

實習醫師病例報告

報告者: Intern L組 呂維仁、趙珮吟、劉冠宏、
劉芳如、楊超捷

指導者: 王文岑醫師 暨口腔病理科全體醫師

97.04.15

General Data

Name:

王x平

Gender:

male

Age:

46

Native:

高雄市

Marital Status:

已婚

Occupation:

自由業

Attending V.S.:

王文岑

First visit:

93.07.12

Chief Complaints

- ✿ White patches over left buccal mucosa and both lips about 2 months



Present Illness

White patches over L't buccal mucosa
and both lips since 2 months ago.

Painless

Removable but appeared soon

Past History

Personal Medical History:

- Denied any systemic disease
- Denied any drug or food allergy

Personal Dental History:

- OD
- Extraction
- Prosthesis
- Attitude toward dental treatment : cooperative

Personal Habits

Risk factors related to malignancy :

- Alcohol: (-)
- Betel nuts: (+) 3y/ 1package/ day,
quitted
- Cigarette: (+) 20 years/ 1 package/ day

Other special habits:

- Denied

Oral Examination

- ❖ Creamy-white patches covered whole L' t BM and posterior R' t BM
- ❖ Removable by scraping



- ✿ White patches covered palate extending from hard palate to soft palate, measuring approximately 5cm x 3cm.
The patches could be removed by scraping it and the surface covered by the white patches was reddish.

- ✿ Upper dentition:

malocclusion



- ❖ White plaques covered the dorsal tongue ranging along the lateral border. The plaques could be removed by scraping it, too.



- ✿ White patches covered the lower lip extending from the left mouth angle to the middle. The patches could be removed.
- ✿ Several small vesicles some crusts around the left mouth angle.
- ✿ Gingival inflammation and cervical abrasion



Physical Examination

Pain

• (-)

Swelling

• (-)

Bleeding tendency:

• (-)

Induration:

• (-)

Fever or local
heat:

• (-)

Lymphadenopathy:

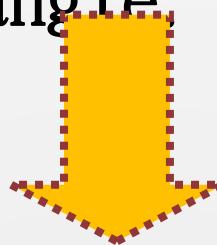
• (-)

Radiography Examination

Nil

Summary of Clinical Features

- ❖ Removable white patches covered whole buccal mucosa, palate, and tongue, asymptomatic.
- ❖ Small vesicles with some crusts around the L' t mouth angle.



Differential Diagnosis

Clinical Evidences

Separated white patches

Reddish(+) after scraping it

Small vesicles

Fever (-)

Edema (-)

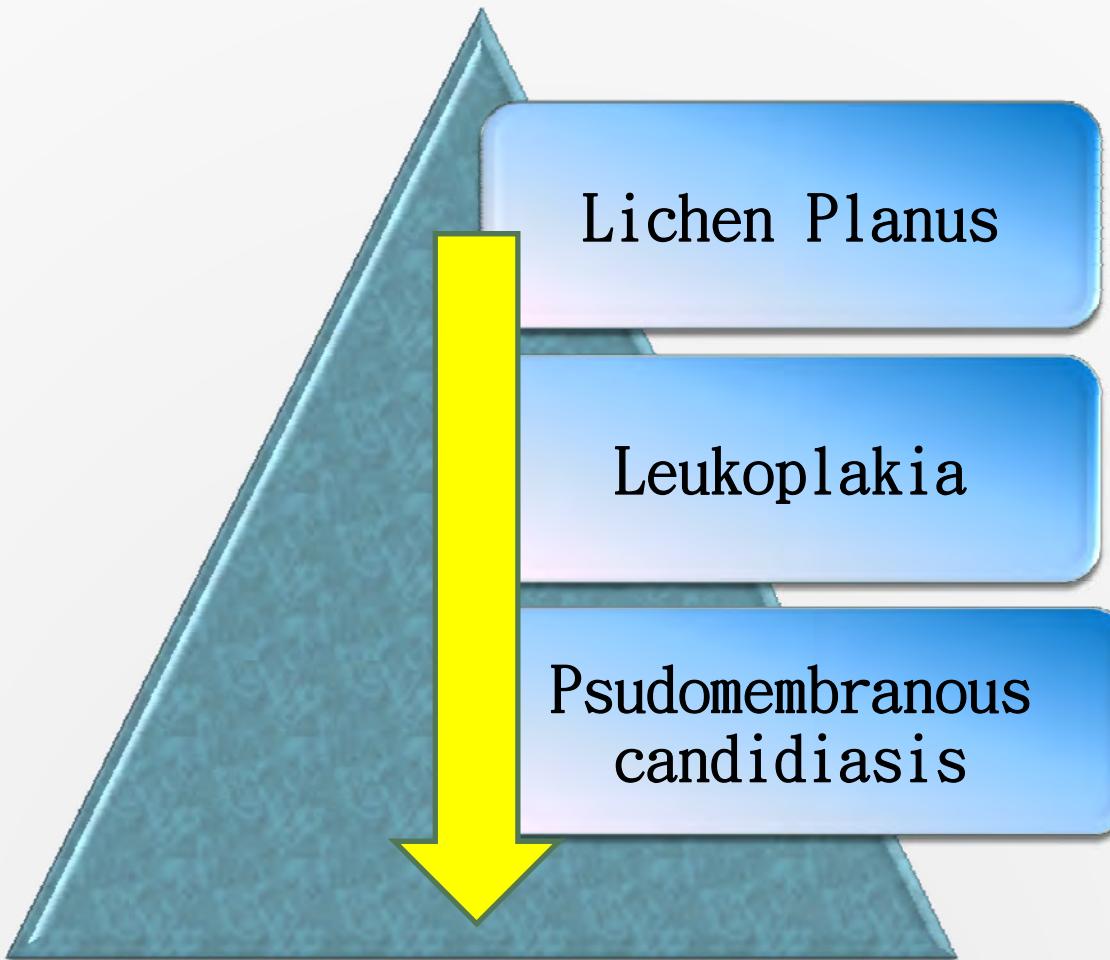
Local heat (-)

