MonoMAC Syndrome in a Patient With a GATA2 Mutation: Case Report and Review of the Literature

Jose F. Camargo,1 Stephen A. Lobo,1 Amy P. Hsu,2 Christa S. Zerbe,2 Gary P. Wormser,1 and Steven M. Holland2

1Division of Infectious Diseases, Department of Medicine, New York Medical College, Valhalla; and 2Laboratory of Clinical Infectious Diseases, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Maryland

We report a case of MonoMAC syndrome in a patient with a GATA2 mutation and discuss the manifestations, diagnosis, and treatment of this novel immunodeficiency disorder.

Keywords. GATA2; MonoMAC; monocytopenia; mycobacterial infection; immunodeficiency.

Monocytopenia and mycobacterial infection (MonoMAC) syndrome is caused by heterozygous mutations in GATA2, resulting in the loss of function of a gene that regulates many aspects of development from hematopoiesis to lymphatic formation. It is also known as combined dendritic cell (DC), monocyte, B and natural killer (NK) lymphoid cell deficiency; familial myelodysplasia/leukemia with lymphedema (Emberger syndrome); and familial leukemia/myelodysplasia. All of these names recognize the same recently described immunodeficiency disorder characterized by profoundly decreased or absent circulating monocytes, DCs, NK cells, and B cells, associated with an increased risk of opportunistic infections and hematological malignancies [1, 2]. Patients typically present during early adulthood with severe or recurrent nontuberculous mycobacterial (NTM) infections, although opportunistic fungal infections and disseminated human papillomavirus (HPV) infections also occur [1, 2]. Both autosomal dominant inheritance and sporadic cases have been identified [1, 2]. Bone marrow transplant has been curative in some cases [2, 3]. Here we describe a 23-year-old Asian man who presented with fever of unknown origin and was ultimately diagnosed with recurrent NTM infection due to MonoMAC syndrome. Infectious disease physicians are among the clinical specialists who are likely to encounter patients with this serious but potentially curable condition, and should become familiar with its presentation, diagnosis, and treatment.

CASE REPORT

A 23-year-old Filipino man presented to the Westchester Medical Center in June 2012 with nodular skin lesions on the anterior aspect of his distal lower extremities of approximately 4 weeks duration. He also complained of intermittent fevers (38.3°C–38.9°C), fatigue, poor appetite, and a 12-pound weight loss over the same period of time. These symptoms were preceded by several months of intermittently productive cough.

The patient had been diagnosed with disseminated Mycobacterium szulgai lung infection involving cervical and mediastinal lymph nodes in August of 2007, the same year he immigrated to the United States. Blood cell count at that time revealed lymphocytopenia (lymphocyte count: 270 cells/mm3) and monocytopenia (monocyte count: 27 cells/mm3). Two months later he developed neutropenia (nadir absolute neutrophil count: 64 cells/mm3) that responded well to treatment with granulocyte colony-stimulating factor. Bone marrow biopsy showed hypocellularity with granulocytic hypoplasia. He was successfully treated with right upper lobectomy and resection of necrotic thoracic lymph nodes in addition to 18 months of antmycobacterial therapy. Past medical history was also significant for recurrent ear infections during childhood, 4 episodes of community-acquired pneumonia since age 12, and recurrent warts on his feet and hands. His brother had had recurrent warts but was otherwise healthy. His sister and mother were healthy, but his father had died of acute bowel infarction.

On physical examination, there were bilateral knee effusions and scattered tender, erythematous, subcutaneous nodules on the pretibial areas. White blood cell count was 3000 cells/mm3 (42% neutrophils, 10% lymphocytes, 1% monocytes, 44% eosinophils, 2% bands); hemoglobin level was 12.7 g/dL; platelet count was 117 × 109/L. The CD4+ T-cell count was 141 cells/mm3 and the CD4/CD8 ratio was 0.99. Ninety-eight percent of the patient’s total lymphocyte count corresponded to T cells (normal percentages: T cells 60%–80%, B cells 10%–20%, and NK cells 5%–10%), indicating B and NK lymphopenia. Electrolytes, creatinine, and liver function tests were within normal limits.
HIV, hepatitis B, and hepatitis C antibody testing was negative. Serum cryptococcal antigen, serum galactomannan, urine Histoplasma antigen, and Coccioides immitis and Histoplasma capsulatum serologies were all negative. The patient had a positive tuberculin skin test (20 mm) but the Quantiferon-TB Gold In-Tube test was negative. Stool ova and parasite examination and Strongyloides antibody test were negative. Serum immunoglobulin levels were within the normal range. Bacterial blood cultures were negative. Sputum fluid obtained from the right knee showed 1600 white cells/mm³ with a neutrophil predominance. Bacterial, fungal, and acid-fast bacilli (AFB) cultures of the synovial fluid were negative. Antineutrophil cytoplasmic antibodies, antinuclear antibodies, complement levels and the angiotensin-converting enzyme level were within normal limits. Computed tomography of the chest showed patchy and nodular pulmonary infiltrates within the right middle, left upper, and left lower lobes with associated mediastinal lymphadenopathy measuring up to 1.2 cm in diameter. Computed tomography of the abdomen showed multiple enhancing hypervascular lesions throughout the liver measuring up to 1.2 cm and a 2.3-cm heterogeneous mass with nodular enhancement in the right lobe of the liver.

