A 48-year-old woman presented with severe epistaxis. Her hematologic profile showed marked thrombocytopenia (3 × 10⁹/L), hemoglobin 11.6 g/dL, leukocyte count 5.2 × 10⁹/L, and an unremarkable blood film except for rare platelets. She tested positive for HIV and the CD4 count was low (20/mm³).

A tentative diagnosis of HIV–immune thrombocytopenic purpura (ITP) was made. She was treated with antiretroviral medications, IVIG, and subsequently with steroids for 4 weeks without improvement. Rituximab was deemed unsafe because of her immunosuppressed status. After 6 weeks of platelet unresponsiveness, a bone marrow examination was performed. The aspirate was dry. The core biopsy showed a hypercellular marrow with a heavy infiltrate of *Mycobacterium avium intracellulare* infection (ZN stain in figure). She was started on 4-drug antituberculosis treatment, and 2 weeks later her platelet count was 30 × 10⁹/L. The platelet count steadily rose to 150 × 10⁹/L by day 20 and was maintained thereafter.

This case highlights the value of performing a bone marrow examination in a patient with presumed HIV-ITP who was poorly responsive to antiretroviral medications and conventional treatment for immune thrombocytopenia. A secondary opportunistic infection was found by the bone marrow examination and the thrombocytopenia became responsive to therapy for atypical mycobacteria.
Atypical mycobacteria in a patient with HIV and ITP

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