Journal Reading: HIV manifestations in Otolaryngology

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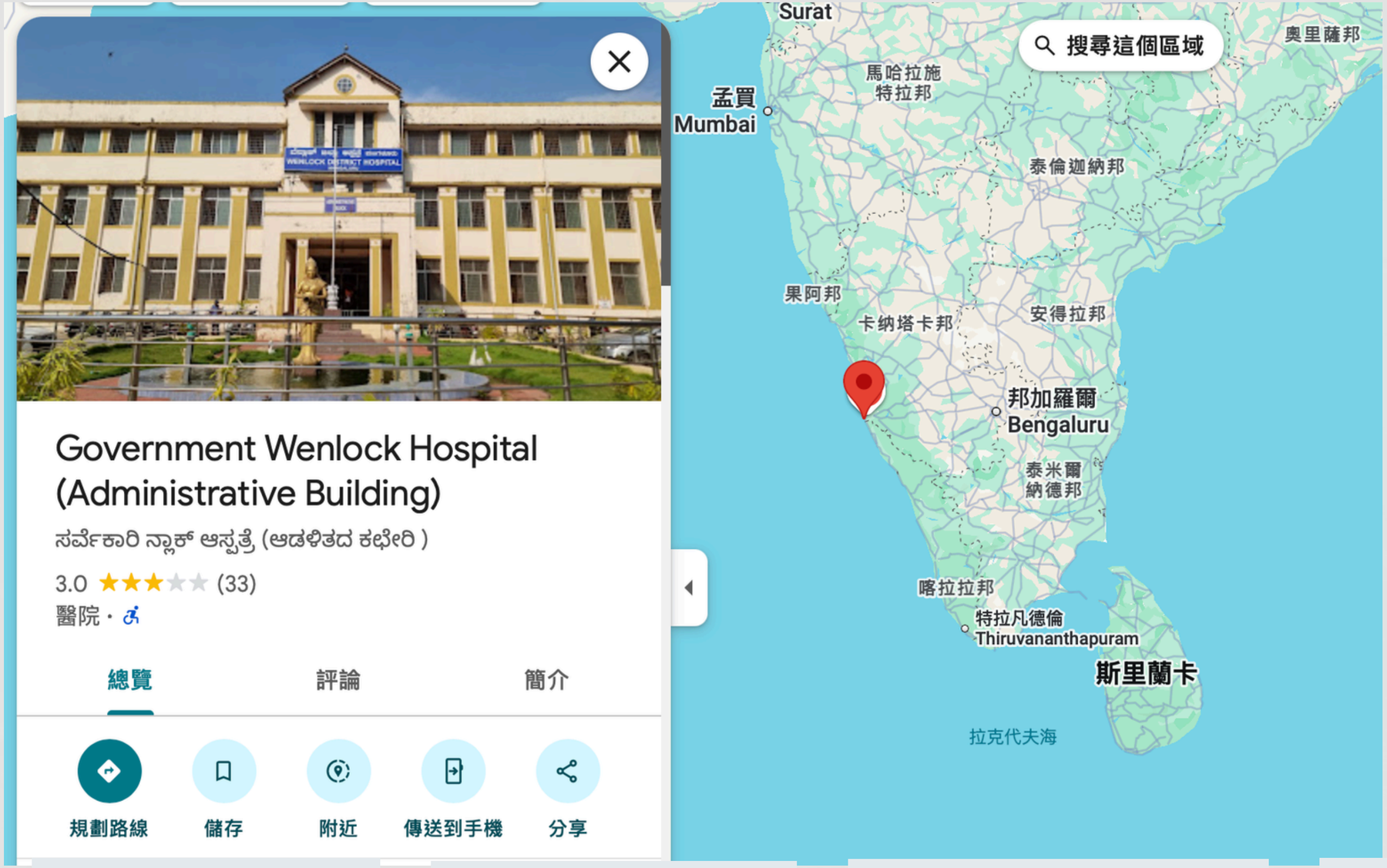

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- **Master of Surgery (MS)**
- **Fellow of the American College of Surgeons (FACS)**

