CASE REPORT – OPEN ACCESS

International Journal of Surgery Case Reports 25 (2016) 128–131

Contents lists available at ScienceDirect

International Journal of Surgery Case Reports

journal homepage: www.casereports.com

Massive gastrointestinal bleeding in AIDS patients secondary to histoplasma and cytomegalovirus infection

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ARTICLE INFO

Article history:
Received 4 February 2016
Received in revised form 23 May 2016
Accepted 25 May 2016
Available online 29 June 2016

Keywords:
Massive gastrointestinal bleeding
Cytomegalovirus
Histoplasmosis
HIV
AIDS
Case report

ABSTRACT

INTRODUCTION: The Cytomegalovirus (CMV) is a virus that affects the host and remains latent. When cellular immunity is suppressed, the virus is reactivated and can cause an asymptomatic or devastating infection in immunosuppressed patients.

On the other hand, Histoplasmosis is typically a respiratory condition. However, in immunosuppressed patients, it may be found in unusual locations, as in the case of an intestinal condition. In some cases, this can be fatal.

Small intestine CMV location is extremely rare.

CASE PRESENTATION: 40-year-old man with AIDS presenting secondary massive lower gastrointestinal bleeding (MLGB) symptoms and ulcer granulomatous injuries located in the proximal ileum produced by the association of CMV and histoplasmosis.

CONCLUSION: Lower gastrointestinal bleeding diagnosis and treatment pose a challenge, considering the intestine extension and difficulties for its exploration. On the other hand, the association between Histoplasmosis and CMV as a massive gastrointestinal bleeding cause has not been described. There is no bibliography on the matter.

1. Introduction

The Cytomegalovirus (CMV) is a virus belonging to the herpesviridae family. It can produce several clinical manifestations according to the age and immune condition of the host [1,2].

Contagion occurs through the contact with bodily fluids such as blood, saliva, vaginal secretion and semen, among others [2].

CMV produces an infection and remains latent. It may reactivate itself once cellular immunity is suppressed, causing an asymptomatic or devastating infection in immunosuppressed patients [3].

CMV is the most common opportunistic pathogenic virus in the acquired immunodeficiency syndrome (AIDS) [4,5].

On the other hand, histoplasmosis is a fungal disease produced by inhaling particles from the ground that are contaminated with birds' excrement containing spores of this fungus [2,5,6].

It is typically a respiratory condition. However, in immunosuppressed patients, it can be found in unusual locations, as in the case of an intestinal condition [2].

In 90% of the cases, histoplasmosis is presented as a mild infection or in an asymptomatic way. In the remaining 10%, it may be presented as a serious lung disease and, sometimes, it can be fatal. In immunosuppressed patients, it is presented as a scattered serious disease [5,7,8]. Patients with CD4 counts, which are less than 150 cells/μL, are at most risk [9].

Small intestine CMV location is highly infrequent [1,10–12].

The association between Histoplasmosis and CMV as a massive gastrointestinal bleeding cause has not been described. There is no bibliography on the matter.

We will introduce below the case of a 40-year-old patient with AIDS presenting secondary massive lower gastrointestinal bleeding (MLGB) symptoms and ulcer granulomatous injuries located in the proximal ileum produced by the association of CMV and histoplasmosis.

2. Report of case

2.1. Personal history

40-year-old male patient, with a recent AIDS diagnose (CD4+ 8/mm^3 and a viral load of 39100 RNA copies– HIV/ml), without antiretroviral therapy and with Herpes Zoster and appendectomy history. The subject has no antecedents of intravenous drug consumption, blood transfusions or risky sexual behavior. At the moment of the admission, the subject had a chest radiograph with

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http://dx.doi.org/10.1016/j.ijscr.2016.05.046

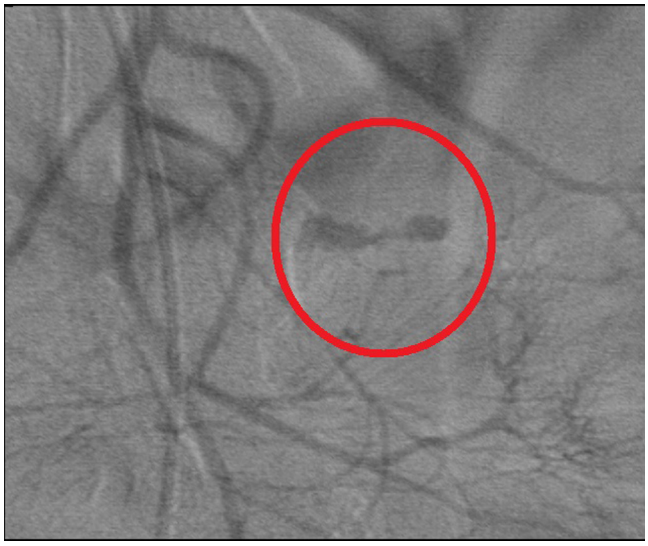

Fig. 1. Mesenteric angiography. Bleeding in the third part of the superior mesenteric artery.

