

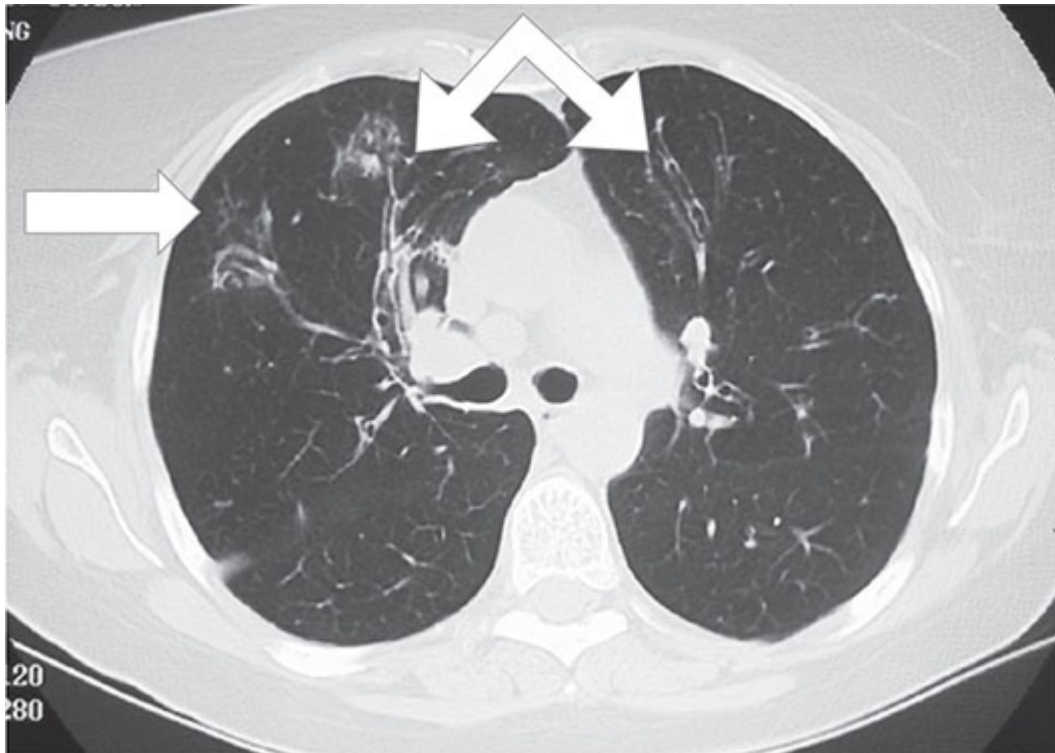


FIGURE 180-2 Chest CT of a patient with pulmonary *Mycobacterium avium* complex infection. Arrows indicate the “tree-in-bud” pattern of bronchiolar inflammation (peripheral right lung) and bronchiectasis (central right and left lungs).

Although many laboratories use DNA probes to identify *M. tuberculosis*, MAC, *M. goodii*, and *M. kansasii*, speciation of NTM helps determine the antimycobacterial therapy to be used. Only testing of MAC organisms for susceptibility to clarithromycin and of *M. kansasii* for susceptibility to rifampin is indicated; few data support other in vitro susceptibility tests, attractive though they appear. MAC isolates that have not been exposed to macrolides are almost always susceptible. NTM that have persisted beyond a course of antimicrobial therapy are often tested for antibiotic susceptibility, but the value and meaning of these tests are undetermined.

■ PREVENTION

Prophylaxis of MAC disease in patients infected with HIV is started when the CD4⁺ T lymphocyte count falls to <50/μL. Azithromycin (1200 mg weekly), clarithromycin (1000 mg daily), or rifabutin (300