Study design and setting

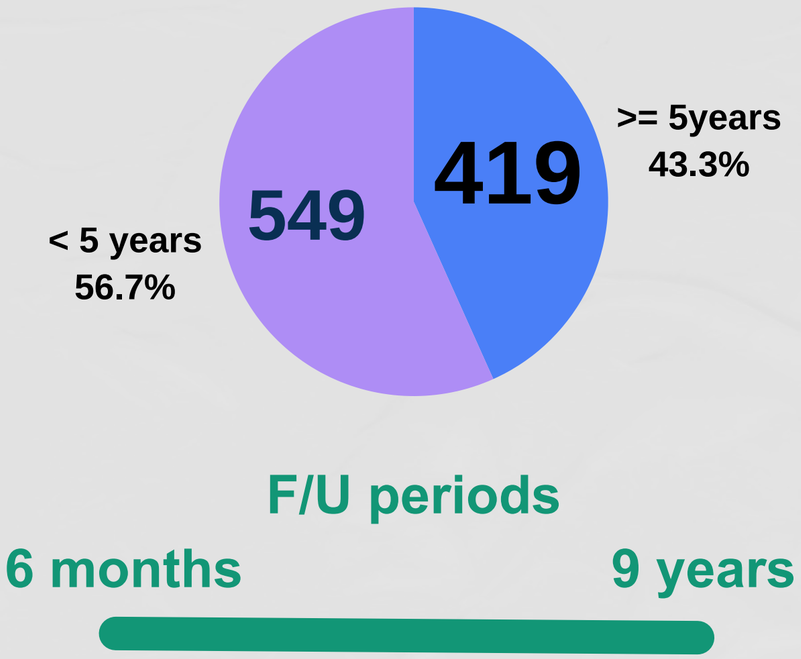
Design	**retrospective + prospective study**
Center	Department of Otolaryngology–Head and Neck Surgery, Kasturba Medical College, Mangalore, **South India**
Period	Jan 1996 – Dec 2004 (**9 years**)
Sample size	968 HIV-positive patients
Main aim	Incidence, presentation, diagnostic tools, management, survival

Patient Recruitment and Workup

- Two sources of patients:
  - ENT clinic and medical wards
- Workup
  - clinical history and ENT examination
  - Baseline laboratory tests
  - ELISA and Western blot
  - Further tests were selected according to lesion site

Treatment strategy and follow-up

- ART regimen
  - 3-drug HAART-era regimen
    - stavudine / zidovudine / lamivudine
    - efavirenz / nevirapine based
    - older toxicity/tolerability profile
- Site-specific management



