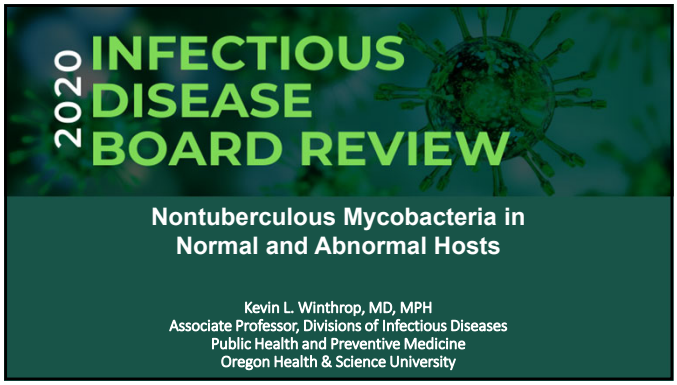
42 - Nontuberculous Mycobacteria in Normal and Abnormal Hosts

Speaker: Kevin Winthrop, MD



Nontuberculous Mycobacterium (NTM)

- "MOTT" or "Atypical"
- Environmental organisms
  - Soil, lakes, rivers, municipal water systems
  - Resistant to chlorine and most disinfectants
- Biofilm
  - Live within amoeba, legionella, others

Laboratory Growth Characteristics

- "Slow" growers (>2 weeks in AFB media, liquid media more quickly)
  - M. avium complex (MAC), *M. kansasii, M. marinum, M. xenopi*
- "Rapid" growers (4-7 days in routine blood agar)
  - *M. abscessus, M. chelonae, M. fortuitum*
- *"Need help" growing*
  - *M. marinum, M. haemophilum, M. ulcerans,*
  - *M. genavense (often molecular ID)*

NTM Disease Clinical Manifestations

- Pulmonary (75%)
  - MAC
  - *M. kansasii*
  - *M. xenopi*
  - *M. abscessus*
  - *M. malmoense*

NTM Disease Clinical Manifestations

Skin and Soft tissue (15%)
- MAC, *M. marinum, M. abscessus, M. chelonae, M. fortuitum, M. kansasii, M. ulcerans*

Lymph node disease (5%)
- *MAC, (historically also M. scrofulaceum)*

Disseminated (5%)
- MAC, *M. kansasii, M. abscessus, M. chelonae, M. haemophilum*

Hypersensitivity pneumonitis (0%)
- *MAC and hot-tubs*

42 - Nontuberculous Mycobacteria in Normal and Abnormal Hosts

Speaker: Kevin Winthrop, MD

Important Bug-Setting Associations

- Corneal Disease
  - *M. chelonae*
- Healthcare/hygiene associated outbreaks
  - *M. chelonae, M. fortuitum, M. abscessus*
- Line-associated
  - *M. mucogenicum*
- HIV setting
  - *MAC, M. kansasii, M. genavense, M. haemophilum*
- Tropical setting
  - *M. ulcerans* (buruli ulcer)

Other Pearls Based on Species

- *M. gordonae*
  - *Contaminant*
- NTM are not communicable
  - Except *M. massilense* in CF
- *M. immunogenum, M. simiae*
  - Pseudo-outbreaks
- *M. szulgai*, *M. kansasii*, and *M. marinum*
  - Cross-react with IGRAs
- *M. fortuitum* lung disease
  - Aspiration
- *M. marinum*
  - Fish and fishtanks

Question #1

2020 INFECTIOUS DISEASE BOARD REVIEW — PREVIEW QUESTION

72 year old female with chronic cough, normal CXR, and 1/3 sputums grow MAC. Which one of the following you do recommend ?

A. CT scan of chest AND Additional sputum AFB cultures
B. Empiric therapy with azithromycin, ethambutol, and rifampin
C. Additional sputum AFB cultures
D. Wait for in vitro susceptibility data and then treat.

