It is more difficult to recognize infection in transplant recipients than it is in persons with normal immune function, since signs and symptoms of infection are often diminished. In addition, noninfectious causes of fever, such as allograft rejection, may develop in transplant recipients. Antimicrobial therapy frequently has toxic effects that may involve interactions with immunosuppressive agents. The spectrum of potential pathogens is broad, and infection often progresses rapidly. Early and specific microbiologic diagnosis is essential for guiding treatment and minimizing nonessential drug therapy. Invasive diagnostic procedures are often required for accurate and timely diagnosis.

Epidemiologic Exposures

Epidemiologic exposures can be divided into four overlapping categories: donor-derived infections, recipient-derived infections, nosocomial infections, and community infections.
Donor-Derived Infections and Screening

Transplanted organs facilitate the transmission of infections from organ donors. Mandatory reporting of transplantation-associated infections has increased awareness of this problem. Most often, these infections (e.g., cytomegalovirus infection, tuberculosis, and Trypanosoma cruzi infection) are latent in transplanted tissues. Transmission may also be due to active donor infection such as viremia or bacteremia that was undiscovered at the time of organ procurement (Fig. 1A).³

Organ donors also may become infected with nosocomial organisms that are resistant to routine surgical antimicrobial prophylaxis, and they may transmit these organisms (e.g., vancomycin-resistant enterococcus and azole-resistant candida species) to recipients.⁴⁻⁶

Clusters of infections derived from deceased donors have been described, including transplantation-associated West Nile virus infection, lymphocytic choriomeningitis virus infection, rabies, human immunodeficiency virus (HIV) infection, and Chagas’ disease.³⁻⁷⁻¹⁰ In recent outbreaks of West Nile virus infection, lymphocytic choriomeningitis virus infection, and rabies, signs of infectious encephalitis in organs from deceased donors were masked by unrelated acute neurologic events and thus were not recognized.

Nonspecific signs such as altered mental status or abnormal results of liver-function tests may be the sole basis on which to investigate potential donor-related infections. In the normal host, infections due to West Nile virus or lymphocytic choriomeningitis virus are generally self-limited. However, in organ-transplant recipients with these infections, rapid progression, permanent neurologic damage, and death are more common because of the broad immunologic deficits that are present after transplantation.

The screening of transplant donors for infection is limited by the available technology and by the short period during which organs from deceased donors can be used. At present, the routine evaluation of donors for infectious disease generally relies on antibody detection with the use of serologic tests for common infections (Fig. 2).

Since seroconversion may not occur during acute infections and the sensitivity of these tests is not 100%, some active infections remain undetected. Some organs that contain unidentified pathogens will inevitably be implanted. Improved donor screening will require the use of more sensitive (e.g., molecular) and rapid assays by organ-procurement organizations. Augmented screening is recommended on a regional basis for endemic or epidemic infections such as West Nile virus infection, Chagas’ disease, and strongyloidiasis.¹¹
Some documented infections, such as sepsis and HIV infection, preclude organ donation. Organs from donors with specified known infections may be considered for specific recipients — provided there is appropriate informed consent — based on the urgency of the need for transplantation and the availability of effective antimicrobial therapies. For example, some livers from donors who were seropositive for Chagas’ disease have been used successfully with benznidazole prophylaxis in regions where the disease is endemic.  

Similarly, although organs from donors infected with the hepatitis B virus (HBV) and who had test results that were positive for antibodies against hepatitis B core antigen and negative for antibodies against hepatitis B surface antigen were rejected in the past, they are currently used for some recipients who have been vaccinated or who were previously infected, provided there is treatment with specific antiserum and anti-HBV antiviral agents.  

The use of organs infected with the hepatitis C virus (HCV) remains controversial and is generally reserved for HCV-infected recipients. Transplantation of organs from deceased donors who had fever or viral syndromes is controversial, and the uncertainty highlights the need for improved microbiologic screening tools. In cases in which the need for transplantation is relatively less urgent, it is reasonable to avoid the use of organs from donors with unexplained fever, rash, encephalitis, or untreated infectious syndromes.