Clinical Distribution

Sex Ratio	**3:1**
most common age	**31-40**

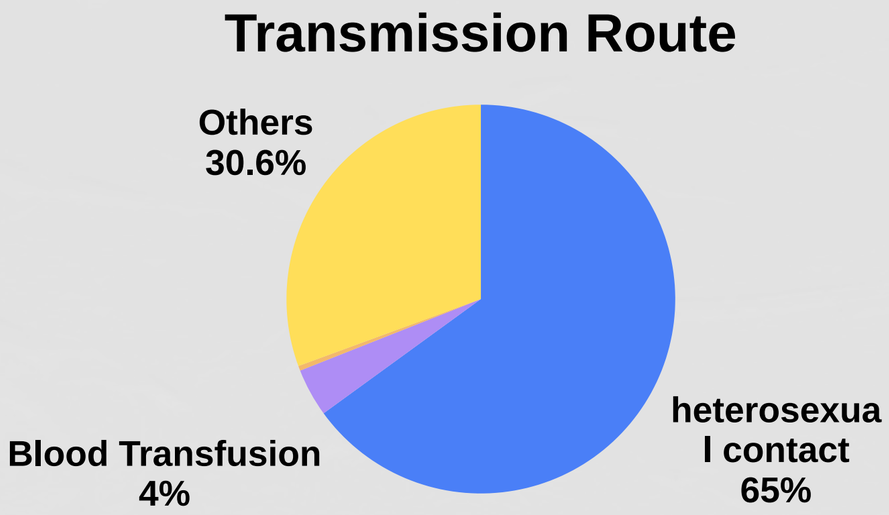
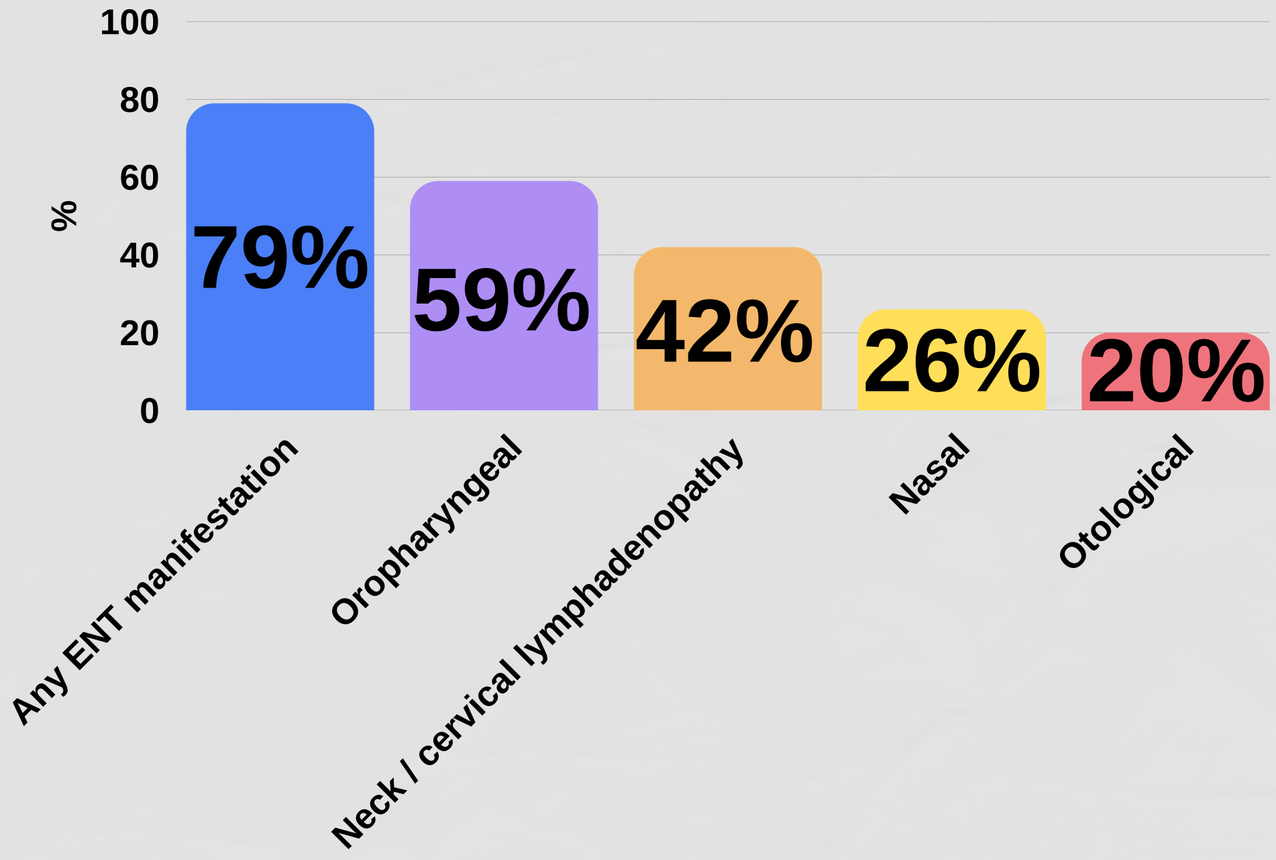


