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Paradoxical deterioration during anti-tubercular treatment in a dialysis patient on maintenance steroid therapy

We report a 38-year-old Chinese woman with lupus nephritis on peritoneal dialysis and long-term maintenance steroid therapy. This patient developed paradoxical deterioration during anti-tubercular therapy for tuberculous lymphadenitis. The deterioration resolved spontaneously without change to pharmacotherapy. Paradoxical deterioration that may spontaneously resolve is a potential complication of anti-tubercular treatment in patients on long-term renal replacement therapy.

Patients with chronic renal failure are more prone to opportunistic infections, including tuberculosis. In patients undergoing continuous ambulatory peritoneal dialysis (CAPD), the prevalence of tuberculosis is several times higher than that of the general population. Nonetheless, a paradoxical response during anti-tubercular therapy has not been reported in such patients and has not, apparently, been previously described in patients receiving long-term steroid therapy. We report a patient with underlying lupus nephritis on CAPD and maintenance steroid therapy who demonstrated a paradoxical deterioration during treatment for tuberculous lymphadenitis.
Case report

The patient was a 38-year-old Chinese woman with end-stage renal failure secondary to lupus nephritis who commenced haemodialysis in 1995. In March 2002, she switched to CAPD because of failed vascular access. A history of cerebral lupus was noted for which long-term maintenance steroid therapy was prescribed (prednisolone 5 mg daily). Lupus activity had been clinically and serologically inactive following commencement of renal replacement therapy.

In September 2002, the patient presented with fever and appearance of a left upper neck swelling. Physical examination revealed enlarged left upper cervical lymph nodes. No other lymph nodes were affected, nor were the liver or spleen. Preliminary investigations revealed the following: normal total white cell count (4.4 x 10^9 /L) with relative lymphopenia (0.6 x 10^9 /L), haemoglobin level of 67 g/L, and platelet count of 90 x 10^9 /L. Erythrocyte sedimentation rate was 32 mm/h and C-reactive protein was elevated at 34.4 mg/L (reference level, <7.6 mg/L). Serum electrolytes and liver function tests were unremarkable. Serum albumin and globulin levels were 23 g/L and 40 g/L, respectively. Her lupus serology was quiescent: antinuclear factor titre 1/160, anti-DNA titre less than 1 IU/mL (reference range, 0-35 IU/mL), complement levels normal (C3, 1140 mg/L [reference range, 760-1500 mg/L]; C4, 300 mg/L [reference range, 90-350 mg/L]). She was seronegative for HIV. Chest radiography revealed clear lung fields and nasal endoscopy was normal. Fine needle aspiration of the left cervical lymph node yielded several millilitres of pus-like material. Smear examination and culture of the aspirate indicated that the acid-fast bacilli were not viable after 2 weeks of anti-tubercular treatment. This, together with the spontaneous resolution of lymphadenopathy while continuing anti-tubercular drugs and with no change in steroid dosage, suggested a diagnosis of paradoxical deterioration. The paradoxical deterioration resolved spontaneously with continuation of anti-tubercular drugs and with no change in steroid dosage.

Discussion

We report a lupus patient on CAPD and maintenance steroid therapy who developed paradoxical deterioration during treatment for tuberculous lymphadenitis. The paradoxical deterioration resolved spontaneously with continuation of anti-tubercular drugs and with no change in steroid dosage.

Paradoxical deterioration during anti-tubercular treatment is diagnosed by exclusion. Enlargement of cervical lymph nodes and appearance of new enlarged lymph nodes in the axilla after initial improvement on anti-tubercular therapy suggests a number of differential diagnoses: inadequate anti-tubercular treatment due to drug resistance or poor drug compliance, concomitant bacterial infection, and, rarely, re-activation of lupus activity. Nonetheless, supervision of anti-tubercular therapy together with biochemical and microbiological testing excluded them all. The demonstration of acid-fast bacilli on direct smear but not from culture of the patient’s axillary lymph node aspirate indicated that the acid-fast bacilli were not viable after 2 weeks of anti-tubercular treatment. This, together with the spontaneous resolution of lymphadenopathy while continuing anti-tubercular treatment, suggested a diagnosis of paradoxical deterioration. The surge in lymphocyte count during the time of apparent clinical deterioration further supported this diagnosis.
The pathogenesis of paradoxical deterioration during anti-tubercular treatment remains to be fully elucidated. It may be related to the development of enhanced immunological responses against \textit{M. tuberculosis} during the course of anti-tubercular therapy.\textsuperscript{16,17} In HIV-infected patients who develop paradoxical deterioration during anti-tubercular treatment after having received highly active antiretroviral therapy, clinical deterioration may be due to the immune reconstitution inflammatory syndrome, an exuberant inflammatory response towards the incubating \textit{Mycobacterium}.\textsuperscript{18} Corticosteroids have been prescribed to treat paradoxical deterioration.\textsuperscript{7} Interestingly this offered no protection for the patient reported here. The dose was nonetheless small and might have been insufficient to entirely suppress the inflammatory response. The concomitant administration of isoniazid might also have reduced the effectiveness of the steroid.

There is no consensus on the optimal treatment for paradoxical deterioration during anti-tubercular treatment. The condition may be self-limiting as demonstrated by our patient. An expectant approach is probably called for with the continuation of anti-tubercular and pre-existing steroid therapy. Such an approach will also avoid the problem of side-effects associated with high-dose steroid therapy.

Paradoxical deterioration during anti-tubercular treatment can occur in CAPD patients on maintenance steroid therapy. Although self-limiting, clinicians should recognise this potential complication. In the absence of other causes of clinical deterioration, spontaneous resolution can be expected with no change required to any anti-tubercular or other concomitant pharmacotherapy.

References