

Piroon Mootsikapun, M.D.

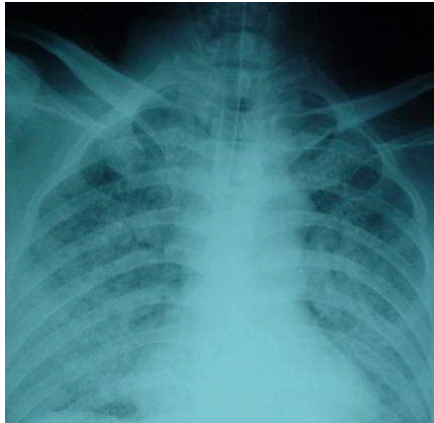


Figure 1. Chest radiography of a 68-year-old monk.

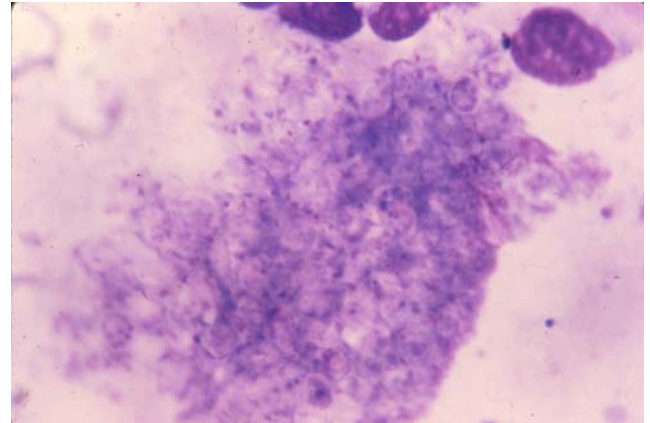


Figure 2. Wright-Giemsa staining of bronchoalveolar lavage.

***Pneumocystis jirovecii* pneumonia**

A patient with *Pneumocystis jirovecii* (previously *P. carinii*) pneumonia¹ commonly presents at the emergency room with acute respiratory failure. It may be the first clinical presentation among HIV-infected patients. Therefore, the physician should consider this opportunistic infection in all patients who present with bilateral progressive pneumonia. A careful physical examination may reveal some clinical clues that suggest HIV infection, and anti-HIV antibody test should be promptly performed. Early diagnosis and treatment will reduce the mortality and morbidity.²

P. jirovecii is now considered a fungus. A unique character of this fungus seen with Wright staining includes ill-defined, amorphous, smoky, dusty aggregates of free trophozoites and/or multiple cysts of 4-8 μ m containing 4-8 trophozoites (Figure 2).

Cotrimoxazole of 15-20 mg/kg/day for 21 day is

the treatment regimen of choice. The patients who have hypoxemia with PaO₂ of <70 mmHg or P(A-a) gradient of greater than 35 mmHg should receive concomitant steroid therapy. After initial treatment, all patients must have cotrimoxazole for secondary prevention of recurrence until they receive antiretroviral therapy and their CD4 cell count is greater than 200 cells/mm³ for at least 3 months.³

References

1. Stringer JR, Beard CB, Miller RF, Wakefield AE. A new name (*Pneumocystis jirovecii*) for *Pneumocystis* from humans. *Emerg Infect Dis* 2002;8:891-6.
2. Alves C, Nicolas JM, Miro JM, et al. Reappraisal of the aetiology and prognostic factors of severe acute respiratory failure in HIV patients. *Eur Respir J* 2001;17:87-93.
3. Thomas CF Jr, Limper AH. *Pneumocystis pneumonia*. *N Engl J Med* 2004;350:2487-98.