**Recipient-Derived Infections and Detection**

Active infection in transplant recipients should be eradicated before transplantation, since immunosuppression will exacerbate the infectious process. Individualized epidemiologic histories can guide preventive strategies.  

Common recipient-derived pathogens include *Mycobacterium tuberculosis*, certain parasites (e.g., *Strongyloides stercoralis* and *T. cruzi*), viruses (e.g., cytomegalovirus, EBV, herpes simplex virus, varicella–zoster virus [which causes shingles], HBV, HCV, and HIV), and endemic fungi (e.g., *Histoplasma capsulatum*, *Coccidioides immitis*, and *Paracoccidioides brasilensis*).  

Activities such as travel, raising pigeons (which is associated with *Cryptococcus neoformans* infection), or marijuana use (which is associated with infection with aspergillosis species) increase the risk of infection. Infections that can be treated or controlled do not preclude transplantation.
planted grafts are colonized with opportunistic infections, including methicillin-resistant Staphylococcus aureus, vancomycin-resistant enterococcus, fluconazole-resistant candida species, Clostridium difficile, and antimicrobial-resistant gram-negative bacteria or aspergillus species. After transplantation, these pathogens may cause pneumonia or may infect hematomas, ascitic fluid, wounds, and catheters.

**Community Infections**

Exposures that are relatively benign in a normal host may lead to major infection after transplantation. Common microorganisms include those noted above, pathogens in soil such as aspergillus or nocardia species, C. neoformans in birds, and respiratory viruses with subsequent bacterial or fungal superinfection.

**NET STATE OF IMMUNOSUPPRESSION AND MONITORING OF IMMUNE FUNCTION**

The net state of immunosuppression refers to all factors that contribute to the patient’s risk of infection (Fig. 3). The main determinants of risk are the dose, duration, and sequence of immunosuppressive therapies. Drug levels are used to guide immunotherapy. This approach often results in toxic effects from drugs (e.g., renal injury from calcineurin inhibitors) and infection or graft rejection. These relatively crude measures of immunosuppression may eventually be supplanted by assays that allow individualization (minimization) of immunosuppression. Some nonspecific and pathogen-specific measures of cell-mediated immune function are available. Unique patterns of gene and protein expression have been observed with specific infections and with graft rejection. In the future, new assays based on these patterns may guide the use of immunosuppression to prevent rejection and infection or to provide care for patients with active infection (Fig. 3).

**PREVENTION OF INFECTION**

Antimicrobial prophylaxis has dramatically altered the incidence and severity of post-transplantation infections (Fig. 4). Three general preventive strategies are used: vaccination, universal prophylaxis,
A

![Graphs of Log_{10} Area (RFU) vs. Cycle No. for CMV, BK, HHV-6, and HHV-7.](image)

B

![Image of Lytic and Latent Epitopes.](image)

C

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<tr>
<th>Lytic Epitopes</th>
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**Net State of Immunodeficiency**
- Immunosuppressive therapy
- Previous therapies (e.g., chemotherapy, antimicrobial agents)
- Mucocutaneous-barrier integrity (e.g., catheters, drains)
- Neutropenia, lymphopenia
- Underlying immunodeficiencies (e.g., hypogammaglobulinemia, SLE)
- Metabolic conditions (e.g., uremia, malnutrition, diabetes, cirrhosis)
- Viral infection (e.g., CMV, HCV, HBV)

**Standard Assays**
- Serologic tests for seroconversion
- Microbiologic cultures and susceptibility testing
- Quantitative viral-load assay and antigen tests
- Histopathological tests and immunostaining

