvement of lung fields and homogeneity overtime suggestive of presumptive pneumocystis jirovecii with tuberculosis infection. Through sulfamethoxazole-trimethoprim (TMP-SMX) treatment combined with micafungin, antibiotics, valacyclovir and anti-tuberculosis treatment, finally, symptoms, such as chest tightness, cough, shortness of breath and desaturation, were improved, renal and liver function were preserved, tacrolimus therapeutic level were maintained and she was discharged by continuing antituberculosis, hepatitis C and immunosuppressive treatment with good clinical symptoms and chest x-ray improvement after discharge.

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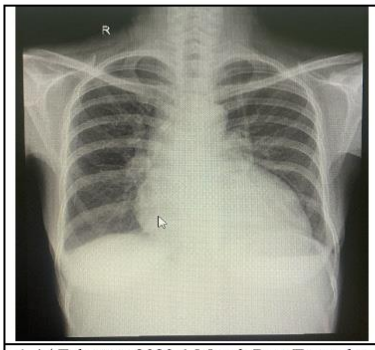
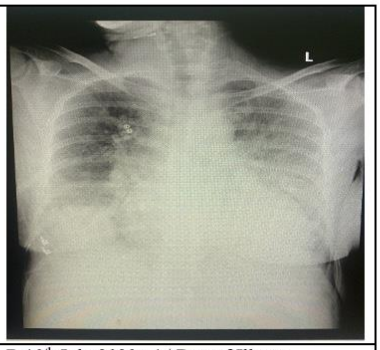
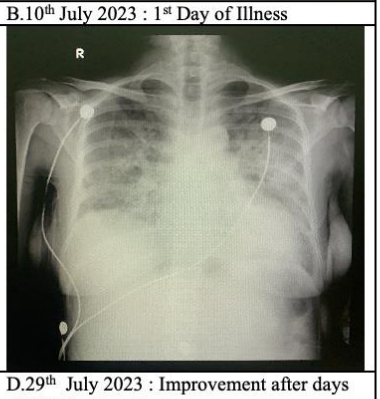
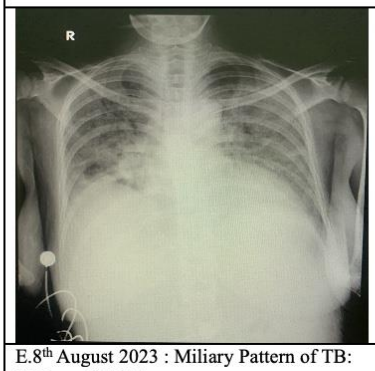
Table 1. The Chest X Rays Changes Of Patients Following Treatment

	
A.1st February 2023:1 Month Post Transplan	B.10th July 2023 : 1st Day of Illness
	
C.24th July 2023 : 1st Day of PCP Treatment	D.29th July 2023 : Improvement after days of PCP treatment
	
E.8th August 2023 : Miliary Pattern of TB: 1st Day of TB Treatment	F.30th August 2023 : 22 Days After TB Treatment

The chest x-rays showed gradual changes in lung infiltrates pattern according time (**A**), The Chest X-Rays 1 month after transplantation before infection (**B**), Infiltrates in both lungs and pulmonary edema grade II on day 1 (**C**), aggravation (with worse infiltrates in both lungs and bilateral pleural effusion) on day 14 (**D**), partial decrease of local consolidation on day 19, 6 days after PCP treatment (**E**), miliary pattern of TB noted in day 29 (**F**), and decreased of local consolidation and pleural effusion on day 51, after 22 days of TB treatment and 21 days of PCP treatment

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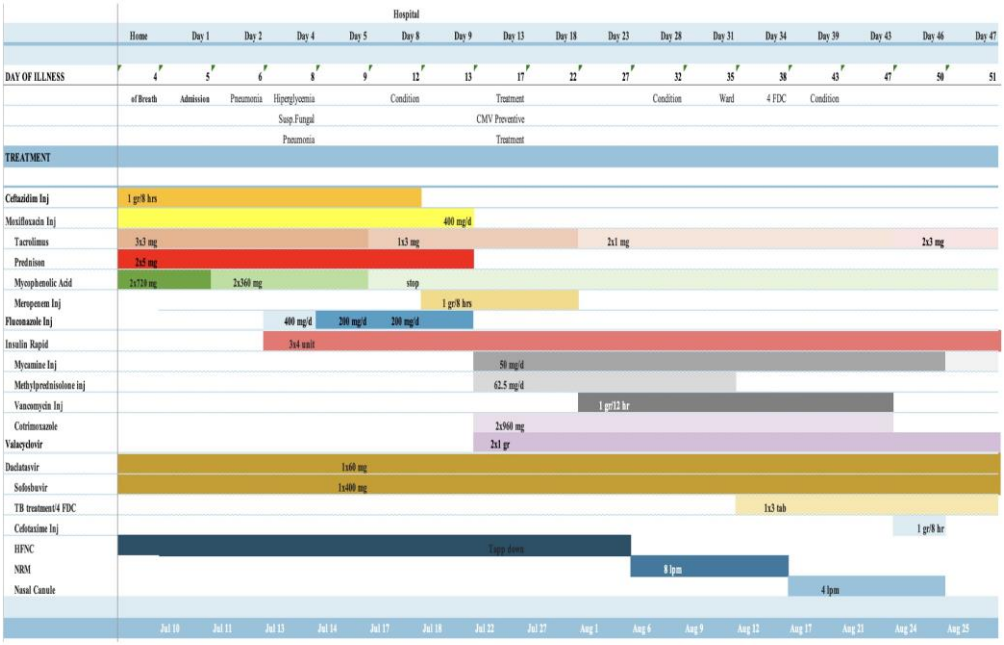

Figure 1. Medication strategy according to day of illness and day of hospitalization, July 10 to August 25, 2023