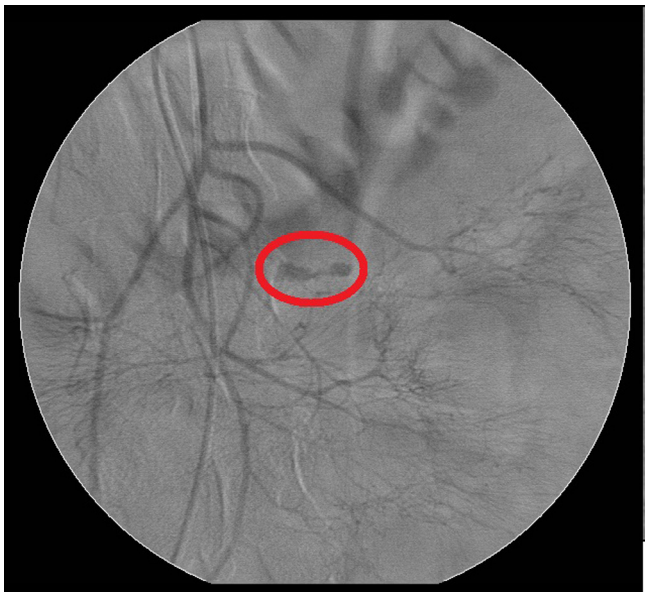

Fig. 2. Mesenteric angiography. Bleeding in the third part of the superior mesenteric artery.

interstitial reticulonodular infiltrates in both lung fields. During the fifth hospitalization day due to an atypical pneumonia, which had started 15 days before with odynophagia, cough, asthenia, night sweats and progressive dyspnea and being able to rest in the last 24 h, the subject presented hematochezia episodes that led to hemodynamic decompensation, requiring hospitalization in the intensive care unit (ICU) for stabilization, evaluation and nursing.

The physical examination revealed an afebrile patient, with low blood pressure (40/80 mm Hg) with tachycardia (110 beats per minute) and sweaty. In addition, the patient presented pale mucous membrane and skin and flat non-distended asymmetrical abdomen due to McBurney's surgical incision. The abdomen was soft, depressible, and not painful upon palpation and with no peritoneal signs. He presented hyperactive bowel sounds, increasing in frequency and intensity and preserved dull liver percussion. The rest was within regular values.

2.2. Laboratory

Erythrocytes 1.8×10^{12}/L; hemoglobin 43 g/L, hematocrit 0.14, leukocytes 6.3×10^{9}/L (0.66 segmented neutrophils. 0.31 lymphocyte. 0.3 monocytes); urea 18.92 mmol/L; creatinine 104.3 μmol/L; APP 81%; KPTT 35 s; platelets 154 000; blood sugar 9.88 mmol/L; ionogram in regular values.

2.3. Complementary methods

In ICU, after administering volumes with crystalloids and colloids and performing the transfusion of four segmented red blood cells volumes, the patient was stabilised. This made possible the realization of a videocolonoscopy, which, due to technical difficulties, was difficult to evaluate. Subsequently, a mesenteric

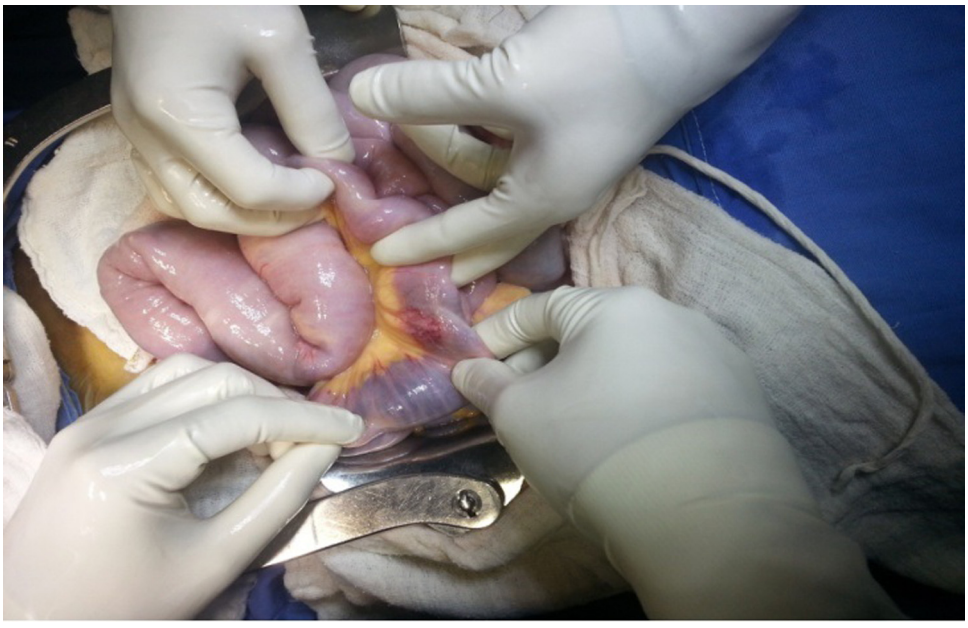

Fig. 3. Surgery. A 2 × 2 cm tumor was observed in the ileum.