Pain(-)

Pus discharge (-)

→ White lesions and/or combined oral infection were suspected

Working Diagnosis of the White Lesion

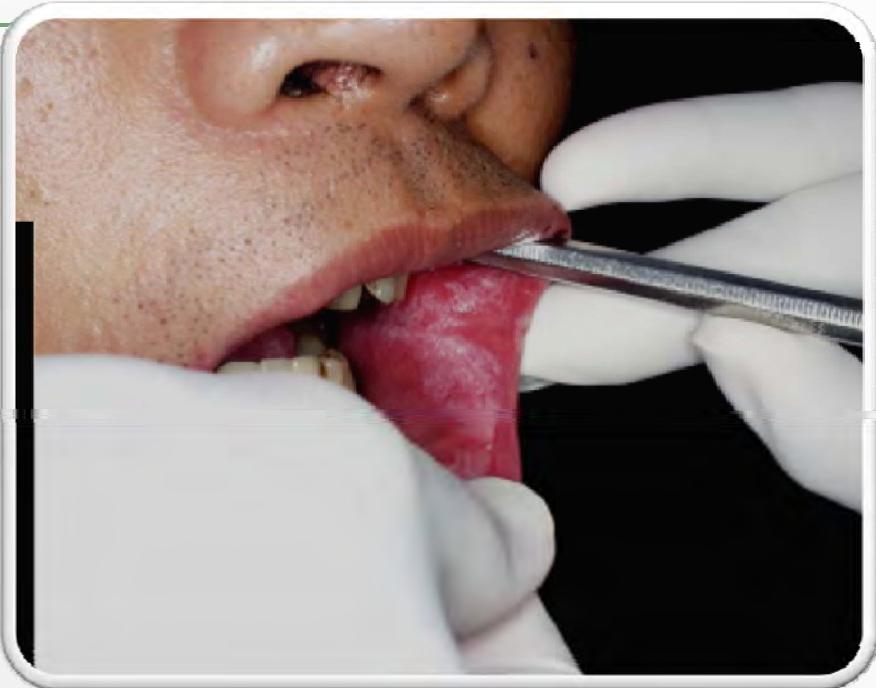


Lichen Planus

	Lichen planus (reticular form)	Our case
Site	Buccal mucosa, tongue, palate, gingival, lip	Buccal mucosa, tongue, palate
Age	middle age	46
Gender	♀	♂
Frequency	0.1%~2.2%	Unknown
Appearance	Lace-like network of white lines (Wickham's striae)	Creamy-white patches
Symptom	Asymptomatic	Asymptomatic
Other clinical feature	Non- removable	Removable



Lichen Planus



Our Case

Leukoplakia

	Leukoplakia	Our case
Site	Buccal mucosa, tongue, palate	Buccal mucosa, tongue, palate
Age	>40	46
Gender	♂	♂
Frequency	Unknown	Unknown
Appearance	White	Creamy-white patches
Mucosal surface	White	Reddish
Symptom	Asymptomatic	Asymptomatic
Other clinical feature	Non- removable	Removable



