## CR73

## Where did the lungs go? Vanishing Lung Syndrome in an HIV positive patient

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INTRODUCTION/OBJECTIVES: Vanishing-lung syndrome is a rare condition characterized by lung emphysema with giant bullae. Giant bullae occupy more than 30% of hemithorax and are often misdiagnosed as pneumothorax. We present the case of a 34-year-old HIV positive man, who had worsening respiratory symptoms for six months before seeking clinical care.
CASE PRESENTATION: In June 2019 the patient presented at the GP clinic due to progressive piercing chestpain and shortness of breath. In patient's history there was a record of treatment with azithromycin for pneumonia (January 2019). He was diagnosed with HIV in 2012 and started taking regular antiretroviral therapy in 2015. With treatment (altegravir, tenofovir/emtricitabine) he achieved undetectable HIV-viremia and was immunocompetent (CD4-lymphocytes 826 st/µl, June 2019). Since 2012 he smoked up to 40 cigarettes/day due to anxiety and depression. Clinical examination performed in June 2019 found right-sided hypersonic sound on percussion and diffusely decreased sounds on auscultation. Spirometry indicated severe obstruction of the small airways. Results of a 6-minute-walk-test was below the reference range (280m, SaO2 95-87%), with severe dyspnea. CT-scan showed billateral emphysema in the upper thorax, with two large bullae completely compressing the lung on the right. After the bulectomy, the lung function improved and the patient had no symptoms.
CONCLUSION: It is important to increase awareness of the risk of COPD in HIV patients, particularly those who smoke and advise them about importance of smoking cessation. Young smokers with emphysema should be offered an HIV-test. HIV is a chronic disease and if well treated, patients do not have reduced life expectancy.

## CR74

## Hepatitis E virus infection after kidney transplantation

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INTRODUCTION/OBJECTIVES: HEV usually presents as acute self-limiting hepatitis. However, in immunocompromised populations it may lead to chronic hepatitis and liver cirrhosis. We present a case of an HEV infection in a kidney transplant recipient.
CASE PRESENTATION: A 23-year-old male kidney recipient presented in August 2020 with elevated liver parameters (AST 36 U/L, ALT 80 U/L, GGT 72 U/L, ALP 98 U/L, bilirubin 10 µmol/L). His past medical history includes two kidney transplants (2003, 2019). His maintenance immunosuppression consisted of tacrolimus, mycophenolate-mofetil, and steroids. His serology for EBV, CMV, HAV, HBV, HCV was negative, while HEV-IgG, IgM and HEV-RNA tested positive. The patient was treated with ribavirin for 8 weeks with dose reduction due to the development of anaemia. At the end of treatment HEV RNA tested negative, and his liver tests returned to normal (AST 24 U/L, ALT 26 U/L, GGT 26, U/L ALP 79 U/L, bilirubin 8 µmol/L) and remained unremarkable until November 2021, when peaked at AST 69 U/L, ALT 170 U/L, GGT 137 U/L, ALP 133 U/L, bilirubin 8 µmol/L. He was re-tested for HEV, and HEV-RNA was 6.43E+5 IU/mL. The patient re-stated a second course of ribavirin scheduled for 12 weeks.
CONCLUSION: In immunocompromised individuals the management of HEV infection may be challenging. The reduction of IS, which may not always be feasible, is the first step, and the addition of ribavirin helps to achieve sustained virological response (SVR). However, patients who do not achieve SVR are at risk of developing advanced liver disease and should be retreated and carefully followed.