**Advanced Assays**
- Multiplex microbiologic assays
- Molecular antimicrobial-susceptibility testing
- Nonspecific immunoassays for degree of immunosuppression
- Intracellular ATP
- Biomarkers of rejection (cytokines)
- Proteomics
- Assays of pathogen-specific immunity
- Cytotoxic lymphocytes
- Mixed lymphocyte cultures
- HLA-linked tetramers
- Intracellular cytokine staining
- Enzyme-linked immunospot assay
- Interferon-release assays
- Genomics (patterns of gene expression) in: Immunosuppression, Infection, Rejection, Drug metabolism
Infections occur in a generally predictable pattern after solid-organ transplantation. The development of infection is delayed by prophylaxis and accelerated by intensified immunosuppression, drug toxic effects that may cause leukopenia, or immunomodulatory viral infections such as infection with cytomegalovirus (CMV), hepatitis C virus (HCV), or Epstein–Barr virus (EBV). At the time of transplantation, a patient’s short-term and long-term risk of infection can be stratified according to donor and recipient screening, the technical outcome of surgery, and the intensity of immunosuppression required to prevent graft rejection. Subsequently, an ongoing assessment of the risk of infection is used to adjust both prophylaxis and immunosuppressive therapy. MRSA denotes methicillin-resistant Staphylococcus aureus, VRE vancomycin-resistant Enterococcus faecalis, HSV herpes simplex virus, LCMV lymphocytic choriomeningitis virus, HIV human immunodeficiency virus, PCP Pneumocystis carinii pneumonia, HBV hepatitis B virus, VZV varicella–zoster virus, SARS severe acute respiratory syndrome, PML progressive multifocal leukoencephalopathy, and PTLD post-transplantation lymphoproliferative disorder. Modified from Fishman and Rubin and Rubin et al.45

![Figure 4. Changing Timeline of Infection after Organ Transplantation.](image)

Promoting lifestyle changes after transplantation may help limit exposures to some potential pathogens. Attention to hand washing should be observed after food preparation, gardening, and contact with feces or secretions. Transplant recipients should avoid close contact with people who have respiratory illnesses, and they should avoid environments such as construction sites, which have known pathogens. Dietary advice might include avoidance of well water and lake water (which may contain cryptosporidium or giardia species), undercooked meats, unwashed fruits and vegetables, and unpasteurized dairy products (which may contain Escherichia coli or Listeria monocytogenes).

Routine surgical prophylaxis varies, depending
on the organ transplanted and local epidemiologic factors. For liver transplantation, antimicrobial agents that provide coverage for skin flora, biliary enterococcus species, anaerobes, and Enterobacteriaceae are routinely prescribed. For lung transplantation, prophylaxis is aimed at gram-negative bacteria, molds, and geographic fungi (e.g., histoplasma). Prophylaxis may be adjusted according to known colonization patterns with pseudomonas, methicillin-resistant S. aureus, vancomycin-resistant enterococcus, or fungi.

Antifungal prophylaxis is based on both risk and epidemiologic factors. Most invasive fungal infections in transplant recipients are due to non-albicans candida and aspergilus species. The greatest risks associated with early fungal infections include aspergilus at the tracheal anastomosis after lung transplantation and candida species after pancreas or liver transplantation. Invasive fungal infections are most common in liver recipients requiring admission to the intensive care unit, surgical re-exploration or retransplantation, or transfusion of large amounts of blood products and in liver recipients with metabolic dysfunction (involving the liver allograft, kidney, or diabetes), respiratory failure, cytomegalovirus infection, or HCV infection. The risk is increased after broad-spectrum antimicrobial therapy. Prophylaxis should be considered in such high-risk hosts.

Most transplantation centers use trimethoprim–sulfamethoxazole prophylaxis for as little as 3 months or for as long as a lifetime to prevent pneumocystis pneumonia as well as infections with Toxoplasma gondii, Isospora belli, Cycospora caytanensis, many nocardia and listeria species, and common urinary, respiratory, and gastrointestinal pathogens. Low-dose trimethoprim–sulfamethoxazole is well tolerated and should be used unless there is evidence that the patient has an allergy or interstitial nephritis. Alternative agents for prophylaxis against pneumocystis include dapsone, atovaquone, and pentamidine, but they are less effective than trimethoprim–sulfamethoxazole and lack the breadth of protection.

