OTORHINOLARYNGOLOGICAL HIV – RELATED PROBLEMS: A PRIVATE PRACTICE EXPERIENCE

BY

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SUMMARY.

This is a retrospective review of six cases that presented with Otorhinolaryngological (ORL) problems associated with human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) at GENIKS Specialist Clinics, Ibadan, Nigeria between January 2002 and June 2003.

The patients all in the productive age group were either non responsive to conventional therapy for the presenting complaints or had features suggestive of immune depression prompting request for HIV screening, which was positive in all cases.

Based on the findings, this paper proposes that all clinicians including otorhinolaryngologists especially should keep an eye for HIV infection hidden behind common ORL diseases and maintain a high level of suspicion for HIV infection in their day – to – day practice.

Key words: *Otorhinolaryngology HIV- related problems, private practice, Nigeria.*

INTRODUCTION.

Human Immunodeficiency Virus (HIV), a RNA retrovirus of the lentivirus subfamily was first isolated by Barre et al in Paris in 1982 and Popovic et al in the United States of America in 1983.[1] It attacks the immune system producing progressive damage to it and leading to the disease complex, AIDS. It has been observed that approximately 40 – 50% of patients with HIV present with lesions in the head and neck region.[2] However, these lesions could be hidden under other commonly occurring ORL diseases thus making it imperative for otolaryngologists to be able to recognize and manage these patients.[3]

It is in this view that six cases of such associations that presented in a private Clinic are reported.

Case 1.

K.T. is a 34-year-old clergyman who was not married. He presented with left otomycosis. He had a previous history of left parotid swelling in 1999, which resolved after antibiotic therapy. He subsequently developed a hearing loss in the left ear. Prior to presentation, he had had a dental extraction. There was no history suggestive of diabetes mellitus either in the patient or his family. Examination revealed a patent external auditory canal with a normal tympanic membrane on the right while a fluffy creamy material filled the left external auditory canal. He had hyperaemic obstructive tonsils. Culture of the left ear swab taken grew candida albicans. Tonsillectomy was done. Initial dressing of the ear was done with fungusol solution (Econazole nitrate) for 28 days with oral Fulcin 250mg bd for 28 days. This was changed as a result of non – response to darktarin dressing which the otomycosis responded to. Retroviral test was done and the result was confirmed positive for HIV sub type 2.

Case 2.

A.F. is a 34-year-old unmarried businesswoman who presented to the clinic with leg trauma after being hit by a taxi. She developed vesicular eruptions on the affected leg, which was resistant to all forms of medication and dressing. In the course of the treatment, she had dysphagia, evaluation of which revealed 'kissing' tonsils and purulent exudates from the crypts. She has had several episodes of recurrent sore throat in the preceding three months. There was no adenoidal vegetation. Culture of the wound swab from the affected leg yielded staphylococcal organism. Retroviral screening was requested for and test was confirmed positive for HIV subtypes 1 and 2. She responded to daily dressing with bacitracin-neomycin-polymyxin ointment and oral amoxicillin clavulanic acid (augumentin) treatment.

Case 3.

O.K. is a 38-year-old unmarried lawyer who presented with loss of appetite, intestinal hurry and weight loss, odinophagia and dysphagia. Examination revealed loss of tongue papillae, oral thrush and multiple ulcers in the mouth. Retroviral test was confirmed positive for HIV subtypes 1 and 2. He died shortly after presentation.

Case 4.

A.O. is a 35-year-old unmarried businessman. He presented with nasal obstruction, snoring, mouth breathing, bilateral multiple neck and parotid swellings. Past medical history revealed that he had been receiving treatment for an undisclosed ailment from traditional healers. Examination revealed bilateral multiple cystic cervical swellings with parotid gland involvement more on the right than the left, adenoid vegetation and prominent tonsils. Punch biopsy of the tonsils was taken as well as request for retroviral test. Tonsil histology was reported as a reactive hyperplasia of the tonsils.

presenting to primary health care professionals and otorhinolaryngologists. The otolaryngologists are often consulted to evaluate cervical adenopathy in HIV patients as well as patients presenting to them with not so obvious associations of HIV as found in these cases. With the ongoing epidemic of the disease and the high percentage of infected individuals presenting with head and neck manifestations, all clinicians especially private medical practitioners, Otolaryngologists inclusive who may be the first point of contact should acknowledge the importance and challenges of HIV to their practice and maintain vigilance.

HIV is an emerging threat to the whole mankind and to face the challenge, proper surveillance, reporting of cases and resources for comprehensive management and prevention as well as for detailed research are very important.

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Table 1: Summary of the clinical features of the patients.

OTORHINOLARYNGOLOGICAL HIV-RELATED PROBLEMS						
Cases	Sex	Age	Aural	Nasal	Throat	Head & Neck
KT	M	34	Otomycosis, hearing loss (L)	-	Obstructive tonsils	-
AF	F	34	-	-	Obstructive tonsils	-
OK	M	38	-	-	Oral thrush, multiple aphthous ulcers	-
AO	M	35	-	Adenoid vegetation	Obstructive tonsils	Bilateral parotidmegaly, multiple cervical swellings
AU	M	36	Acute otitis externa (L)	-	-	-
NE	F	28	Acute suppurative otitis media (R)	-	Oral candidiasis, lymphoid hyperplasia	-