Pneumocystis Pneumonia (PCP)

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Pneumocystis pneumonia (PCP) is a potentially life-threatening infection that occurs in immunocompromised individuals [1]. The following illustrates such a case: A 59-year-old non-smoker male who works as a teacher presented with a 3-week history of dry cough and shortness of breath. He denied any night sweats but complained of losing 6 kg of weight over a 3-month period. He has a past history of rheumatoid arthritis for which he takes adalimumab. He has no significant family history and lives with his wife. On examination, he was pyrexic with a temperature of 38.5 degrees Celsius, tachycardic and hypoxic.

There was no raised JVP, no cervical lymphadenopathy, heart sounds were normal with no murmur and there was good air entry bilaterally on auscultation of his chest. Abdomen was soft and non-tender with no organomegaly and neurological examination was normal. His inflammatory markers and LDH were mildly raised.

Figure 1: CXR showing bilateral interstitial infiltrates.

His CXR showed bilateral interstitial infiltrates. He was subsequently booked for a CT Thorax which showed ground glass opacities bilaterally. He was then booked for a bronchoscopy and had a Broncho alveolar lavage which came back positive for Pneumocystic pneumonia (PCP). His HIV status was negative. He was started on trimethoprim-sulfamethoxazole.

In patients without HIV infection, PCP typically presents as fulminant respiratory failure associated with fever and dry cough. This is in contrast to PCP in HIV-infected patients, in whom the infection is usually indolent [2]. The typical radiographic features of PCP in HIV-uninfected patients are diffuse, bilateral, interstitial infiltrates [3]. PCP is most commonly diagnosed by microscopy with staining of an induced sputum specimen or Broncho alveolar lavage fluid [4]. Trimethoprim-sulfamethoxazole is the preferred medication for the treatment of PCP in patients without HIV infection. The usual duration of therapy is 21 days. The outcomes for immunocompromised patients without HIV infection treated for PCP are generally worse than in those with HIV infection; mortality from PCP in patients with HIV is approximately 10 to 20 percent compared with 35 to 50 percent in those without HIV.

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**Figure 2:** CT Thorax showing ground glass opacities.

**Bibliography**


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