

Hydroxychloroquine/tacrolimus

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Peripheral T-cell lymphoma unspecified and acute hypoxaemic respiratory failure: case report

A 44-year-old woman developed peripheral T-cell lymphoma unspecified and acute hypoxaemic respiratory failure following treatment with hydroxychloroquine and tacrolimus [*routes, dosages and time to reactions onsets not stated*].

The woman had antisynthetase syndrome (ASS) and rheumatoid arthritis since 18 years which was complicated by nonspecific interstitial pneumonitis since 5 years. She was started on hydroxychloroquine and tacrolimus ASS. Her initial BP was 149/59mm Hg, RR was 26/minute, body temperature was 38.2°C, HR was 103 /minute and pulse oximetry was 79% on room air. She had coarse bi-basilar crackles and was in mild to moderate respiratory distress. New diffuse bilateral patchy alveolar and interstitial opacities were revealed by chest radiography. Her platelet count was 2 68 000, haemoglobin was 12.2 g/dL, WBC was 24 500 /mm³ (54% lymphocytes and 38% neutrophils), blood urea nitrogen was 26, creatinine was 1.01 mg/dL and potassium was 5.0 mEq/L. Initial differential diagnoses comprised of an acute exacerbation of interstitial lung and the adult respiratory distress syndrome (ARDS) from infection. She was supported with high-flow oxygen via nasal cannula after being admitted to the ICU. She was empirically on antimicrobials targeting health care-associated infectious pneumonia-induced ARDS, but she failed to improve. A bilateral patchy consolidation and multiple enlarged axillary and mediastinal lymph nodes were revealed by a chest CT on hospital day 2. Her hypoxaemia and clinical condition continued to decline requiring an endotracheal intubation on hospital day 3. On hospital day 5, video-assisted thoracoscopic biopsies from the right middle and lower lobes revealed peripheral T-cell lymphoma, not otherwise specified. Staging evaluation showed stage 4 disease.

The woman was commenced on a chemotherapeutic regimen of vincristine, cyclophosphamide, doxorubicin and prednisone on hospital day 10. An interval improvement in pulmonary infiltrates and patchy consolidation was revealed by a chest CT. On hospital day 13, she was extubated. She was discharged on hospital day 28 with 3 L/minute O₂. She showed complete resolution of hypoxaemic respiratory failure

Author comment: *"Proposed mechanisms for this association includes dysregulated immunity and chronic immunosuppression in RA, which disables the immune system from surveying and suppressing neoplastic lymphoid cell line and virus growth."* *"Our case highlights 2 rare and important findings. First, our case highlights malignancy in the setting of ASS. Second, it highlights the presentation of PTCL-NOS as an acute hypoxemic respiratory failure in a patient with ASS."*

Aqeel M, et al. An unusual suspect causing hypoxemic respiratory failure. Journal of Investigative Medicine High Impact Case Reports 5: 1-5, No. 1, 01 Jan 2017.
Available from: URL: <http://doi.org/10.1177/2324709616687587> - USA

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