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Clinical report

Trèlat's beads as oral manifestations in patients with HIV/TB

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ABSTRACT

Tuberculosis (TB) is a contagious infectious disease caused by *Mycobacterium tuberculosis* (Koch's bacillus). Co-infection with human immunodeficiency virus (HIV) and TB has reached a significant importance as a public health problem and this association has been recognized as the most significant event that changed "the balance between man and Koch's bacillus" in the last century, and has a large contribution to the risk for disease spreading. Tuberculosis has two main standard categories of clinical manifestations: primary and secondary. Primary TB is responsible for the initial infection with lungs being the involved organ. Oral lesions are observed as a secondary TB clinical manifestation with most frequent sites being hard and soft palate, tongue, lips, gums, tonsils, and salivary glands. A case of classical TB lesions in the oral cavity is reported, and the importance of a correct diagnosis through careful history taking is emphasized. Treatment selection needs to be done assertively, with great determination and building a link between patient and treatment protocol, in order to promote patient's adherence.

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Manifestaciónes orales en pacientes con VIH/TB evidenciado a través de los Granos de Trélat

Palabras clave:
VIH
Tuberculosis oral
Salud pública

RESUMEN

La tuberculosis (TB) es una enfermedad infecciosa contagiosa causada por *Mycobacterium tuberculosis* (bacilo de Koch). La coinfección del Virus de Inmunodeficiencia Humana (VIH) con TB son problemas de salud pública graves, además que esta asociación ha sido identificado como el evento más significativo que cambió "el equilibrio entre el hombre y el bacilo de Koch" en el último siglo y es crucial en el riesgo de propagación de la enfermedad. La tuberculosis se manifiesta en dos estándares: primaria y secundaria; el primario es responsable de la infección inicial y el órgano de elección es el pulmón. Las lesiones orales se observan

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a nivel secundario y los sitios más frecuentes son el paladar duro y blando, lengua, labios, encías, amígdalas y las glándulas salivales. Esta revisión presenta un caso con lesiones clásicas de tuberculosis en la cavidad bucal haciendo hincapié en la importancia de un correcto diagnóstico a través de la anamnesis. El tratamiento se debe hacer con la seguridad, la determinación y la formación de enlaces que facilitan la adherencia del paciente al tratamiento.

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Introduction

Tuberculosis (TB) is a chronic infectious granulomatous disease caused by the aerobic bacillus *Mycobacterium tuberculosis*, called Koch's bacillus discovered by Robert Koch in 1882.[1–4]

Tuberculosis is a major public health concern especially in Asia and Africa, and is still among the most life-threatening infectious diseases, resulting in high mortality risk in adults. With a prevalence of 9.2 million new cases diagnosed, in the world, which occurred 1.7 million tuberculosis deaths in 2006, and was possible to notice that 0.7 million cases and 0.2 million deaths were in HIV positive.[5,6] The WHO report of 2008 showed the expected incidence of 9.4 million TB cases, about 139 cases per 100,000 individuals; This represents an increase of 100 thousand new cases in 2007.[7,8] Interestingly, there seems to be a high rate of co-infection that includes TB and HIV patients, responsible for almost 28% of tuberculosis deaths.[8,9] The countries with the largest number of cases in 2009 were India and China. Tuberculosis in India is a public health problem, with a fifth (21%) of all TB cases in the world.[10]

There is a relation between the disease intense growth with the acquired immunodeficiency syndrome (AIDS) by the population affected, due to the T lymphocyte issue, the largest component of the cellular immune response against *M. tuberculosis*, causing serious implications.[1,3,4] The infections are the result of bacillus spread directly from person to person, transmitted by an individual with an active disease.[1,3,11]

The infection is distinguished by two phases: primary and secondary. The primary tuberculosis is mild, manifesting with fever, chills, cough and sputum production.[1,3,11] Microorganisms produce initially a non-specific inflammatory chronic reaction. In most individuals, primary infection results from a local fiber calcified nodule, situated in the initial site of involvement. However, live microorganisms may be present in these nodes and remain dormant for many years, until some other episode of immunosuppression happens and the disease can be activated.[11]

Only about 5–10% of TB patients' progress from infection to active disease and a coexisting immunosuppression is often responsible. In rare situations, active TB may manifest on primary infection. However, the disease activation usually develops in other stages, from the reactivation of the microorganism in a previously infected person, such reactivation is characteristically associated with a compromised host defense system, it may cause lung disease and is called secondary tuberculosis. Granulomatous lesions may promote diffuse dissemination through the vascular system by tubercle bacilli, which may result in liver, renal, gastrointestinal and meninges involvement.[1,3,11,12]

The extrapulmonary tuberculosis is about 25% of TB lesions, 10–35% are found in the region of the head and neck and 0.2–1.5% in the oral cavity.[8] The most common extrapulmonary regions in the head and neck are the cervical lymph nodes, followed by the larynx and ear. The regions much less common are nasal cavity, nasopharynx, oral, parotid gland, esophagus and spine.[11]

In the last two decades due to decreased treatment adherence and control of TB cases and with the advent of AIDS, there is the development of multi-resistant of Koch bacillus, occurring gradually, increasing the number of diseases cases, resulting in pharyngo-laryngeal lesions, associated or isolated.[13]

The tuberculosis lesions in the oral cavity are rare and may occur anywhere, being more frequent in tongue, palate, lips, mucosa, gums, brake, jaw bones, periapical region, tonsils, uvula, pharynx and larynx can manifest as a chronic irregular ulcer, shallow or deep, painless, vegetating surface, with numerous yellowish submucosal points (granules of Trélat), tending to size increase slowly and progress to deep ulcers on the basis of purulent lesions, containing active microorganisms and highly infectious.[3,8,10,11]

The presentations include areas of nodular leukoplastic, it may also occur as a granuloma, osteomyelitis, or salivary gland disease.[8]

The oral lesions of primary tuberculosis usually involve gums, mucobucal sulcus and inflammation areas adjacent tooth extraction sites, and the secondary tuberculosis oral lesions occur in the tongue, palate and lips, and may involve the maxillary bones, occurring microorganism penetrations in the area and periapical inflammation through the bloodstream or through a pulp exposed to the oral environment.[3] Usually it is associated with lymph node regionalized. The tuberculosis osteomyelitis in the jaw has been reported and appears as not defined radiolucent areas.[3,11]

It is important to note that infectious oral ulcers may present a similar shape to the other ulcerative oral cavity lesions, for that reason there is the need of microscopic diagnosis, in conjunction with tuberculin skin test (Mantoux), or sputum culture.[8,10]

Case report

Male patient, 43 years old, dark skin, heterosexual, with incomplete college degree, married, referred to Center of Study and Treatment for Patients with Special Needs (CEAPE) – Paulista University – Indianapolis Campus – São Paulo – Brazil, anamnesis report showed illicit drugs addiction,

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