Leukoplakia



Leukoplakia



Our Case



Our Case

Pseudomembrane candidiasis

	Pseudomembrane candidiasis	Our case
Site	Buccal mucosa, dorsal tongue, palate	Buccal mucosa, tongue, palate
Age	> 40	46
Gender	♀	♂
Frequency	Common	Unknown
Appearance	Creamy-white to yellow plaques	Creamy-white patches
Mucosal surface	Reddish	Reddish
Symptom	Asymptomatic or foul taste, burning mouth sensation	Asymptomatic
Other clinical feature	Removable 	Removable 



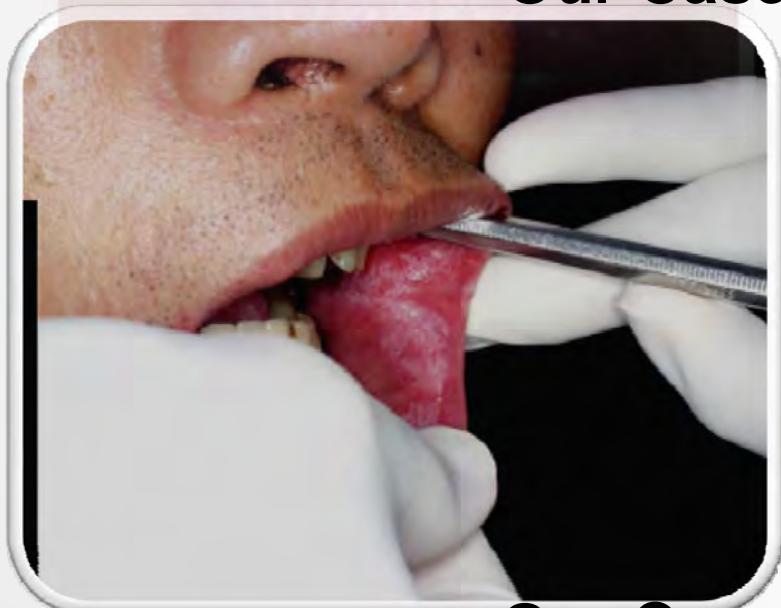
Pseudomembrane candidiasis



Our Case

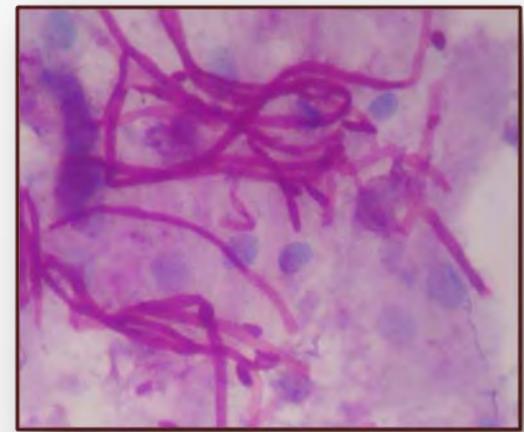
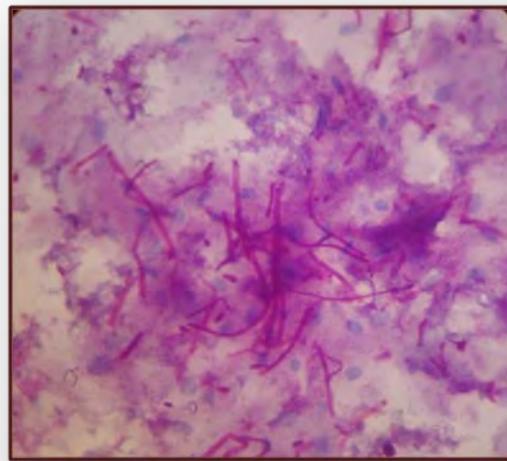
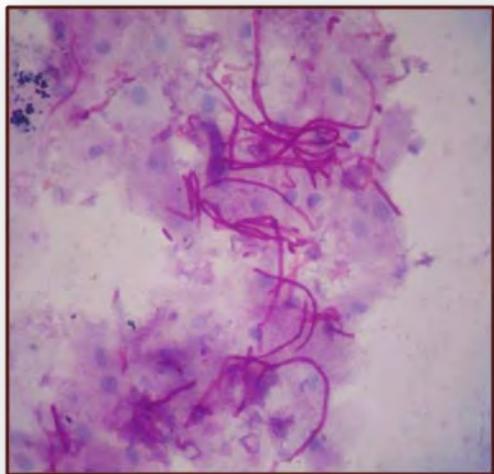


