Acute Cervical Lymphadenopathy

To the Editor: Acute cervical lymphadenopathy has not been reported as a symptom of *Mycobacterium genavense* infection. In June 1994, a 32-year-old injecting drug user, who had been monitored since 1987 for human immunodeficiency virus (HIV) infection at the outpatient clinic of the Infectious Disease Institute, Perugia, Italy, was admitted to a hospital with fever (39°C) and progressive swelling over the submandibular region and neck. In addition to being febrile, upon physical examination the patient had tender left submandibular and cervical lymphadenopathy approximately 3 cm in diameter, with redness and edema of the overlying skin. The CD4+ lymphocyte count was 0.01 x 10^9/L. A specimen obtained by needle aspiration of the submandibular lymph node contained numerous acid-fast bacilli, and the patient was treated with isoniazid, rifampin, ethambutol, and amikacin for presumed *Mycobacterium tuberculosis* with a good response; however, 10 days later, the patient's submandibular pain recurred along with abdominal pain and bowel irregularities. Gastroscopy showed superficial duodenal erosions, and acid-fast bacilli were visualized by microscopy. Shortly thereafter, pain and swelling of the patient's right ankle developed, and small lesions were noted on the dorsum of the right foot. Clarithromycin was substituted for the amikacin for suspected without a clear response, and a course of steroids was initiated with clinical improvement. Symptoms recurred when the steroids were tapered. Ciprofloxacin was substituted for isoniazid, and amikacin was readministered. Material from a repeat needle aspiration of the submandibular node 1 month later also showed acid-fast bacilli by microscopy.

Cultures of the initial submandibular aspirate demonstrated poor growth in Bactec 13A broth and did not grow on solid media. The specimen was sent to a reference laboratory where acid-fast bacilli were successfully isolated 10 weeks later in Middlebrook agar containing mycobactin J. These acid-fast bacilli were subsequently identified as *M. genavense* by high-pressure liquid chromatography and nucleic acid sequencing of the 16S rRNA. By this point, the patient had improved on a regimen of isoniazid, pyrazinamide, clofazimine, and amikacin for presumed *M. genavense* infection, and this regimen was continued. The patient died 19 months later; cultures for mycobacteria were persistently negative even when antimycobacterial drugs were discontinued 16 months after the initial episode.

M. genavense is a novel mycobacterial species that causes serious disseminated infections with massive involvement of the small intestine, spleen, liver, and abdominal lymph nodes in profoundly immunocompromised persons. Cultures with Bactec 13A vials containing radiometric liquid medium are generally positive but subcultures on solid media are unsuccessful (1). Lowering the pH of medium to six enhances its growth (1), while adding mycobactin J to Middlebrook 7H11 (2) solid media can help in the isolation. The suppression of growth of *M. genavense* by NAP can cause confusion with the *M. tuberculosis* complex; however, *M. genavense* can be easily distinguished by its slow growth and its dysgonic nature. At present, the way to identify *M. genavense* is by 16S rRNA sequencing (3). High-pressure liquid chromatography can be used (4).

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