Pulmonary NTM

2007 ATS/IDSA diagnostic criteria:

- Patient has both radiographic evidence of disease and pulmonary symptoms

AND

- At least 2 sputum cultures positive, or
- One BAL or tissue specimen with positive culture, or
- Tissue with granulomatous histopathology in conjunction with positive culture (BAL or sputum)

Griffith D et al. *AJRCCM* 2007

Pulmonary NTM

- MAC is most common etiology (60-90%)
- M. kansasii and M. abscessus
  - *M. kansasii* primarily in the South
  - Recent *M. abscessus* increase in CF
- Other organisms of importance
  - *M. xenopi* (northern US/ Canada, Europe)
  - *M. malmoense* (Europe)

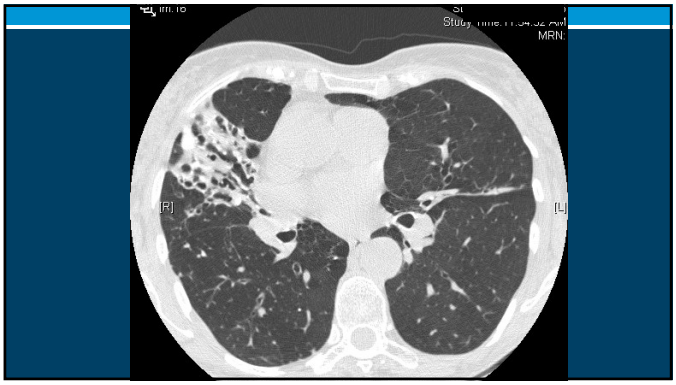
Two Types of MAC Pulmonary Diseases

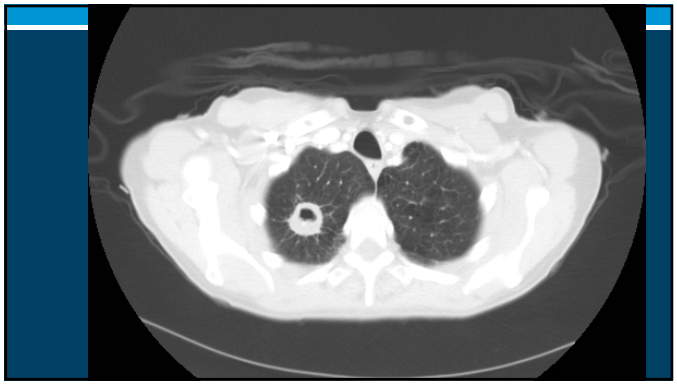
- Older male, smoker, COPD
  - Apical cavitary or fibronodular disease
  - More rapidly progressive
- Older female ("Lady-Windermere")
  - Scoliosis, thin, pectus deformities*, hypomastia
  - Nodular and interstitial nodular infiltrate
  - Bronchiectasis right middle lobe / lingula
  - Bronchiolitis ("tree and bud") on HRCT
  - Slowly progressive

*Iseman MD et al. *Am Rev Respir Dis.* 1991

42 - Nontuberculous Mycobacteria in Normal and Abnormal Hosts

Speaker: Kevin Winthrop, MD





Pulmonary NTM Risk Factors

- Underlying lung architectural abnormalities
  - Bronchiectasis, CF, α-1, emphysema
  - Prior TB, GERD/aspiration
- Exposure/transmission
  - Gardening/soil, Hot tubs
- Immunosuppressives
  - Prednisone, inhaled corticosteroids, biologics

NTM Pulmonary Disease Diagnosis

- Diagnosis ≠ decision to treat
  - Observation vs. suppression vs. cure

MAC Therapeutic Options

- Treatment best defined for MAC
  - Start Macrolide, rifampin, ethambutol
  - Amikacin first 1-2 months for cavitary disease
  - Treatment duration 18-24 months (12 month culture negative)
  - Macrolide monotherapy is contraindicated
  - Recommended to test susceptibility for macrolide
  - TIW okay if non-cavitary or not re-infection

42 - Nontuberculous Mycobacteria in Normal and Abnormal Hosts

Speaker: Kevin Winthrop, MD

Pulmonary M. kansasii Therapy

- *M. kansasii* clinically more like TB
  - Thin-walled cavities, upper lobes
  - Treatment with INH, RIF, EMB
  - TIW therapy ok
  - Treatment duration: 12 months culture negativity
  - High treatment success rates (90%+)
  - RIF is key drug.

