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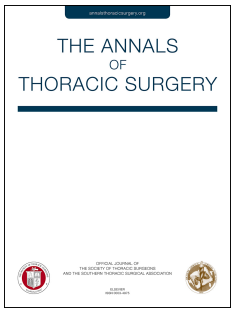

Lung Transplantation in Tuberculosis

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Lung Transplantation in Tuberculosis

To the Editor:

We read with interest the article of Yeo and colleagues (1) regarding lung transplantation (LTx) and tuberculosis (TB). Despite all technical issues with previous pneumonectomy and lung scars, the patient had satisfactory outcome without recurrence. However, no information was included regarding prophylaxis, which is very important in a scenario of immunosuppression.

Brazil has an incidence of TB of 42 cases/100,000 and is among the 20 highest TB burden countries based on incidence and absolute number (2). Although it has the lowest incidence rate, Brazil has the highest activity of organ transplantation among them. Since TB incidence increases 20-74x in solid organ recipients with a mortality rate up to 30% (3), management of TB in immunosuppressed patients requires special attention.

According to ISHLT registry, only 2.7% of all transplants are performed due to non-CF bronchiectasis. However, in our group this incidence is much higher (18.3%). Thirteen cases were identified as latent TB infection (LTBi), with 10 LTx due to previous TB and 3 Tuberculin Skin Test positive. The first point regards technical issues in patients with intense pleural adhesions due to TB. Meticulous dissection is necessary to avoid uncontrolled bleeding, especially if cardiopulmonary bypass is required. But even cases with severe asymmetric thorax can be managed with bilateral LTx. There are four scenarios of TB infection and transplantation: endogenous reactivation, donor-derived reactivation, De novo infection and pre-transplant active TB (4). The first situation refers to LTBi in which the majority of candidates for LTx due to bronchiectasis and previous TB are located. LTBi should be screened and strategies for prophylaxis are mandatory. In our cohort, patients with LTBi were treated with isoniazid for six months on the waiting list. At transplant time, the surgical outcomes