Table 1. Presenting symptoms in our series

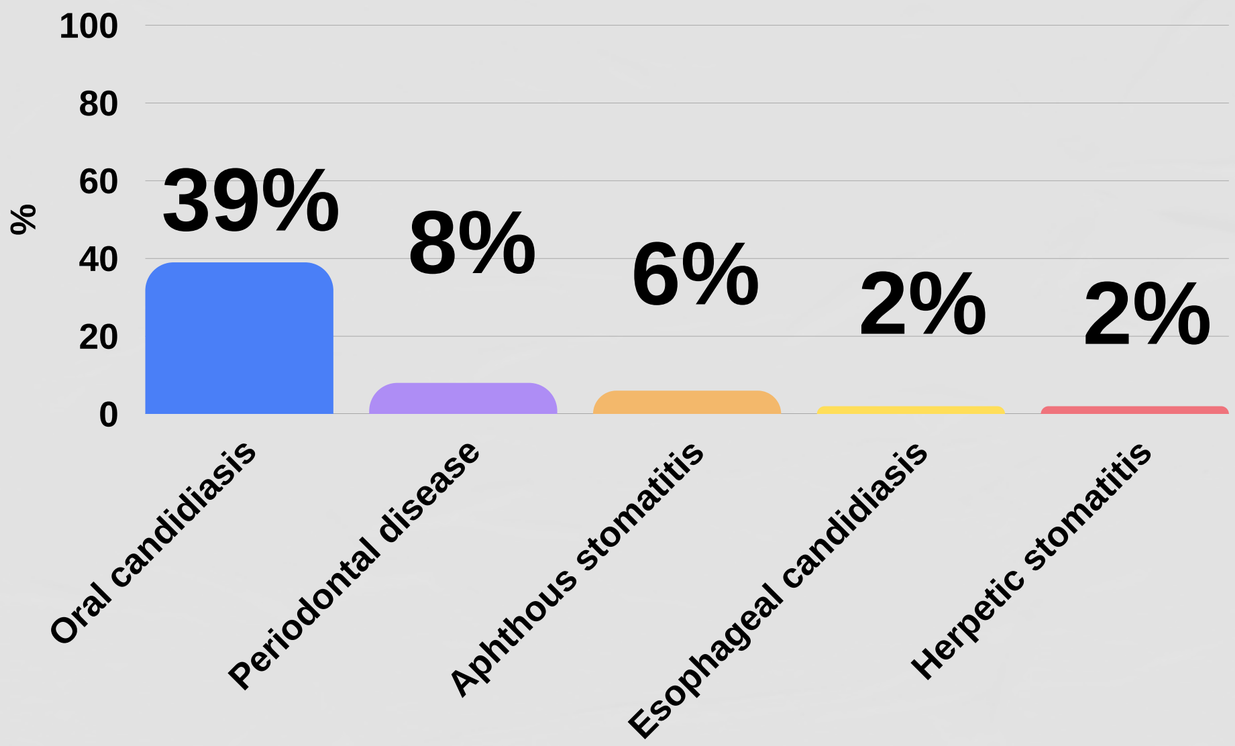
Symptoms	No. of patients	Percentage
Cough with expectoration	620	64
Weight loss	503	53
Fever	387	40
Generalized weakness	232	24
Oral and oropharyngeal complaints	474	49
Neck swelling	436	45
Nasal complaints	251	26
Ear complaints	193	20
GIT complaints	154	16
Dyspnea	39	4
Altered sensorium	39	4

Main results: where do HIV patients show up in ENT?

