

Reporte de Caso – Case Report

Fatal endocarditis in a traveler with Paracoccidioidomycosis and HIV/AIDS*

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Abstract

Paracoccidioidomycosis (PCM) has been rarely reported among HIV patients, despite being an endemic mycosis in South America. For this reason we report a clinical case of PCM presenting as first clinical manifestation of HIV/AIDS. A female patient, 34-y-old, born in Porlamar, Margarita Island, Venezuela, presented persistent cough with dyspnea and asthenia, of 5 months of evolution, sometimes fever (39°C); she received previously different antimicrobial treatments. No significant personal medical history. At intake, physical examination: BP 110/70mmHg, HR: 90bpm, RR: 25bpm, T.37°C. She presented in regular general conditions, hydrated, mild mucocutaneous paleness, caquetic. Cardiopulmonary evaluation revealed respiratory sounds in both hemithorax, with ronchus and bulous sounds in both sides. Rest physical examination without apparent alterations. Income diagnosis: Bronchopneumonia; TB to be rule out. Patient begun to receive Azithromycin 500mg po od x 5d. IgG serology for *Chlamydomyces pneumoniae* was positive (1:32 dil), IgM for *Mycoplasma pneumoniae* negative. TB studies were all negative. Due to dyspnea Hydrocortisone is given at 100mg VEV q6h x3d. Mycology serology was positive for *Paracoccidioides brasiliensis*, after this itraconazole is given at 100mg po od x6months. Hydrocortisone was omitted. HIV ELISA was positive, confirmed by Western-blot. No hematological or lymphocytic alterations were observed up to this moment. HIV infection and endemic tropical diseases interaction has become a major concern, but its mechanisms are still poorly understood. PCM, a South America endemic deep mycosis, may provide an interesting model to investigate this, as features of most HIV-PCM-coinfected patients are difficult to classify into standard acute and chronic PCM forms.

Key Words: paracoccidioidomycosis, HIV, AIDS, neglected diseases. *Rev Soc Med Quir Hosp Emerg Perez de Leon* 2007; 38(Suppl 1):27-28.

Introduction

Paracoccidioidomycosis is a systemic and endemic emerging mycosis in South America.

Paracoccidioidomycosis is characterized by its chronicity and by the severity of the disseminated form in healthy individuals, as well as in immunocompromised individuals co-infected with HIV, resulting, in the latter, in a mortality rate in the range of 30 - 45%.¹

Although this, paracoccidioidomycosis has been rarely reported among HIV/AIDS patients.

For this reason we report a clinical case of paracoccidioidomycosis presenting as first clinical manifestation of HIV/AIDS.²⁻⁷

Case Report

A 34-year-old female, born and living in Porlamar, Margarita Island, Venezuela, presented with complains of persistent cough with dyspnea and asthenia, of 5 months of evolution, sometimes fever (temperature measured in 39°C); she received previously different antimicrobial treatments. No significant personal medical history, including non-i.v. drug user. At intake, physical examination: BP 110/70 mmHg, HR: 90 bpm, RR: 25 bpm, T. 37°C. She presented in regular general conditions, hydrated, mild mucocutaneous paleness, caquetic. Cardiopulmonary evaluation revealed

respiratory sounds in both hemithorax, with ronchus and bulous sounds in both sides. Rest physical examination without apparent alterations.

Income diagnosis: Bronchopneumonia; TB to be rule out. Patient begun to receive Azithromycin 500 mg p.o. o.d. • 5d. IgG serology for *Chlamydomphila pneumoniae* was positive (1:32 dil), IgM for *Mycoplasma pneumoniae* negative. TB studies were all negative. Due to dyspnea Hydrocortisone is given at 100 mg VEV q6h • 3d. Mycology serology was positive for *Paracoccidioides brasiliensis*, after this itraconazole is indicated at 100 mg p.o. o.d. • 6 months. Hydrocortisone was omitted. HIV ELISA was positive, confirmed by Western-blot. No hematological or lymphocytic alterations were observed up to this moment. Due to supplies problem in the institution patient was referred to another one, where she dies 3 days after due to pulmonary and cardiovascular complications, postmortem diagnosis as death cause was endocarditis.

Discussion

According to some authors, the frequency of paracoccidioidomycosis in the HIV-infected population is not known to differ from that reported for this mycosis in non-HIV patients. But epidemiological studies are needed to define real situation of tropical endemic mycosis and its interaction with HIV/AIDS.⁴

Paracoccidioidomycosis, a South America endemic deep mycosis, may provide an interesting model to investigate HIV infection and endemic tropical diseases interaction, as features of most HIV-Paracoccidioidomycosis-coinfected patients are difficult to classify into standard acute and chronic Paracoccidioidomycosis forms.⁷

Many aspects of HIV-Paracoccidioidomycosis need to be further studied; some authors suggest that patients

with moderate, rather than severe, immunosuppression may have forms of paracoccidioidomycosis with a pathologic process intermediate to those seen in the immunologically normal host and the full AIDS syndrome.⁵⁻⁹

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