Pseudomembrane candidiasis



Our Case

Cytological Exam (PAS)



Pathological report:

- Candidiasis, buccal, tongue, palate, smear cytology

Clinical Impression

**Oral
candidiasis** over
BM, palate, tongue

**Herpes
simplex
virus
infection**
over L't mouth
angle

**Underline
disease** ?

Pathogenic Differential Diagnosis of Candidiasis

Pathogenesis	Our case
Drugs/Medications: multiple antibiotic, corticosteroids...	No medications
Endocrinopathies: DM, Hypoadrenalinism, Hypothyroidism...	No history → examination
Hematologic Disorders : Lymphoma, Leukemia...	No history → examination
Immunodeficiency: HIV, Thymic alymphoplasia...	No history → examination
Leukocyte Disorders: Myeloperoxidase deficiency...	No history → examination

Pathogenic Differential Diagnosis of Candidiasis (cont~)

Pathogenesis

Our case

Malignancy :

Leukemia, Thymoma...

Nutritional Deficiencies :

Iron deficiency, Vitamin B deficiency...

Other : Radiation therapy, xerostomia, old age, denture use...

No history

→ examination

Balanced taking food

→ examination

No radiation therapy;
Middle age;

No denture

R/O other pathogenesis

Doubt of candidiasis with other disorders

Arrange patient to Lab survey

Treatment Planning

- ✿ Antifungal treatment
- ✿ Further Lab survey to R/O possibility of other disorders or infections

Treatment Course

< 93-07-12 > First Visit

(Tx 1)
OE

- Multiple removable white patches over whole oral cavity, including mouth floor

Imp

- Candidiasis of mouth
- Herpes simplex infection L't mouth angle

Tx

- Take smear slides for buccal, palate and tongue dorsal → Rx: Diflucant
- Lab survey
 - CBC-I ; Herpes simplex virus serol
 - HIV 1+2 (ELISA)
 - TP ; Bil ; GOT ; GPT ; Alk-p ; UN ; CRTN ; GGT

< 93-07-19 > See Report 93-7-12

(Tx~~B2~~) : WNL

	P' t data	normal	unit
WBC	8. 00	4. 0-10. 0	X1000/u1
RBC	4. 84	4. 5-6. 0	X10^6/u1
Hgb	14. 7	13-17	g/dl
Hct	45. 2	40-53	%
MCV	93. 4	79. 0-101. 0	f1
MCH	30. 4	26. 0-35. 0	Pg
MCHC	32. 5	31. 0-37. 0	g/dl
PLT	212	130. 0-500. 0	X1000/u1
RDW-CV	13. 2	11. 5-14. 5	%
RDW-SD	45. 1	36. 0-46. 0	f1

	P' t data	normal	unit
Protein	7. 37	6. 0-8. 3	gm/dl
Albumin	3. 68	3. 5-5. 0	gm/dl
A/G	1. 00	1. 50-2. 01	
Bil(Total)	0. 50	0. 2-1. 0	mg/dl
Bil(Direct)	0. 07	0-0. 2	mg/dl
Bil(Ind.)	0. 40	0. 0-0. 8	mg/dl
GOT(AST)	30	10-42	IU/L
GPT(ALT)	29	10-40	IU/L
ALP	84	32-92	IU/L
UN	15. 9	7. 0-18. 0	mg/dl
Creatinine	0. 86	0. 6-1. 3	mg/dl
GGT	52	7-64	IU/L

Treatment Course cont~

- + Lab data

Herpes simplex virus < 1:4 →
Negative
(positive $\geq 1:4$)

- + ELISA of HIV :



Treatment Course cont~

< 93-07-19 >

Cont~

OE

- Multiple removable white patches disappeared 2 days after last visit post medication

Imp

- Oral candidiasis , suspect HIV infection

Tx

- Western blot test
 - Anti HIV-I
 - Anti HIV-II

Treatment Course cont~

< 93-07-26 > See Report 93-07-19

(Tx 3)



HIV WB (+)

OE

- White patches disappeared



Final Impression

- Oral candidiasis
- Human immunodeficiency virus (HIV) infection

Tx

- Referred p't to Infection Dept.