Sex Ratio	**3:1**
most common age	**31-40**



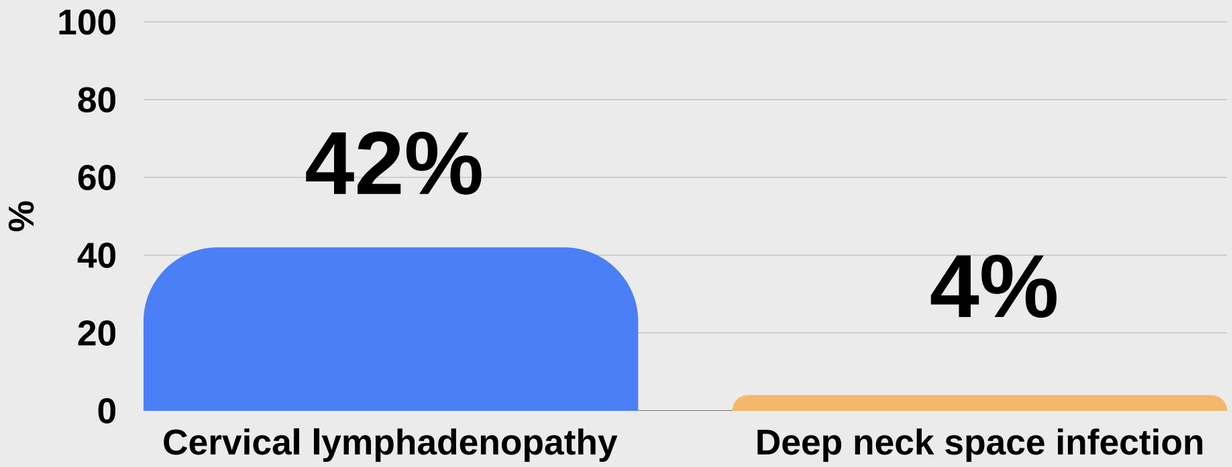
Oropharyngeal Manifestation



Candidiasis, oral cavity HIV (+)

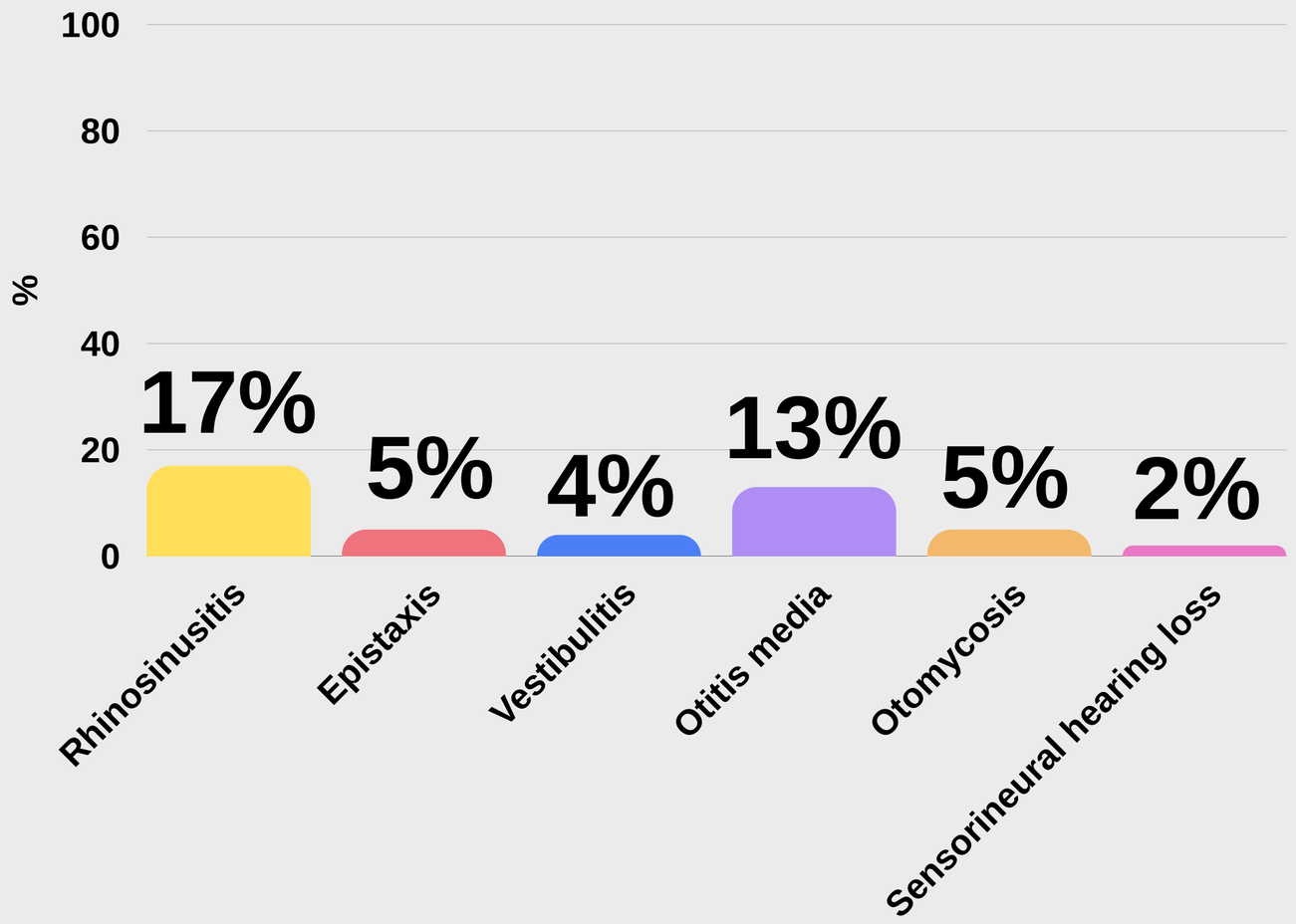
Candidiasis, hard palete HIV (+)