Pulmonary M. abscessus Therapy

- *M. boletti, M. massiliense, M. abscessus*
  - Inducible macrolide resistance--erm (41) gene
- "Cure" = rare
- More rapidly progressive than MAC
- 3-4 drugs for 18-24 months
  - 4-6 months "induction" phase
  - "suppressive strategy" thereafter

M. abscessus Therapy

- Parenteral agents
  - Tigecycline 50mg QD, Cefoxitin 2gm TID, Imipenem 1000mg BID, Amikacin 10mg/kg TIW
- Oral agents
  - Clofazimine 50-100mg QD, *Linezolid 600mg QD, moxifloxacin 400mg QD (rarely suscep)*
  - Surgical resection

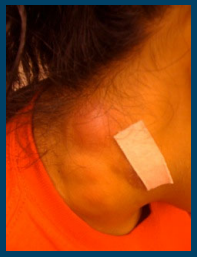
EXTRAPULMONARY NTM

1. Immunocompetent settings
2. Immunocompromised settings

Immunocompetent settings

- Nail salon, trauma, surgical or injection procedures, fishtank, hot tubs
- Rapid or slow growing NTM
- Incubation period
  - Infection usually occurs 2-8 weeks after contact with contaminated water source

Children under 5 years NTM > TB



- Usually MAC
  - Males > females, age 1-2 years old
- Surgical resection alone is best therapy
- Adjunctive ABX rarely needed

42 - Nontuberculous Mycobacteria in Normal and Abnormal Hosts

Speaker: Kevin Winthrop, MD

Post- plastic surgery

- Usually Rapid Grower:
  - *M. chelonae*
- Remove foreign-bodies
- Therapy as per in-vitro susceptibility
- Length 4-6 months

M. marinum---fish tank granuloma

Treatment: multiple drugs

- Macrolides, sulfonamides, doxycycline, rifampin, ethambutol
- Treat with 2 agents X 3-4 months.
- Surgical debridement if necessary

Nail Salon Furunculosis

- Outbreaks and sporadic
- Rapid Growers most common (*M. fortuitum)*
- Oral antibiotics
  - 4 months fluoroquinolone and/or doxycycline
  - Can be self-limited

Tattoo-associated

- *M. chelonae*
- Tattoo-ink outbreaks
- 2-3 months oral therapy
  - Based on *in-vitro* susceptibility
  - 1-2 agents
  - Macrolides almost always

Question # 2

20 y.o. male complains of fever, night sweats and weight loss. Has generalized lymphadenopathy. HIV antibody positive; CD4 20 cells/ul. Node biopsy: non-caseating granuloma, AFB seen.

Question # 2

Based on the most likely diagnosis, which of the following do you recommend :

A. Start MAC therapy
B. Start HAART plus MAC prophylaxis
C. Start MAC therapy and HAART
D. Start HAART only

42 - Nontuberculous Mycobacteria in Normal and Abnormal Hosts

Speaker: Kevin Winthrop, MD

NTM in HIV

- Disseminated MAC
- GI route of infection
- Less frequent in HAART era
- Related issues
  - Clofazimine = increases mortality (do not use!)
  - Rifabutin dose adjustment with PI
  - Immune reconstitution inflammatory syndrome (IRIS)

TABLE 7. REGIMENS FOR TREATMENT AND PREVENTION OF DISSEMINATED *MYCOBACTERIUM AVIUM* IN HIV-INFECTED PATIENTS

Preferred (A, I)*	Alternative (B, I)*
Treatment	
Clarithromycin 500 mg orally twice daily + Ethambutol 15 mg/kg orally daily ± Rifabutin† 300 mg orally daily	Azithromycin 500 mg daily + Ethambutol 15 mg/kg daily ± Rifabutin† 300–450 mg orally daily
Prevention‡	
Azithromycin 1,200 mg orally weekly	Clarithromycin 500 mg orally twice daily or Rifabutin† 300 mg orally daily

* For evidence quality, see Table 1.
† Rifabutin dose may need to be modified based on drug–drug interactions (see text).
‡ Preventive therapy indicated for persons with < 50 CD4+ cells/μl; may stop if > 100 cells/μl.

