



Short Communication

Human metapneumovirus pneumonia in patients with hematological malignancies



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ABSTRACT

Background: Human metapneumovirus (HMPV) has recently emerged as a cause of respiratory infections in hematological patients. Clinical data are lacking to guide the management of HMPV pneumonias.

Objectives: To characterize the clinical and radiographic presentation and outcome of HMPV pneumonias diagnosed in hematological patients.

Study design: We screened the patients with a positive HMPV respiratory test in two French teaching hospitals between 2007 and 2011. Among them, the medical charts from the hematological patients who presented with HMPV pneumonia were reviewed.

Results: Among the 54 patients with several underlying hematological conditions who were positive for HMPV, we found 13 cases of HMPV pneumonias. HMPV could be the cause of pneumonia as a single pathogen without associated upper respiratory infection. Centrilobular nodules were constant on lung computed tomography scans. No patients died despite the absence of administration of antiviral treatments.

Conclusions: Our data provide further insights in the diagnosis and management of HMPV pneumonias in this setting.

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1. Background

The development of molecular techniques has highlighted the role of emerging respiratory viruses (RV), particularly in immunocompromised patients. Human metapneumovirus (HMPV)

is a paramyxovirus identified in the early 2000s that is closely related to the respiratory syncytial virus (RSV). The clinical spectrum of HMPV infections ranges from asymptomatic carriage in the airways to upper respiratory tract infection disease (URTID) and severe pneumonia [1–6]. To date, the few published epidemiological or clinical data on HMPV pneumonias in hematological patients have focused on hematopoietic stem cell transplant (HSCT) recipients [2–6], and this virus is still poorly recognized. Due to the lack of clinical data on HMPV infections, the fourth European conference on infections in leukemia could not make any recommendations for the management of HMPV infections in hematological patients in recent guidelines [7].

Abbreviations: HMPV, human metapneumovirus; HSCT, hematopoietic stem cell transplant; URTID, upper respiratory tract infection disease; BAL, bronchoalveolar lavage; RV, respiratory virus; HRCT, high resolution computed tomography.

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2. Objective

We sought to characterize the clinical and radiographic presentation and outcome of HMPV pneumonias diagnosed in hematological patients over a four-year period in two French teaching hospitals.

3. Study design

These cases were diagnosed in two French centers between January 1, 2007, and October 31, 2011. Hospital Saint Louis, Paris is a 650 bed teaching hospital that includes 350 beds dedicated to onco-hematology adult patients. The Poitiers teaching hospital has 1413 beds for both adults and children including 64 beds for onco-hematology. In both centers, RVs are screened in the nasopharyngeal aspirate and/or bronchoalveolar lavage (BAL) in all hematological patients who present with acute respiratory tract symptoms. In Hospital Saint Louis, Paris, from October 2007 to October 2009 HMPV was detected using immunofluorescence testing (Argene, Verniolle, France). Since November 2009, the detection of HMPV is performed using 200 μ L of respiratory specimen using a molecular multiplex assay, RespiFinder[®], (Pathofinder, Maastricht, The Netherlands), which enables the detection and differentiation of 14 RVs including the following: influenza viruses A and B; parainfluenza viruses, RSV; rhinovirus; human coronaviruses, adenovirus and HMPV [8]. In the Poitiers teaching hospital, during the study period, HMPV and other respiratory pathogens (Influenza viruses A and B, parainfluenza viruses, RSV, rhinovirus, human coronaviruses 229E and OC43, adenovirus, *Chlamydia pneumoniae* and *Mycoplasma pneumoniae*) were detected using multiplex or monoplex nucleic acid amplification [9–11].

Pneumonia was defined as the presence of dyspnea and/or hypoxia with a new infiltrate on imaging. URTID was defined as the presence of coryza, pharyngitis, sinusitis and/or cough with or without fever, no hypoxemia and clear chest imaging. BAL samples were tested for bacteria (direct examination and culture) and fungi (immunofluorescence and molecular biology for *Pneumocystis jirovecii*; direct examination and culture for other species). When bronchoscopy could not be performed, the presence of bacteria and fungi was evaluated in induced sputum samples. To describe the initial high resolution computed tomography (HRCT) findings in patients with HMPV pneumonia, we reviewed the HRCT scans performed shortly (<5 days) after the onset of symptoms.

