

# HIV and Mucocutaneous Leishmaniasis Coinfection in Argentina Patient: Case Report

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## Image Article

Here we report the case of a 47-year-old Caucasian man, who was taken to consultation to our Department of Tropical Medicine, as he had clinical symptoms of mucocutaneous leishmaniasis. The lesion started 7 months before with rhinorrhea, epistaxis, erythema and edema of the nasal septum. He was treated with inhaled fluticasone and oral corticosteroids by an otorhinolaryngologist, due to the worsening of the symptoms.

At the time of the consultation, he was very thin, his general condition was stable, with dysphonia, and difficulty to swallow. The inspection of the oral mucosa showed a white exudate consistent with the diagnosis of orofacial candidiasis. The physical examination revealed an extensive disfiguring and mutilating facial lesion, with destruction of turbinates, nasal cartilage, bones of the nose and hard palate. The lesion also compromised the soft tissues of the nasal, oral, laryngeal and pharyngeal mucosa (Figure 1).



**Figure 1:** Ulcerative, destructive and mutilating lesion of the nasal and oral cavities, the upper lip is compromised as well, in a patient with HIV/*Leishmania* coinfection.

The microscopic examination of nasal mucosa biopsy samples allowed the visualization of *Leishmania* amastigotes with Giemsa stain. Subsequently, the samples were analyzed by nested-PCR and *L. (V.) braziliensis* infection was confirmed. Bone marrow aspirate was negative to *Leishmania*. The diagnosis of visceral Leishmaniasis was dismissed. HIV and *Leishmania* serology tests were positive. The patient was treated with liposomal amphotericin B but three weeks later he died as a result of cachexia and bronchopneumonia due to aspiration.

This patient, who was a forest engineer profession, informed that 18 months before he had travelled to Formosa, an endemic area of Leishmaniasis in Argentina. This would be the first case reported in the country of advanced mucocutaneous leishmaniasis, as a way of presentation of an unknown HIV infection.

Due to the high incidence of new HIV infections, in the north of the country, an area that is endemic to leishmaniasis, it would be important to alert family physicians as regards the importance of early detection of HIV infection, especially in patients with epistaxis and nasal obstruction, which are the first clinical symptoms. Unfortunately, HIV infection has the potential to negatively affect the natural course of a mucocutaneous leishmaniasis, in the same way that immunosuppression promotes a rapid spread of the parasite with a poor prognosis to treatment.