

Case Report

Two Case Reports Of Isolated Epiglottic Signs Of Hiv Infection.

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Abstract

HIV is still difficult to diagnose because of its vague clinical manifestations and primarily flu-like symptoms, such as fever, headache, sore throat, and general weakness. While laryngeal symptoms are uncommon, mouth lesions including oral candidiasis and Kaposi sarcoma are very commonly linked to HIV infection. We present two instances of Endoscopy of recently diagnosed HIV patients who presented with a sore throat showed an epiglottic ulcerative tumor-like lesion. Because of the recurrent symptoms and the possibility of malignancy, a laryngomicrosurgical biopsy of the lesions was conducted. Acute and chronic inflammation were seen in the results, but no pathology diagnosis was made. Additional laboratory testing was planned taking into account HIV infection, Epstein-Barr virus (EBV), and autoimmune illnesses because of their enduring and unusual symptoms. HIV infection was confirmed by the results. After receiving effective antiviral therapy, these individuals' laryngeal symptoms subsided in a matter of weeks. In order to properly treat individuals who have idiopathic and persistent epiglottitis or an epiglottic ulcer following medicinal treatment, HIV infection must be taken into consideration as a possible cause.

Keywords : HIV; larynx; epiglottis; epiglottitis; epiglottic tumor.

INTRODUCTION

In addition to being a prevalent symptom in the general population, aphathous ulcers in the oral mucosa are also among the most prevalent in HIV patients [1]. In immunocompromised patients, it can be persistent and recurrent, and it is more likely to appear later in life. HIV infection stage. HIV infection is also commonly linked to other oral symptoms, such as herpes infection, cancrum oris, oral candidiasis, and Kaposi sarcoma [2]. However, there is a dearth of English-language literature examining laryngeal symptoms in HIV patients, and isolated ulcerative lesions across the epiglottis are uncommon in HIV patients [3]. Two cases of recently diagnosed HIV patients exhibiting clinical manifestations of epiglottic lesions were seen by us.

CASE PRESENTATIONS

Case Report 1

One day of severe odynophagia brought a 56-year-old man to our emergency room. He said he occasionally smoked cigarettes. Edematous and erythematous changes, along with ulcers across the epiglottis and patent airway, were observed during an otolaryngological examination.

Acute epiglottitis was the first diagnosis, and he was admitted to the hospital on June 23, 2014, for the treatment of medicines. After his clinical condition stabilized, he was released five days later. Nevertheless, the patient returned to the emergency room the day after being released due to recurrent episodes of acute odynophagia. Diffuse granulation tissues over the epiglottis were observed by the fiberscope examination, raising the possibility of a tumor or mycobacterial infection (Figure 1). Along with tuberculosis testing, a laryngomicrosurgical biopsy was scheduled. The final pathology report revealed both acute and chronic inflammation and a negative acid-fast stain result. With the immunological system in mind Blood tests for HIV and autoimmune-related antigens were set up with a positive HIV Western blot result and a high level of HIV RNA copy (RNA copy: 581,183 copies/mL), regardless of deficiency or virus infection action department. Additionally, an esophagogastroduodenoscopy was scheduled without any particular results. Other biochemical tests, such as those for hepatitis A, hepatitis B, and syphilis C virus, all of which were tested and found to be negative. He began antiretroviral therapy (ART) on August 8, 2014, with amivudine 150, zidovudine 300, and Efavirenz 600 mg because his CD4 T cell count was low (16.0 cells/ μ L). After using ART for two weeks, his symptoms subsided.

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Received: 07-Jan-2025, ; **Editor Assigned:** 08-Jan-2025 ; **Reviewed:** 20-Jan-2025, ; **Published:** 28-Jan-2025,

Citation: Wan-Ne Line. Two Case Reports of Isolated Epiglottic Signs of HIV Infection. *Advances in Tropical Medicine*. 2025 January; 1(1).

