**Mesenteric lymphadenopathy caused by Penicillium marneffei in a renal transplant recipient**

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A 38-year old second cadaveric renal transplant recipient presented with fever, chills, and rigor and paraumbilical abdominal pain for 3 days. He had a biopsy-proven acute cellular rejection 4 months before the admission requiring pulse steroid treatment and intensification of the immunosuppressive regime. His immunosuppressive regimen consisted of prednisolone 7.5 mg daily, tacrolimus 1.5 mg in the morning, and 1 mg in the afternoon, and mycophenolate mofetil 750 mg twice a day at the time of presentation. Physical examination revealed mild tenderness over the paraumbilical area with no guarding or rebound. No hepatomegaly or splenomegaly was detected. Investigation revealed normochromic normocytic anemia (hemoglobin 7.7 g/dL), low white cell count with lymphopenia (0.1 x 10^9/L), and mildly prolonged prothrombin time and activated partial thromboplastin time. Renal and liver function tests revealed sodium 125 mM, potassium 4.1 mM, bicarbonate 14 mM, urea 28.1 mM, creatinine 385 μM, bilirubin 15 μM, alkaline phosphatase 161 IU/L, alanine aminotransferase 26 IU/L. His fever did not respond to broad-spectrum antibiotic therapy.

Enhanced-contrast computer tomography of abdomen revealed a group of enlarged mesenteric lymph nodes matted together (Panel A). Ultrasound-guided fine needle aspiration biopsy of the mesenteric lymph nodes showed small amount of necrotic material mixed with histiocytes. There were fair amounts of yeast-like organisms found on Grocott and periodic acid SCHIFF reaction with diastase (PASD) stain. These organisms were round to oval, measured 3 to 6 microns in diameter, and some contained cross-septation. The histology was consistent with *Penicillium marneffei* infection (1). Blood culture and marrow blood culture later showed positive culture for *P. marneffei*. His condition improved after intravenous amphotericin B therapy and the patient was discharged on day 30.

Disseminated *P. marneffei* is a unique dimorphic fungal infection endemic in southeast Asia, southern China, and Hong Kong. It is one of the commonest opportunistic infections among acquired immunodeficiency syndrome (AIDS) patients in areas of endemicity, and is considered an indicator disease for AIDS. It has also been reported in patients who have impaired cellular immunity (2,3). The common presenting symptoms include fever, anemia, weight loss, fungemia, pulmonary infiltrates, and lymphadenopathy (3). The diagnosis is usually made by identification of the fungus in clinical specimen. Intravenous amphotericin B followed by oral itraconazole therapy is usually effective in controlling the infection (4). High index of suspicion, especially in human immunodeficiency virus negative patients, is required for early diagnosis and treatment of this potentially treatable infection.

**REFERENCES**