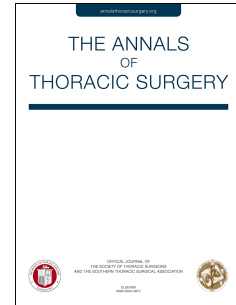


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Lung transplantation in tuberculosis (reply)

Hye Ju Yeo, MD, Woo Hyun Cho, MD, Doosoo Jeon, MD, Dohyung Kim, MD, Yun Seong Kim, MD



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Lung transplantation in tuberculosis (reply)

Reply to the Editor:

We read with great interest the letter published by Samano et al (1) regarding our article (2). As pointed out by Samano et al, latent tuberculosis infection (LTBI) before transplantation should be treated with standard of care (3). As in-depth supplement, treatment strategy requires to be individualized according to the regional incidence of tuberculosis, which is related to the rate of resistance to isoniazid, patients' vulnerability to hepatotoxicity, and predicted waiting time for transplantation (3). However, previously cured tuberculosis cases require a more complex treatment approach. Unfortunately, no specific guidelines for tuberculosis detection and prophylaxis in transplant recipients with a previous history of tuberculosis treatment are available, except careful surveillance, as well as early detection and treatment.

In our case, we encountered problems in transplant patients that could not be solved using the general LTBI treatment principle, which raises the following questions. First, how can we differentiate the subclinical disease, LTBI, in patients with severe lung destruction based on previous tuberculosis treatment? Current tools for LTBI diagnosis, including the tuberculin skin test and interferon gamma releasing assay, are not able to differentiate between past and new tuberculosis infections in patients treated for tuberculosis previously. In such cases, the LTBI treatment should be determined based on the patient's risk of developing tuberculosis, including clinical factors such as the possibility of a recent contact with tuberculosis patients and regional prevalence of tuberculosis. Second, how can we treat LTBI in patients who had undergone tuberculosis treatment previously? What is the appropriate LTBI treatment regimen for patients who had undergone multidrug-resistant tuberculosis treatment previously? To date, these questions remain unaddressed (4). For these reasons, we exercised caution when planning lung transplantation for our patient. We completely reviewed the treatment history including treatment regimen and duration, as well as presence or absence of cure and performed microbiologic screening tests using bronchoscopic samples before listing a recipient. Then, subsequent microbiologic and histologic screening tests using native lung samples were performed at

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