Presumed to Peril: Disseminated Mycobacterium Abscessus Unveiled by TNF Inhibitor in a Misdiagnosed 21-Year-Old

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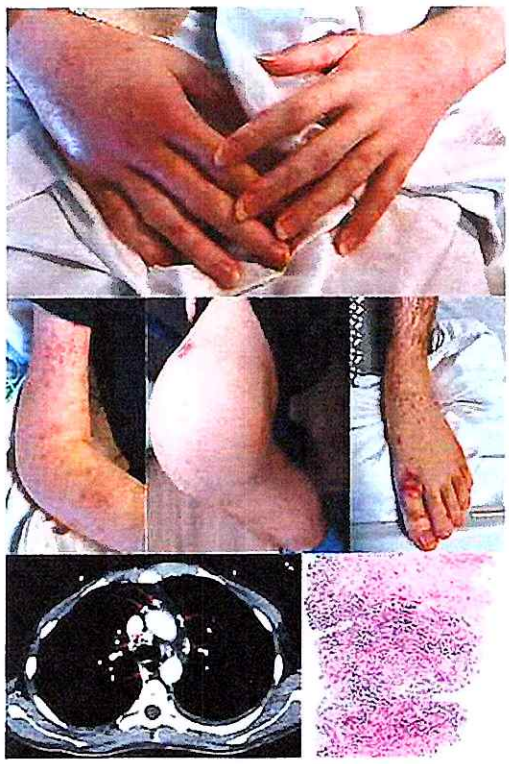
Abstract:

A young adult was diagnosed with sarcoidosis and started on oral steroids and then infliximab. Symptoms instead worsened, leading to a final diagnosis of disseminated mycobacterium abscessus.

A 21 year-old male, with a family history of sarcoidosis, had symptoms of night sweats, fever, chills, weight loss, and skin nodules. Infectious work up was initially normal. CT and MRI imaging showed calcified mediastinal, abdominal, and retroperitoneal lymph nodes. The first left retroperitoneal lymph node biopsy showed necrotizing inflammation. The second one showed a vaguely granulomatous appearance, but no well-formed true granulomas, and an area of necrosis. Biopsy of a subcutaneous mass showed necrotic tissue.



He was diagnosed with sarcoidosis on the basis of his biopsy showing necrotizing inflammation, family history, persistent fever, and negative infectious workup. ACE level and lysozyme levels were normal, and serologies were negative for ANCA vasculitis, SLE, rheumatoid arthritis. He continued to have symptoms on high dose prednisone, so he was started on infliximab. He developed polyarthritis after the first infusion, which was presumed to be due to sarcoidosis. Patient had a high fever during the second infusion of infliximab. His repeat blood cultures, skin biopsy, and synovial fluid culture from right knee arthrocentesis grew mycobacterium abscessus. Bone marrow biopsy for pancytopenia was negative for infection, leukemia, lymphoma, and sarcoidosis in the bone.

This is a rare case presentation of mycobacterium infection that was initially considered to be sarcoidosis and only revealed after starting treatment with a TNF alpha inhibitor. It is well known that TNF alpha inhibitors can worsen mycobacterium infections, which is what triggered the dissemination of infection in our patient to his skin, joints, lungs, and lymph nodes. On retrospective evaluation, it is unlikely that he has sarcoidosis as he did not improve with prednisone or infliximab infusion and biopsy showing necrotizing inflammation can present with mycobacterium infections. Patient's gene study showed he has GATA2 deficiency and his clinical presentation can be explained by Mono-Mac syndrome.