

SPEAKER 1: So when we look at patients and presentation with mycobacterial infections, a few patterns arise. As we know, women seem to be the predominant group having these infections, though not exclusively so. The presentation, I think, is helpful because it demonstrates some elimination of, or insight into the underlying circumstance. And again, bronchiectasis underlies or precedes along with these infections.

So that what we see are symptoms circumstances that are subtle and represent the indolent disease that we're dealing with. So that cough may happen, but to variable degrees. Sputum production may happen, but to variable degrees. Fatigue is a common, but not exclusive feature. As you might imagine with a chronic inflammatory infectious disease, there might be problems with weight gain or a particularly notable, and maybe worsening process of weight loss.

So that a frequent presentation is of a woman with some fatigue, and thin weight or weight loss, who presents with some cough and some sputum production. And it's perhaps in that context not too surprising that recognition of a problem, evaluation of that problem, and specific diagnosis of that problem, might be delayed, unfortunately, over a course of years.

There are added features that confound the circumstance. As we know, a background state of smoking and airways disease can be a risk factor for acquisition of NTM infections. In active, current, ongoing smokers, then the cough, and the fatigue, and the difficulty in weight gain, might be masqueraded by the cigarette smoking and attributed exclusively to the cigarette smoking, rather than to the possibility there might be an indolent infection that's substantial and may be a predominant driver of infectious disease.

Acute onset illness is uncommon in this circumstance. So that febrile process, sudden production of a lot of sputum, is not a common constellation of symptoms to occur with these patients. In fact, if that sort of process occurs, it's highly unlikely that it's an NTM infection causing those acute symptoms. But they certainly can happen.

Co-pathogen circumstance is going to happen so that somebody might have chronic colonization with bacteria, such as haemophilus or pseudomonas. There might be fungi recovered in sputum cultures, as well, including aspergillus and other fungi. So there may be multiple opportunities for a physician to be distracted from identifying the real pathogen, particularly when it takes that notable step of having an index of suspicion for looking for mycobacteria, rather than simply sending sputum samples for routine bacterial culture.

And unless there's some sense of evolution of a longer-term infectious pathogen-- an infectious disease-- the clinician may, in fact, not be driven to address, and investigate, and evaluate specifically for mycobacterial pathogens.