The prevention of post-transplantation cytomegalovirus and other herpesvirus infections and the availability of oral antiviral agents have revolutionized post-transplantation care. Two preventive strategies have emerged. With universal prophylaxis, antimicrobial therapy is provided to all at-risk patients for a defined period. In contrast, with preemptive therapy, sensitive quantitative assays (e.g., molecular assays and antigen detection) are used to monitor patients at predefined intervals in order to detect infection before symptoms arise. Depending on the potential pathogen and institutional protocols, a positive assay triggers the initiation of antimicrobial therapy, a reduction in the intensity of immunosuppression, intensified monitoring, or all of these steps. Preemptive therapy incurs extra costs for monitoring and coordination of outpatient care, but it avoids the costs and toxic effects of prophylactic antiviral therapy.

The crude risk of specific infections has traditionally been defined by means of serologic testing; the risk is lower in a seropositive host or higher in a seronegative recipient of an organ from a seropositive donor. A variety of newer techniques (e.g., HLA-linked tetramer binding and intracellular cytokine staining) measure pathogen-specific immunity and provide insight into the risk of specific infections and the ability of the host to clear invasive disease (Fig. 3).

**CHANGING THE PATTERN OF INFECTION**

Early in the evolution of solid-organ transplantation, there was a limited number of available immunosuppressive agents, and antirejection protocols (i.e., use of corticosteroids, calcineurin inhibitors, and azathioprine) were relatively standardized. As a result, the timeline for the development of common post-transplantation infections was relatively predictable. Changes in immunosuppressive regimens, routine prophylaxis, and improved graft survival have altered the original pattern (Fig. 4). Corticosteroid-sparing regimens and antipneumocystis prophylaxis have made pneumocystis pneumonia less common. Herpesvirus infections are uncommon while patients are receiving antiviral prophylaxis. Newer immunosuppressive approaches, including the use of sirolimus, mycophenylate mofetil, T-cell and B-cell depletion, and costimulatory blockade, have largely replaced high-dose corticosteroids and azathioprine.

With changes in typical immunosuppression, new patterns of infection have emerged. Sirolimus-based regimens have been associated with idiosyncratic noninfectious pneumonitis, which is easily confused with pneumocystis pneumonia or
viral pneumonia. T-lymphocyte–depleting antibodies commonly used for initial or induction therapy are associated with increased viral activation — notably, activation of cytomegalovirus, EBV, and HIV. Cellular depletion after induction therapy often persists beyond the period of antimicrobial prophylaxis, resulting in late infections with viruses such as cytomegalovirus and JC polyomavirus as well as fungal infections and malignant conditions after transplantation. Infections that occur after the usual period or that are unusually severe suggest excessive immunosuppression or exposure. The timeline for a given patient is reset with each episode of rejection or intensification of immunosuppression (e.g., with bolus corticosteroids), with an increased risk of opportunistic infections.

**EARLY POST-TRANSPLANTATION PERIOD**

Opportunistic infections are generally absent during the first month after transplantation, since the full effect of immunosuppression is not yet present. Infections such as viremia and candidemia in this period are generally donor-derived or recipient-derived, or they are associated with technical complications of surgery (Fig. 1B). Therapy must be guided by antimicrobial-susceptibility data, making microbiologic analysis of aspirates or biopsy specimens essential. *C. difficile* colitis is common in this setting. Early graft injuries (e.g., ischemia of bile ducts or pulmonary reperfusion injury) may later become foci for liver or lung abscesses (Fig. 1B). Unexplained early signs of infection, such as hepatitis, pneumonitis, encephalitis, rash, and leukopenia, may be donor-derived.