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Case Report 2

In 2018, a 38-year-old man had both tonsillectomy and adenoidectomy because of persistent tonsillitis and adenoid enlargement. The histology result revealed tonsil and adenoid lymphoid hyperplasia. He appeared at a nearby clinic in February 2021 for two months of persistent sore throat. He didn't smoke, drink, or chew betelnuts as a habit. Because the local clinic suspected a laryngeal lesion, they referred him to our otolaryngology department. An inflammatory lesion with chondritis over the right epiglottis was discovered by fiberscope inspection; neither the bilateral vocal cords nor their motility were affected (Figure 2). Because of its ulcerative appearance, the first thought was that it was a malignant laryngeal tumor. Consequently, a laryngomicrosurgery biopsy was scheduled, and the biopsy specimen's final histopathological investigation revealed neither aberrant lymphoid antigen expression nor aberrant lymphoid location. cells, in line with a reactive process both immunohistochemically and morphologically. The samples contained sporadic Epstein-Barr virus (EBV)-infected cells, and granulation tissue, ulcer, and dispersed EBV+ cells were diagnosed. Laboratory tests revealed microcytic anemia (Hb: 9.6 g/dL, Hct: 31.5%), but other findings were normal. Medication was ineffective in treating the persistent problem. We scheduled additional biochemical testing for autoimmune disease-related antigens, HIV infection, and EBV infection because we had prior experience managing a persistent epiglottic ulcer with unclear pathology findings. The outcomes showed that the HIV Ag/Ab combo test was reactive (3385.0) (reference range < 1). After that, he was moved to the infection section to get HIV therapy. Comprehensive laboratory testing for syphilis, hepatitis, and immunological status was conducted. The patient had latent syphilis (Nontreponemal test > 1:1280; Rapid plasma recovery = 1:8) and a low absolute CD4 count (54.0 cells/ μ L). After receiving treatment for latent syphilis, he began taking 300 mg of lamivudine, 50 mg of dolutegravir, and 600 mg of abacavir as part of ART. The symptoms eventually subsided a few weeks later.

DISCUSSION

Epiglottitis involvement is uncommon in HIV infection, which frequently manifests as flu-like symptoms. We highlighted the possible origin of HIV infection in idiopathic and persistent epiglottic lesions in this investigation by reporting two HIV patients with an isolated epiglottic tumor-like lesion. Patients with HIV/AIDS frequently develop oral ulcers, however epiglottic ulcers that resemble tumor lesions are uncommon. The symptoms of the patient and the features of the lesion determine how epiglottic ulcers are treated. A biopsy should be performed to rule out malignancy in cases of persistent non-healing ulcers and lesions with aberrant features,

such as uneven borders, heterogeneous appearances, and destructive structure. A biopsy and excision should be considered for bigger masses that are obstructing the larynx. If not, regular fiberscope inspection combined with careful observation is preferred [4]. Furthermore, it wasn't until 1989 when acute epiglottitis in HIV individuals was documented [5]. Five instances of acute epiglottitis in AIDS patients were reported in a New York research. These patients' condition progressed quickly and devastatingly; some even required tracheostomies or intubations. The study recommended aggressive airway intervention due to rapidly increasing airway blockage. One patient was diagnosed following therapy for acute epiglottitis, and four of the five patients had a prior medical history of a positive HIV antibody test.

In a brief period of time, our first patient experienced recurring acute epiglottitis with atypical granulation formation. Because of the epiglottic lesion's endurance and tumor-like appearance, a biopsy was performed on it. The pathological analysis revealed only inflammation. Our second patient had a persistent sore throat that was not improving with medicine. The epiglottitis had chondritis and ulceration, according to flexible laryngoscopy. The persistent nature of the cancerous tumor initially impressed. Treatment became more challenging due to the histopathological analysis's inconclusive results.

Malignancy and an uncommon infection were suspected since both patients' epiglottic lesions presented unusually and responded poorly to conservative treatment. But in both cases, the pathology report was equivocal, therefore an immunodeficiency-related issue was taken into consideration. Once they began taking antiviral medication, their symptoms went away.

Oral hairy leukoplakia, unexplained lymphadenopathy, and unexplained oral candidiasis are among the head and neck lesions that are recommended for HIV testing in indicator disorders, where the rate of untreated HIV infection is higher than 0.5% [6]. There is no list of laryngeal symptoms. However, the larynx is also a site of involvement, and individuals with HIV are susceptible to uncommon infections. According to a review of the literature, as the larynx is a vital anatomical region and the illness progression can be swift and devastating, a precise diagnosis is essential for timely and successful treatment [5]. A biopsy with culture should be obtained to establish the diagnosis, as a definitive diagnosis is still difficult to get. In addition, a biopsy should be scheduled and a neoplasm should be explored if conservative treatment for the laryngeal lesions is ineffective. In conclusion, a biopsy should be performed to differentiate between an uncommon illness and a tumor when a patient has chronic symptoms that are unresponsive to conservative therapy. HIV infection should be evaluated when an atypical infection or an inconclusive pathology result is diagnosed.

CONCLUSION

When examining odd laryngeal lesions that mimic a laryngeal tumor or epiglottitis, it is crucial to keep in mind that immunodeficiency conditions, such as HIV infection, may be the underlying cause. When patients have laryngeal problems that are not improving with conservative measures, doctors need to know how to use decision trees and differential diagnosis.

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