Good's syndrome

To the Editor-We read with interest the article on "Good's syndrome in a patient with cytomegalovirus retinitis" written by Yong et al. We diagnosed a 58-yearold man with Good's syndrome who had a different clinical presentation. Our patient had an invasive cortical thymoma (type B2) managed with a thymectomy and left upper lobectomy. He developed a pleural recurrence of the thymoma 9 years later, and had recurrent chest infections. Computed tomography showed bronchiectasis in both lungs and maxillary sinusitis. Our patient had a normal immunoglobulin (Ig) G level (14.34 g/L) and low IgA (0.08 g/L) and IgM levels (0.1 g/L). The normal IgG level was accounted for by the presence of a monoclonal gammopathy of 8.8 g/L. A peripheral blood lymphocyte subset profile showed a normal CD8+ count (931 /µL) with a decreased CD4+ count (143 /µL) and an absence of B cells. The bone marrow aspirate was consistent with a monoclonal gammopathy of undetermined significance with absence of B cells. Monoclonal gammopathy is known to be associated with Good's syndrome.² Patients with recurrent or persistent infections that fail to respond as expected should be investigated for an underlying immunodeficiency³; and a normal Ig level may require further investigation for a co-existing gammopathy. Unfortunately, our patient died of a chest infection despite multiple courses of antibiotics and intravenous Ig.

Ida WY Wong, FHKCP, FHKAM (Medicine)
E-mail: idawongwy@yahoo.com.hk
KK Chan, FHKCP, FHKAM (Medicine)
KS Chan, FRCP, FHKAM (Medicine)
Pulmonary and Palliative Care Unit
Haven of Hope Hospital, 8 Haven of Hope Road
Tseung Kwan O, Hong Kong

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