**INTERMEDIATE POST-TRANSPLANTATION PERIOD**

Viral pathogens and allograft rejection are responsible for the majority of febrile episodes that occur during the period from 1 to 6 months after transplantation. Trimethoprim–sulfamethoxazole prophylaxis generally prevents most urinary tract infections and opportunistic infections such as pneumocystis pneumonia, *L. monocytogenes* infection, *T. gondii* infection, and infection with sulfasusceptible nocardia species. Infection due to endemic fungi, aspergillus, cryptococcus, *T. cruzi*, or strongyloides may occur. Herpesvirus infections are uncommon with antiviral prophylaxis. However, other viral pathogens, including polyomavirus BK, adenovirus, and recurrent HCV, have emerged. Given the array of potential pathogens, in the future, multiplex quantitative assays will be used to monitor acute infections (Fig. 3).

**LATE POST-TRANSPLANTATION PERIOD**

The risk of infection diminishes 6 months after transplantation, since immunosuppressive therapy is usually tapered in recipients who have satisfactory allograft function. However, transplant recipients have a persistently increased risk of infection due to community-acquired pathogens (Fig. 4). In some patients, chronic viral infections may cause allograft injury (e.g., cirrhosis from HCV infection in liver-transplant recipients, bronchiolitis obliterans in lung-transplant recipients, accelerated vasculopathy in heart-transplant recipients with cytomegalovirus infection) or a malignant condition such as post-transplantation lymphoproliferative disorder (PTLD) or skin or anogenital cancers (Fig. 1). Recurrent infection may develop in some patients despite minimization of their immunosuppression. These patients are at increased risk for opportunistic infection with listeria or nocardia species, invasive fungal pathogens such as zygomycetes and dematiaceous molds, and unusual organisms (e.g., rhodococcus species). Minimal signs of infection merit careful evaluation in such high-risk patients; they may benefit from lifetime trimethoprim–sulfamethoxazole or antifungal prophylaxis. Such long-term prophylaxis carries some risk of the development of microbial resistance to the prophylactic agents and possible future drug interactions.

**COMMON INFECTIONS IN TRANSPLANTATION**

Early and specific microbiologic diagnosis is essential in the immunocompromised host, often necessitating invasive diagnostic techniques. Reduction in the intensity of immunosuppression may be useful until the acute process is controlled, although this approach risks allograft rejection. Reversal of immune deficits such as neutropenia or hypogammaglobulinemia may be achieved by the administration of colony-stimulating factors or intravenous immune globulin. Viral coinfection must be recognized and treated.

**CYTOMEGALOVIRUS INFECTION**

Cytomegalovirus infection may cause both invasive disease, or “direct effects,” and a variety of secondary immune phenomena (Fig. 5) in trans-
Invasive disease generally occurs during the first year after completion of prophylaxis and is manifested most often as fever and neutropenia; some patients have lymphadenopathy, hepatitis, thrombocytopenia, pneumonitis, gastrointestinal invasion (with diffuse colitis, gastritis, ulcers, and bleeding), pancreatitis, chorioretinitis (which is often late), or meningoencephalitis (which is uncommon). Cytomegalovirus infection is also associated with an overall increase in the risk of additional infections, including infections with other viruses and EBV-associated PTLD. In addition, cytomegalovirus infection may contribute to vasculopathy in heart-allograft recipients and to the bronchiolitis obliterans syndrome in lung-allograft recipients.

**Epidemiology**
Primary infection, reactivation, or viral superinfection with cytomegalovirus may develop in transplant recipients. Serologic assays are useful in determining a patient’s risk of infection, but they are generally of little use in the diagnosis of acute infections. Seropositivity is also associated with the presence of cellular immunity. Primary infection, the most severe form of disease, occurs when seronegative recipients who have not previously received immunologic therapy receive allografts from latently infected, seropositive donors (i.e., D+/R– combinations). Without antiviral prophylaxis, most newly infected patients have asymptomatic viremia, although invasive disease develops in a subgroup of patients. Seroconversion in seronegative transplant recipients who have received allografts from seropositive donors generally occurs during the first year after transplantation; however, 25% of recipients do not undergo seroconversion and may benefit from prolonged prophylaxis.

