Virulent Course of Bacterial Pneumonia in a Male Homosexual

To the Editor:

We have had occasion to review some of the case reports by White and associates on "Life-Threatening Bacterial Pneumonia in Male Homosexuals with Laboratory Findings of A.I.D.S." We would like to report a case with features that are very similar to Dr. White's case.

Our patient was a 32-year-old male homosexual who was admitted to Hahnemann University Hospital in September, 1981 with severe right-sided abdominal pain, nausea and vomiting. His past medical history was completely negative except for chronic active hepatitis treated in another state. Chest x-ray examination on admission demonstrated a small patchy infiltrate in the right lower lobe. The patient's mental status was clear and there was no evidence of aspiration. U.G.I. test results were negative, with no evidence of esophageal perforation. Soon after admission, the patient began to spike high fevers and complain of severe bilateral pleuritic chest pain. Blood cultures were positive for small gram-negative rods, which subsequently grew out Hemophilus influenzae. Within 48 hrs of admission, his pulmonary status began to markedly deteriorate. His chest x-ray film showed bilateral infiltrates associated with large bilateral effusions. Bilateral chest tubes were placed and approximately 1.5 L of pus drained from each hemithorax. The drainage from both chest tubes grew out H. influenzae. A laparotomy was performed and results were unremarkable. The patient was started on therapy with ampicillin, 2 g i.v. every four hours. Four days after admission, chest x-ray film showed a widening in the cardiac silhouette. A bedside echocardiographic examination showed a large pericardial effusion. A sub-xiphoid pericardial tube was placed, which drained 250 ml of pus also containing H. influenzae. The patient continued to have a stormy course and was switched to therapy with intravenous choloramphenicol. A repeat echocardiographic examination showed reaccumulation of pericardial fluid despite the pericardiocentesis. Chest x-ray films also revealed worsening of pleural effusions despite chest tube drainage in good position. Post-operatively, the patient continued to reaccumulate pleural and pericardial fluid. He remained febrile and extremely toxic. He was taken back to surgery 24 hrs after the pericardial tube placement for a pericardectomy; bilateral decortication and drainage of mediastinal pus. The patient improved for a brief period of time; however, a repeat CT scan showed more pleural and pericardial collection. The patient returned to surgery yet another time for more drainage of pus. This time, he became afbrile post-operatively and subsequently began to recover despite a superinfection of the pleural space with enterococcus. The patient exhibited absence of delayed skin test reactivity throughout the hospitalization, and lymphopenia was also present throughout. After a prolonged and stormy hospital course, the patient finally recovered and was sent home. His total hospital time was over 10 wks. He was followed and remained well for approximately one year following these events and was then lost to follow-up.

The identification of helper/suppressor T-cell subsets was unavailable at this institution at that time.

Discussion

Hemophilus influenzae is a gram-negative organism which is classically seen to cause a wide spectrum of disease in the pediatric age group. While thought to be less common in adults, the literature reports numerous cases of H. influenzae infections in adults of all ages. These patients are typically middle-aged and older and have some type of associated medical disorder.

The patient we have just reported developed an overwhelming virulent course with Hemophilus influenzae, which would be very uncommon in a previously healthy 32-year-old man. The combination of mediastinitis, pericarditis and bilateral empyema is very rare as a complication of pneumonia in any patient population. There was no evidence that these complications arose from esophageal rupture. We agree with Dr. White that bacterial infections may be important in the immune status of the homosexual population. The clinical care of this homosexual patient certainly is not typical and further understanding of the immune status of these individuals is certainly warranted, especially involving their B-cell function.

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Reference


AeroBid Inhalers

To the Editor:

In January 1985, Key Pharmaceuticals supplied five AeroBid (flunisolide) inhaler systems. While demonstrating these units to patients, it became apparent that using the device as specified in the manufacturer's instructions did not release one dose of medication, despite multiple depressions of the cartridge. A series of tests (Table 1) were performed to compare the AeroBid inhaler system to the Beclomethasone (Glaxo) inhaler and the Azmacort (triamcinolone acetonide, Rorer) inhaler.

Table 1—Number of Depressions Needed to Deliver Metered Dose Inhaler Medication

<table>
<thead>
<tr>
<th>Number of depressions</th>
<th>Total Units Tested</th>
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<tr>
<td>1</td>
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<td>3</td>
<td>4</td>
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<td>5</td>
<td>6</td>
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AeroBid: 1 1 2 1 5
Beclomethasone: 3 2 5
Azmacort: 1 4 5