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CHRONIC PHARYNGITIS AND MULTIPLE SOFT PALATE PERFORATION IN AN HIV POSITIVE PATIENT

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SUMMARY

The clinical manifestation of HIV/AIDS vary on the duration of infection and the organ or system of the body that is most affected [1]. A case of severe chronic pharyngitis and soft palate perforation in a middle aged woman with the acquired immune deficiency syndrome (AIDS)is hereby presented. Although pharyngitis is one of the common minor signs of AIDS, associated soft palate perforation has not been reported to the best of my knowledge. This patient was said to have tested negative to HIV 1 and 2 screening in another teaching hospital 6 months prior to presentation in the ENT clinic of O.O.U.T.H Sagamu. This report is at advocating the need for repeated investigations and screening for HIV particularly when there is a persistent clinical feature strongly suggestive of AIDS. Should we even start to contemplate therapeutic trail of antiretroviral drugs in some cares?.

KEY WORDS: Chronic Pharyngitis, Soft Palate Perforation, AIDS, HIV Infection.

INTRODUCTION

Since the first reported case of HIV/AIDS in Nigeria in 1984[2] inflection by the Human Immunodeficiency Virus has continue to be the increase despite all efforts to check its spread and improvement in the diagnosis and palliative treatment of AIDS[3,4] presently, AIDS is almost at an epidemic proportion.

Chronic pharyngitis is a common condition in otolaryngological practice and it could be caused by either specific infective or reactive conditions. It is also one of the minor signs of AIDS particularly manifesting as oropharyngeal candidiasis, according to WHO clinical case definition for AIDS (1986b). However, associated destruction of the pharynx with multiple perforation of the soft palate as a result of HIV infection was not found in the literature review hence one of the reasons for this case report.

CASE REPORT

A. M. G. is a 45 year old business woman who in the ENT clinic of O. O. U. T. H. in June 2000 over 1year history of severe sore Throat and Dysphagia which has progressively gotten worse. She was said to have been receiving treatment at a teaching hospital in Lagos but without any improvement which made her to come to our clinic. There was associated progressive weight loss, low grade fever and generally feeling unwell. On examination she was found to be chronically ill looking and depressed but not pale nor febrile. There was mild trismus and the oropharynx was chronically inflamed with association multiple buccal and lingual ulcers, whitish fibrinous discharge, fibrotic tonsils and multiple perforation of the soft palate (bot no history of nasal regurgitation of fluids no swallowing or nasal speech). There was no palpable cervical node. Her weight was 65.5kg. All others systems were essentially normal. A diagnosis of chronic pharyngitis was made? Tuberculosis to rule out HIV infection and malignancy. Throat swab was taken for M/C/S which yielded moderate growth of alpha heamolytic strept, WBC count was 8,000/MM^3 N 72%, L 28%, PCV 30%, ESR 62 mm/Hr.(Wintrobe)ZN stain for AFB was negative. Screening for HIV infection was not done at this stage because patient claimed to have tested negative to HIV screening done 6 months previous at the teaching hospital where she had been receiving treatment before and production a photocopy of the result. Despite treatment with the appropriate antibiotic according to the sensitivity report of the throat swab and other adjunct therapy there was no improvement. A tonsilar biopsy was done to rule our malignance and the histopathology report showed chronic tonsillitis. Patient's condition got worse and 3 months later she because severely ill, very pale (P CV 23%) wasted (weight 53%kg) and complained of severe for HIV infection (ELISA Technique) and was found to be position to HIV 1.A confirmation test was also strongly positive.(Western Blot). She was commenced on triple therapy of Antiretroviral drugs of various combination including stavudine d4T (Zerit), Lamivudine 3TC (Epivir), Ritonavir RTV (Norvir), Didanosine (Vidoes) etc with other adjunct treatment. She responded dramatically to treatment and because symptoms free after about months except for the persistent multiple perforation of the palate as shown in fig. 1. Her weight increased to 83kg n 3 months and over 90kg after 1 year of treatment.

DISCUSSION

Although most cases of sore throat are caused by relatively benign infections or noninfectious disease processes, pharyngitis may herald serious or even fatal illness.5 Typical symptoms of primary HIV infection included pharyngitis 70% which is next in frequency only to fever 90% and adenopathy 74%.[4] Angyo et al[6] also reported lymphadenopathy in 34.8% of children with AIDS in Jos Nigeria. However ,there was no significant palpable lymph node enlargement in this patient. Specific chronic pharyngitis may be caused by condition like syphilis, tuberculosis, scleroma and leprosy. Throat swab for ZN stain for AFB was found to be negative in this patient and there was no evidence of oral thrush at

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presentation. The ESR was moderately raised (62MM/Hr. Wintrobe) which is also suggestive of a chronic infection or malignancy. Anther probable cause of chronic sore throat and weight loss is cancer of the tonsil or base of the tongue but the histopathology report of the tonsil biopsy was chronic tonsillitis. Patient was not screened for HIV infection at presentation because she was said to have tested negative to same 6 month age at the teaching hospital where she was receiving treatment before and she produced a photocopy of the test result to support her claim. This could not be a case of 'window period' because she was already manifesting the symptoms before the test was done. She denied any from of extra marital sexual contact although the husband tested negative to HIV 1 and 2 screening and there was no history of blood transfusion prior to presentation. The full blood count (FBC)picture was also more suggest of an acute pyogenic infection (WBC 8, 000 /MM^3 neutrophyl 72%,lymphocytes 28%and PCV 30%). Anaemia, leucopenia, lymphopenia and Lymphocytopenia are found in 30% to 40% of HIV/AIDS patient[7]. HIV infection is believed to be causing increase in the incidence of certain organ e.g. Acute pancreatitis and pyogenic thyroiditis[8,9]

Screening for HIV should be considered for patients complaining of persistent chronic sorethroat. Clinicians should not shy away from repeating HIV screening test even if it is said to have been negative in recent past particularly in the face of overwhelming clinical features. Although the level of immunodepression in this patient was enough to cause severe chronic pharyngitis with perforation of the soft palate for over 1 year before the commencement of antiretroviral drugs she responded very well to treatment within 3 months as shown by the weight gain and state of general well being. It is believed that the patient would have even done better had the anti-retroviral treatment been commended earlier. May be we should even start to think of therapeutic trial of antiretroviral therapy in the presence of overwhelming clinical evidence of HIV infection even if HIV screening is negative. However, the of the drugs their side effects and the stigma attached to AIDS will need to be serious considered.

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