**Prevention**
Both universal antiviral prophylaxis and preemptive antiviral therapy reduce the risk of invasive
that phosphorylates the drug) or the cytomegalovirus present, it is most often due to mutations in the megalovirus infection is uncommon, but when present, it is most often due to mutations in the cytomegalovirus UL97 gene (a viral protein kinase that phosphorylates the drug) or the UL54 gene (cytomegalovirus DNA polymerase). Such resistance may present as slowly responsive or relapsing infection, most commonly in patients who were seronegative for cytomegalovirus at the time of transplantation and received allografts from seropositive donors, in patients who receive inadequate or prolonged doses of oral ganciclovir or valganciclovir, especially during active infection, or in patients who undergo intensified immunosuppression. Recipients of lung transplants are also at relatively high risk for resistance to ganciclovir. Ganciclovir resistance has been observed with both universal and preemptive approaches.52–54

**Diagnosis and Therapy**

Quantitative diagnostic assays for cytomegalovirus are essential for management of infection. These include molecular assays (polymerase-chain-reaction [PCR] and other amplification assays) and antigen-detection (pp65 antigenemia) assays. In patients with neurologic manifestations of cytomegalovirus infection (including chorioretinitis) and gastrointestinal disease (colitis and gastritis, often with ulceration), blood-based cytomegalovirus assays may be negative. Thus, invasive procedures such as colonoscopy with biopsy or lumbar puncture may be necessary. Invasive disease and the cytomegalovirus syndrome (which is manifested as fever and leukopenia) warrant therapy, generally with intravenous ganciclovir. Results of studies of oral valganciclovir therapy for cytomegalovirus disease are encouraging.85,86 Intravenous ganciclovir is currently preferred for the initiation of therapy for gastrointestinal disease. Documentation of cure in patients with gastrointestinal cytomegalovirus infection includes negative results of microbiologic assays and healing of ulcers and colitis on endoscopic evaluation. Relapse, which is common with inadequate therapy, carries the risk of the emergence of resistance to antiviral agents.

**Epstein–Barr Virus and Post-Transplantation Lymphoproliferative Disorder**

PTLD, a heterogeneous group of lymphoproliferative disorders, occurs in 3 to 10% of adults who are solid-organ transplant recipients; it is associated with a reported mortality of 40 to 60%.87–89 PTLD accounts for more than half of post-transplantation malignant conditions in pediatric solid-organ–transplant recipients. It varies from a benign polyclonal, B-cell, infectious mononucleo-
osis-like syndrome to malignant, monoclonal lym-
phoma.90-92 Risk factors for PTLD include primary
EBV infection after transplantation in seronega-
tive recipients of allografts from seropositive do-
nors, allograft rejection, exposure to antilympho-
cyte antisera, and cytomegalovirus coinfection.
PTLD occurring in the first year after transplan-
tation is usually CD20+ and B cell in origin. In
contrast, later disease may be EBV-negative and
T cell, natural killer cell, or null cell in origin,
generally with a worse prognosis.

The role of EBV in non–B-cell PTLD is less
clear. The clinical presentation of EBV-associated
PTLD varies (Table 1). PTLD is generally extra-
nodal, often with mass lesions in proximity to the
transplanted organ. Both B-cell and T-cell PTLD
may infiltrate allografts and may be confused with
allograft rejection or other viral processes. Oc-
casionally, patients with PTLD have evidence of
remitting–relapsing EBV infection, which reflects
an interplay between antiviral immunity and im-
munosuppression.

Quantitative EBV viral-load testing, flow cytom-
etry, analysis of immunoglobulin gene rearrange-
ments, and histologic analysis with staining for
EBV-derived RNA are helpful in guiding the diag-
nosis and management of PTLD.93,94 In the poly-
clonal form, particularly in children, a reduction
in immunosuppression may lead to regression of
the PTLD but poses the risk of allograft rejection.
The progression of disease requires alternative ap-
proaches that may include the administration of
chemotherapy, irradiation (for central nervous sys-
tem disease), and treatment with anti-CD20 anti-
obodies. Adoptive immunotherapy (T-cell trans-
fer) is under investigation as a treatment strategy
for PTLD. Further data are needed to define a pos-
sible protective role of sirolimus against PTLD.93