Griffith D et al. AJRCCM 2007

Immunosuppression other than HIV

- Most frequently disseminated
  - Local inoculation versus GI route
- Risk factors and conditions
- ESRD, prednisone, biologic immunosuppressives
- Cancer, transplant, leukemia (hairy cell)
- Auto-antibody and cytokine/receptor deficiency states
  - INF-gamma, IL12-23 pathway, STAT-1
- Disease split between RGM and slow growers
  - RGM more common here than in pulmonary disease

M. chelonae in cancer patient

M. chelonae and *M. fortuitum* treatment

- *M. chelonae*
  - Macrolides,flouroquinolone, linezolid
  - IV drugs include aminoglycosides, imipenem, cefoxitin, tigecycline
  - Note: tobramycin is best for *M. chelonae*
- *M. fortuitum*
  - Macrolides, flourquinolone, bactrim, doxy (50%)
  - IV drugs include aminoglycosides, imipenem, cefoxitin, tigecycline

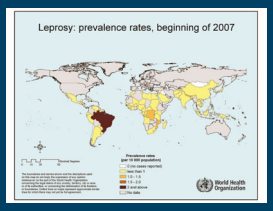
Length of treatment for disseminated infection
3 drugs (including 1 IV) X 4-6 months
Depends on immunosuppression reversal

MYCOBACTERIUM CHIMAERA

- Slow growing. M. avium complex.
- Requires molecular identification
- Over 150 cases from open heart surgery: prosthetic valve, vascular graft, LVAD, heart transplant
- Aerosol from contaminated heater-cooler units used in operating room for cardiac by-pass.
- Time to diagnosis 1.7-3.6 years post-op, with cases reported up to 6 years postoperatively.
- Mycobacterial blood cultures
- Treatment: ???

Hansen's Disease (Leprosy)

- Rare in US (40-50 cases per year)
  - Armadillos and gulf region
  - Rest imported
- Most humans resistant
  - Household contacts at risk (low risk)
  - Nasopharyngeal transmission?
- *M. leprae* does not grow in culture



42 - Nontuberculous Mycobacteria in Normal and Abnormal Hosts

Speaker: Kevin Winthrop, MD

Leprosy Disease Classification

- Paucibacillary (PB)
- Most common form
  - *"Tuberculoid"*
  - Bacillary load < 1 million
  - Skin biopsy: AFB negative
  - ≤5 skin lesions
- Multibacillary (MB)
  - *"Lepromatous"*
  - Massive bacillary load
  - Skin biopsy: Floridly positive for AFB
  - >5 skin lesions.

Leprosy Treatment

- PB (6 months)
  - Dapsone 100mg daily
  - *Rifampin 600mg once monthly
- MB (12 months)
  - Dapsone 100mg daily
  - Clofazamine 50mg daily
  - *Rifampin 600mg once monthly OR
  - *Clofazamine 300mg once monthly

Complications: reversal reactions, erythema nodosum
Treat with prednisone, thalidomide, other

Top 10 or 12 NTM pearls for the Boards

- Footbaths = *M. fortuitum* or other RGM
- *Plastic Surgery* = *M. chelonae* or other RGM
- Equitorial Africa = *M. ulcerans*
- HIV disseminated MAC that doesn't grow = think of *M. genavense*
- M. abscessus usually has inducible macrolide resistance (erm gene)
- Macrolide, EMB, RIF for 18-24 months for pulmonary MAC
- *M. gordonae* is 99.9% a contaminant
- ATS/IDSA pulmonary case definition: need one BAL or two sputums or tissue
- Know NTM species that cross-react with TB IGRAs
- No clofazimine in HIV related MAC
- *M. kansasii* behaves like TB---responds to TB drugs (RIF, EMB, INH)
- PZA not useful for any NTM