UNUSUAL SEPTIC MANIFESTATIONS OF ADVANCED HIV

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A 42-year-old Malaysian man was transferred from a rural hospital with chest pain and sepsis. Computed tomography (CT) scanning revealed a cavitary right upper lobe pneumonia, bilateral pleural effusions, widespread lymphadenopathy and hepatosplenomegaly, concerning for tuberculosis (TB). Past medical history was unavailable in the setting of critical illness and language barrier.

HIV serology was positive, with a viral load of 4.5 million copies/ml and CD4 count below 35 cells. Sputum culture was positive for *Nocardia abscessus* and subsequent cultures revealed acid fast bacilli (AFBs). Empirical Nocardia and TB therapy were commenced, with transition to MAC therapy following serial negative TB PCR. Bronchoscopy additionally demonstrated a weakly positive *Pneumocystis jirovecci* PCR. Biopsy of a destructive rib lesion revealed AFBs on histopathology and cultured *Nocardia abscessus*.

He was intubated peri-cardiac arrest on day four. Mycolytic blood cultures grew mixed Candida – C. *albicans* and C. *glabrata*. He had oropharyngeal candidiasis, but the source of candidaemia was unclear. Ophthalmic examination revealed candida chorioretinitis, with no evidence of CMV retinitis, despite moderate CMV viraemia. He was treated with caspofungin. Other complications included persistent bicytopenia and delirium.

He was initiated on tenofovir disoproxil/emtricitabine and dolutegravir one week after commencing treatment for Nocardia and MAC, with good virologic response.

A lip lesion and progressive deterioration in conscious state with seizure activity occurred one week after starting antiretroviral therapy. Brain MRI revealed parenchymal changes predominantly in the temporal lobes, consistent with HSV encephalitis, and early ventriculitis. Both CMV and HSV-1 were identified from the lip lesion and CSF. Electroencephalogram demonstrated non-convulsive status epilepticus. He remains critically unwell on ganciclovir.

Nocardiosis and Candida sepsis with chorioretinitis are unusual manifestations of advanced HIV, co-existing in our case with AIDS-defining illnesses. This patient's continuing severity of illness, language barrier and residential status added further complexity to a difficult case.

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