**Polyomaviruses BK and JC**

Polyomaviruses have been identified in transplant
recipients in association with nephropathy (e.g.,
polyomavirus BK–associated nephropathy) and
ureteral obstruction, and the JC virus has been
associated with progressive multifocal leuko-
encephalopathy.95-99 No effective antiviral therapy
exists for polyomaviruses. Detection of BK virus
nucleic acids in blood and urine has been useful
for assessing responses to therapy in patients with
polyomavirus-associated nephropathy. Therapy re-
quires a reduction in immunosuppression. Experi-
mental therapies include cidofovir, an inhibitor of
viral DNA synthesis that has considerable neph-
rotoxicity; leflunomide, an immunosuppressive
agent with antiviral properties against BK virus
and cytomegalovirus; and intravenous immune
globulin. None of these agents have been shown
to have efficacy in the treatment of polyomaviruses
or have been subjected to rigorous controlled tri-
als. In patients with renal failure due to polyoma-
ivirus-associated nephropathy, successful retrans-
plantation has been achieved after reversal of
immunosuppression for a sufficient time to allow
the emergence of antiviral immunity.98,99

**Pneumonitis and Pneumocystis Infection**

Pneumocystis pneumonia remains common in the
absence of specific prophylaxis.56,100 Pneumocys-
tis pneumonia should be considered in patients in
whom marked hypoxemia, dyspnea, and cough de-
velop in spite of a paucity of physical or radiologic
findings. No radiographic patterns are pathogno-
monic in the immunocompromised host. Com-
puted tomographic imaging is useful to define
the extent of disease and to direct invasive tech-
niques for microbiologic sampling. Noninfectious
processes may contribute to the pathogenesis of
pneumonitis; these processes include the toxic

<table>
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<tr>
<th>Table 1. Clinical Presentations of Post-Transplantation Lymphoproliferative Disorder Associated with Epstein–Barr Virus.</th>
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<tr>
<td>Unexplained fever (fever of unknown origin)</td>
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<tr>
<td>Mononucleosis-like syndrome (fever, malaise, pharyngitis, tonsillitis)</td>
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<tr>
<td>Gastrointestinal bleeding, obstruction, or perforation</td>
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<td>Abdominal-mass lesions</td>
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<td>Infiltrative disease of the allograft</td>
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<td>Hepatocellular or pancreatic dysfunction</td>
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<td>Central nervous system disease</td>
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**CENTRAL NERVOUS SYSTEM INFECTION**

Central nervous system infection in transplant
recipients is a medical emergency. The broad spec-
trum of causative organisms includes listeria, her-
pes simplex virus, JC virus, and C. neofor mans. Em-
pirical therapy must be initiated while the results
of imaging studies (preferably magnetic resonance
imaging), lumbar puncture (including studies such
as PCR for detection of herpes simplex virus and
cryptococcal antigen), blood cultures, and other
cultures are pending. Included in the differential
diagnosis are noninfectious causes such as toxic
effects of calcineurin inhibitors and lymphoma.

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effects of sirolimus, which may be obscured by coinfection.60

CONCLUSIONS

The study of infectious diseases associated with transplantation focuses on the prevention of infection in transplant recipients. The interaction of infection and immunosuppression is the central concern. The induction of immunologic tolerance so that exogenous immunosuppression is avoided in transplant recipients, might, if successful, reduce the risk of infection after transplantation. However, two caveats would remain. First, exposures to infections subsequent to the development of tolerance might abrogate tolerance and induce allograft rejection.101,102 Second, the induction of tolerance to an allograft might induce immunologic unresponsiveness to latent organisms in that organ.

Techniques currently under development, such as more sensitive microbiologic assays, immunoadsays, and genomic and proteomic markers, may provide the potential for individualized immunosuppression and prophylactic strategies (Fig. 3).103,104 Such assays may ultimately permit a more dynamic assessment of the immune status of transplant recipients over time, allowing titration of immunosuppression and reducing deaths from infection and malignant conditions.105

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