A biopsy of the skin lesions showed panniculitis consistent with erythema nodosum; bacterial, fungal, and AFB cultures were negative. A percutaneous fine-needle aspiration biopsy of the lesions in the right hepatic lobe showed an Epstein-Barr virus (EBV)-associated smooth muscle tumor; bacterial, fungal, and AFB cultures were negative. A transbronchial biopsy of the lung showed nonnecrotizing granulomas, but fungal and AFB stains were negative. Culture from 2 of 3 separate expectorated sputum samples and from bronchoalveolar lavage (BAL) fluid yielded M. avium complex (MAC). The patient’s fever, skin lesions, and respiratory and constitutional symptoms resolved within 2 weeks of anti-MAC therapy consisting of ethambutol, rifabutin, and clarithromycin. The constellation of peripheral cytopenias, recurrent NTM, HPV infections, EBV-associated smooth muscle tumors, and autoimmune phenomena led to the suspicion of MonoMAC syndrome. Genetic testing found a heterozygous mutation in GATA2 (c.1186C > T; p.R396W) confirming the diagnosis of GATA2 deficiency. This mutation has been previously reported in patients with MonoMAC syndrome [4]. His brother and sister tested negative for GATA2 mutations. The patient has now been referred for bone marrow transplant.

**DISCUSSION**

In addition to MonoMAC, other adult-onset primary immunodeficiency disorders can be associated with NTM infections. These include the warts, hypogammaglobulinemia, infections, and myelokathexis (WHIM) syndrome, which results from dominant gain of function mutations in chemokine receptor CXCR4 leading to retention of mature neutrophils in the bone marrow [5]; and a more recently described immunodeficiency syndrome characterized by the presence of anti–interferon-γ autoantibodies in Asian adults with disseminated NTM [6].
WHIM is unlikely to explain this patient’s presentation, as he had normal serum immunoglobulin levels and a hypocellular bone marrow. Although we did not measure serum anti-interferon-γ antibodies in our patient, the presence of peripheral cytopenias, hypocellular bone marrow, and a GATA2 mutation support the diagnosis of MonoMAC.

At least 25 cases of MonoMAC have been reported [1, 2, 7, 8]. The main characteristics of MonoMAC syndrome are listed in Table 1. At present, there does not appear to be any racial/ethnic predilection with reported cases in Whites, Asians, and Hispanics. The syndrome was first described by Vinh et al after identifying a group of 18 patients (mean age: 31 years) with disseminated NTM and other opportunistic infections [1]. Seventy-eight percent of the patients in this cohort developed NTM disease, with slow-growing mycobacteria accounting for most of these infections. MAC was identified in blood and/or other sterile sites in more than one-half of these cases [1]. Other infections seen in MonoMAC syndrome are presented in Table 1.

Noninfectious conditions have also been described in Mono-MAC [1, 2, 8, 9] (Table 1). Erythema nodosum and pulmonary alveolar proteinosis have each been seen in up to one-third of patients [1] and can be the presenting feature [2]. Patients with pulmonary alveolar proteinosis, including those without documented GATA2 mutations, have an increased risk of opportunistic fungal and mycobacterial infections [10].

Profound peripheral blood monocytopenia and B and NK cell lymphopenia are characteristic of patients with MonoMAC [1, 2, 7, 8]. Notably, monocytopenia in these patients can exist for more than a decade before a diagnosis is made [2]. Other cytopenias seen in MonoMAC are listed in Table 1. Despite the near absence of circulating monocytes and DCs, tissue macrophages and epidermal Langerhans cells are preserved in Mono-MAC [1, 2, 11]. Similarly, despite marked B-cell lymphopenia, serum immunoglobulin levels remain within normal limits and tissue plasma cells remain detectable in skin and bone marrow biopsies of patients with MonoMAC [1, 11]. Although it is unknown whether tissue NK cells are also spared in MonoMAC, our patient had detectable NK cells in synovial fluid.

The bone marrow of patients with MonoMAC is characterized by hypocellularity, fibrosis, and multilineage dysplasia [1, 2, 11]. Cytogenetic abnormalities are common [1, 11]. Progression to myelodysplastic syndrome (MDS) or acute myeloid leukemia (AML) is one of the most serious complications of this syndrome. One-half of the 18 patients reported by Vinh et al were diagnosed with MDS/AML by age 32, and complications associated with hematological malignancy accounted for 4 of the 5 deaths in this cohort [1]. Conceivably, some of the previous reports of NTM infections in patients with MDS/AML [12] might represent unrecognized cases of GATA2 mutation.

Mortality of MonoMAC syndrome can be as high as 28% [1]. Allogeneic hematopoietic stem cell transplantation has been shown to be an effective strategy to reconstitute the depleted hematopoietic compartments and reverse the clinical phenotype seen in affected patients [2, 3]. It is unknown whether there is any role for the use of growth factors such as granulocyte macrophage colony-stimulating factor to correct the peripheral monocytopenia, whether antimicrobial prophylaxis against MAC and specific immunization protocols (eg, HPV vaccination) are indicated, or whether prevention of infections can prevent neo-plastic complications later in life.

Notes

Acknowledgments. Because of space constraints, we regret our inability to cite other excellent papers that have also examined the clinical significance of GATA2 mutations.

Financial support. This work was supported in part by the Division of Intramural Research, National Institute of Allergy and Infectious Diseases, National Institutes of Health.

Potential conflicts of interest. All authors: No reported conflicts. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

References