Neck Manifestation



Cervical lymphadenopathy HIV (+)

Nasal and Otologic manifestations



Discussion: Clinical Interpretation

- Oral/oropharyngeal disease was the dominant ENT presentation.
- Cervical lymphadenopathy should not be oversimplified.
- Sinonasal and otologic disease may become difficult to manage.

Discussion: Clinical Interpretation

- **Oral/oropharyngeal disease was the dominant ENT presentation.**
  - **This is consistent with prior reports of oral lesions in HIV. (50%-80%, Williams., 1987, Deb et al., 2003).**
  - **Extension to the hypopharynx/larynx may cause severe odynophagia (Silverman et al., 1986).**
  - **Consider esophageal involvement if symptoms are extensive.**

Discussion: Clinical Interpretation

- **Cervical lymphadenopathy should not be oversimplified.**
  - **Neck involvement diverse from reactive lymphadenitis, tuberculous lymphadenitis, and lymphoma.**

Discussion: Clinical Interpretation

- **Cervical lymphadenopathy should not be oversimplified.**
  - **FNAC/ Biopsy should be considered when:**

1. marked constitutional symptoms with otherwise negative findings on evaluation;
2. adenopathy that is clearly asymmetric or nongeneralized;
3. a single disproportionately enlarging node in a patient with generalized adenopathy;
4. peripheral cytopenia with otherwise negative findings on evaluation;
5. other reasons for suspicion of a treatable pathological process.

- **Small-cleaved lymphoma**
- **Focal Kaposi's sarcoma**
- **Disseminated tuberculosis**
- **Histoplasmosis**

(Abrams et al., 1986)

Discussion: Clinical Interpretation

- **Sinonasal and otologic disease may become difficult to manage.**
  - **Progressive immunosuppression may lead to chronic or refractory disease.(Sample et al., 1990).**
  - **Persistent symptoms warrant culture and CT imaging.**
  - **FESS may be useful in selected sinonasal cases.**

Take-Home Message

- **Think HIV when common ENT complaints become recurrent, extensive, or atypical.**
- **The oral cavity/oropharynx is the most important site to recognize.**
- **Neck masses in HIV need structured differential diagnosis.**
- **Persistent sinonasal or otologic disease may require escalation of workup and management.**

Reference

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Thanks!

Please applaud and no hard questions

Survival / mortality in this cohort

Table 4
Causes of mortality in our series

Mortality	No. of cases	Percentage
Death	112	11.5
Meningitis	40	4.1
Pulmonary TB	25	2.6
Pneumonia/wasting syndrome	24	2.4
HIV encephalopathy	15	1.5
Acute renal failure	2	0.2
Hepatic failure	2	0.2
Suicide	2	0.2

Interpret cautiously: pre-modern ART era, incomplete long-term follow-up

Early HAART-era regimen vs current ART

This paper (1996–2004)	Current practice
3-drug HAART-era regimen	Early ART for all patients
stavudine / zidovudine / lamivudine	TAF/TDF + FTC/3TC backbone
efavirenz / nevirapine based	INSTI-based, e.g. bictegravir or dolutegravir
older toxicity/tolerability profile	better tolerated, higher-barrier modern regimens