4. Results

During the study period, a total of 11267 HMPV tests were performed in both centers (1677 immunofluorescence HMPV tests and 9590 molecular HMPV tests). HMPV was detected in a total of 171 respiratory samples (1.5%) in 131 patients including 77 patients of the general hospital population and 54 hematological patients.

Thirteen of these hematological patients (24%) had a diagnosis of HMPV pneumonia whereas the diagnosis of URTID was retained for the others. All the nonhematological patients positive for HMPV were diagnosed with URTID. The clinical features of the patients with pneumonia are described in Table 1. Six patients were allogeneic HSCT recipients, with a median time of 4.3 months [1.8–5.8] after HSCT and two had previously experienced an autologous HSCT. Nine of the HMPV infections occurred during the winter (69%), one in spring, one in autumn and two in summer. The infection was considered to be community acquired in 10 patients and nosocomial in three. Eleven patients had HMPV as a single pathogen, and 2 patients had rhinovirus co-infection of the lung. No bacteria or fungus was found in the respiratory samples at the time of HMPV pneumonia diagnosis. Seven patients with HMPV

pneumonia presented no URTID (54%). However, among the seven patients who did not present with URTI symptoms, a nasopharyngeal aspirate was available for five patients that were all positive for HMPV. Six patients presented with both URTID and pneumonia. All of the six patients who initially presented with URTID progressed to pneumonia with a mean interval of 4 days (range, 3–5 days). The most frequent symptoms were cough and dyspnea in all patients, fever in 11 (85%), and wheezing in 11 (85%). In 12 patients, a lung HRCT scan was performed at a mean time of 2.5 days after the onset of symptoms (range, 1–5 days). HRCT findings were mainly small blurred ill-defined centrilobular nodules, branching centrilobular nodules and ground glass opacities (Table 1, Fig. 1). Bilateral involvement was observed in all patients, predominantly in the lower lobes. Nine patients (69%) had lymphopenia (≤ 0.6 cells/ μ L), whereas 5 (38%) had neutropenia (< 500 cells/ μ L). Two patients were admitted to an intensive care unit, but none required ventilation.

None of the patients were treated with any antiviral therapy, such as inhaled or oral ribavirin. All patients received broad-spectrum antibiotics. HMPV pneumonia resolved in all patients, and they were all alive three months after HMPV pneumonia diagnosis.

5. Discussion

We found that HMPV pneumonia may occur in several hematological conditions although previous studies have focused on HSCT. Whatever the underlying condition, the clinical and radiological presentation was similar. Contrary to previously described findings, half of our patients had no signs of URTID in the days that preceded the diagnosis of HMPV pneumonia.

Lung CT scan is a cornerstone in the management of respiratory infections in hematological patients [12]. The presence of centrilobular nodules was strikingly noted in almost all of our cases of HMPV pneumonia and should suggest the diagnosis, especially in the winter. The fact that only rhinovirus was detected as copathogens in only two patients suggests that the HPMV could by itself be the cause of respiratory infection and confirms previous data [2].

The striking feature of our study is the good prognosis of our patients. In previous series that focused on HSCT recipients, mortality has been reported to be between 10 and 40% [4,6]. In our series over a period of 4 years, including all consecutive hematological patients with a diagnosis of HMPV pneumonia, no patients died, even though 8/13 patients required oxygen and among them two needed intensive care. Our data are even more striking in that none of our patients had received any anti-viral treatment. There is little data to determine risk factors for mortality of HMPV pneumonia in hematological patients. When available individual data are analyzed, a number of deaths are not directly related to the virus: relapse of hematological disease, lung cancer, other severe infection, or, in a few cases, the patient's desire to limit care [4,6]. Other factors are likely to be involved such as an underlying lung disease, especially bronchiolitis obliterans in the case of allogeneic HSCT recipients. The very early onset of HMPV pneumonia after transplantation is also a factor likely to impact mortality. Renaud et al. identified several risk factors for HMPV-related mortality in a population of HSCT recipients including the severity of the pneumonia, peripheral blood stem cell or cord blood as stem cell sources and the use of corticosteroids [6].

Although some authors have suggested that ribavirin could be an effective option for treating HMPV infection, preliminary data regarding the effect of ribavirin on HMPV pneumonia do not support a significant effect [6,13]. In summary, we showed that HMPV pneumonia can occur in hematological patients other than HSCT recipients with a suggestive radiological pattern. Although

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