Dysphagia and esophageal ulcerations in HIV patient

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Short relevant history

A 41 years-old caucasian male with AIDS-associated progressive multifocal leukoencephalopathy, suddenly developed persistent painless dysphagia for solid foods. No other symptoms were present, namely fever, abdominal pain, vomiting or regurgitation. The patient had abandoned medical care and had stopped his anti-retroviral therapy several months before admission.

On physical examination, he was slender and afebrile, with normal vital signs. No lymphadenopathy was present and no oropharyngeal mucosal lesions were seen. The physical examination of the neck was unremarkable. Cardiopulmonary examination was normal and the abdomen had no tenderness or organomegaly.

Laboratory data showed : hemoglobin 7.5 g/L (normal value 11.5-18 g/L), leucocyte 2,53 109/L (normal value 4-11109/L), 55.8% neutrophils (normal value 40-74%) and platelet 38000 109/L (normal value 130-400 109/L). The CD4+lymphocyte count was 203/mm3 with viral human immunodeficiency virus (HIV) burden of 50 copies/ml. An upper gastrointestinal endoscopy was performed and two different types of lesions were found : in the upper third of the esophagus there was an irregular circumferential ulcer covered with a whitish exudate, occupying 3 cm of the esophageal length (Fig. 1). The middle third of the esophagus looked normal, but above the gastroesophageal junction a segment was seen with granular non-ulcerated mucosa, with erythematous focal areas (Fig. 2). Several biopsies were taken from both lesions.

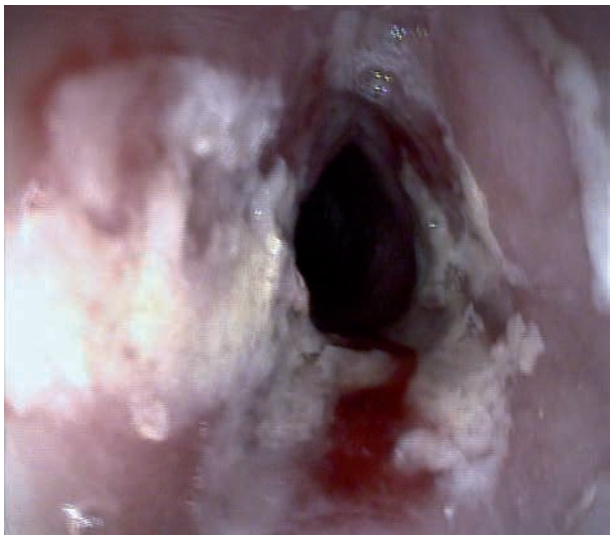

Fig. 1. — Circumferential ulcer in the upper esophagus with whitish exudate.

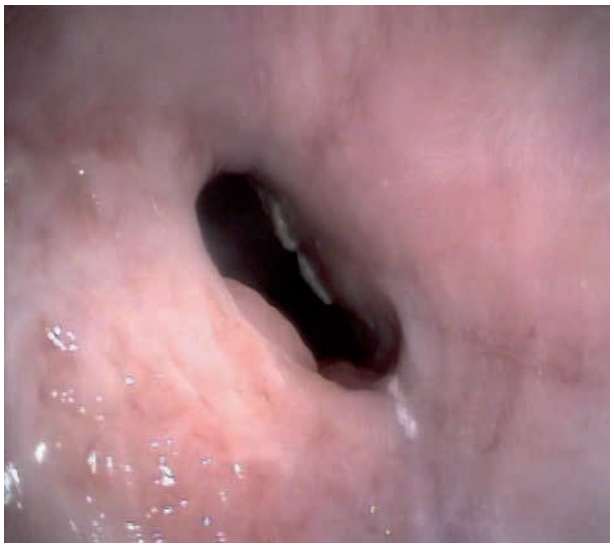

Fig. 2. — Erythematous spots in the distal esophagus, just above gastroesophageal junction.

Answer

Performing an upper GI endoscopy in this patient allowed the exclusion of neoplastic lesions, such as primary lymphoma, Kaposi's sarcoma or infectious lesions. Biopsies of both esophageal lesions showed mucosal infiltration with macrophages, containing intracytoplasmic Leishmania amastigotes (Fig. 3). The majority of visceral leishmaniasis (VL) in HIV patients appear in advanced stages of disease, with CD4 lymphocytes is less 200/mm3. The atypical sites are also influenced by immunological status, once such gastrointestinal involvement could be present in 10% of HIV cases.

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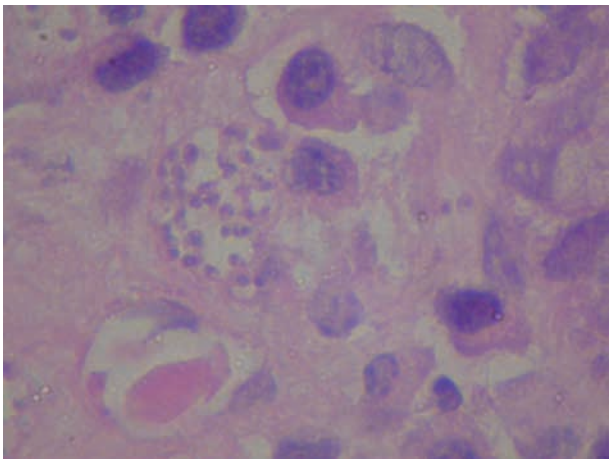

Fig. 3. — Esophageal biopsies : mucosal infiltration with macrophages containing intracytoplasmic Leishmania amastigotes.

The esophageal lesions in VL are usually described as ulcers or polypoid lesions, but there are no endoscopic pathognomonic finding of VL. Leishmania amastigotes can be found in normal appearance mucosa in 45% of cases of VL/HIV infection. If the digestive tract is the source of the symptoms, an endoscopic examination with biopsies is indicated, even when endoscopic findings are absent. In our case, the bone marrow aspirate was performed, showing intracytoplasmtic leishmaniae. This exam is the gold standard in classic triad fever, splenomegaly and pancytopenia, being compulsory to evaluate the extension of VL infections in case of atypical symptoms.

Our patient was treated with liposomal amphotericin (3 mg/Kg), improving his clinical situation. We should bear the possibility of leishmaniasis in HIV patients presenting dysphagia, particularly in patients with CD4 low count, even with atypical symptoms of VL.