Treatment Courses (Infection Dept)

Tx1 < 93-08-11 > HIV Tx

Rx :

- Diflucan (50mg) 2# QD x 21days

Examination:

- CBC, Chest X-ray (CXR), Urine test

Tx2~ < 93-09-01 >

Anti-HCV:
(+)

VL:146000
copies/ml
(>50
copies/ml)

CD4:157
(<200)

HBsAG: (-)

STS: (-)

CXR :
Consider
pneumonia
in ant.
segment of
right upper
lobe

Rx :

- Diflucan (50mg) 2# QD x 7days
- Combivir 1# BID x 7days
- Kaletra 3# BID x 7days



Start HAART

Examination:

- CXR, CBC

Tx3~4 < 93-09-08 > ~ < 93-09-15 > 1st month of HAART

BW : 48-50 kg

E.S.R : 31
mm/h (>10
mm/h)

CRP : 5.26
ug/ml (>5
ug/ml)

CXR : Interval
resolution of
bronchopneu-
monia at ant.
segment of
right upper
lobe
(compared
with 8/12)

Abd. echo
report(on
9/13) : Hepatic
nodule
(0.82cm)

Rx :

< 93-09-08 > < 93-09-15 >

- | | | |
|--------------------|----------------|----------|
| • Diflucan (50mg) | 2# QD x 7days | x 28days |
| • Combivir | 1# BID x 7days | x 28days |
| • Viracept (250mg) | 5# BID x 7days | x28days |

Tx5~6 < 93-10-13 > ~ < 93-10-27 > 2nd month of HAART

O

- Aggravated diarrhea, palpitation , anxiety, suicidal idea

Tx

- Suggest combivir plus viramune, and continue diflucan

Rx

- Diflucan (50mg) 2# QD x 14days
- Xanax(0.25mg) 1# TID x 28days
- Combivir 1# BID x 14days
- Viramune(200mg) 1# BID x 14days

Tx7 < 93-11-24 > 3rd month of HAART

O

- Aggravated diarrhea, palpitation, anxiety improved

Tx8~9 < 93-12-22 > ~ < 93-12-27 > 4th month of HAART

O

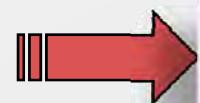
- No diarrhea, no palpitation after switching to combivir plus
- Viramune, mild nausea sensation, headache no rash

Examination (93-12-22)

CBC:
WNL

VL <50
copies/ml

CD4 :417



Back to normal range

Tx10~15 < 94-04-13 > ~ < 95-04-19 > 8th~20th month of HAART

O

- Skin itching, eczema, suicide idea

Rx

- | | |
|-----------------------|----------------|
| • Ichderm Cream(15gm) | 1#BID x 28days |
| • ClariTYNE(10mg) | 1# QD x 28days |
| • Esperson(5gm) | 1# BID x 7days |

Examination (94-07-13)

CBC,
CXR, Abd.
Echo

VL<50
copies/ml

CD4:220

Abd.
Echo:
Hepatic
nodule(0.6
cm)

Examination (95-01-15)

CBC,
CXR, AFP

VL<50
copies/ml

CD4:307

AFP:5.3
ng/ml (<
20 ng/ml)

Tx16 < 96-03-21 > Lost f/u for about 1 year since 95/04/19
(於95年7月底自行停藥)

O

- Skin papules, carbuncle, insomnia, Pt refused psychiatric Tx

Rx

- Elomet Cream(5gm) 1 tube BID x 7days
- Fusotex(5gm) 1# BID x 7days
- Estazolam(2mg) 1# QD x 28days
- Xanax(0.25mg) 1# TID x 28days
- Viramune(200mg) 1# BID x 28days
- Combivir 1# BID x 28days

Examination

CBC, CXR,
Abd. Echo,
AFP

VL=2450
copies/ml

CD4:70

AFP : 6.9
ng/ml (< 20
ng/ml)

Tx17 < 96-04-04 > Continue HAART

O

- Carbuncle and insomnia improve

Rx

- Ditto

Tx18~20 < 96-05-02 > ~ < 96-06-29 > Continue HAART

O

- Occupation improve, skin papules, carbuncle

Rx

- Cloxacillin(250mg) 2# QID x 14days
- Septon(5gm) 1# BID x 30days
- Fusotex(5gm) 1# TID x 7days

Examination(96-06-29)

CBC, CXR,
Abd. Echo,
AFP

VL<50
copies/ml

CD4:177

AFP : 6.9
ng/ml (< 20
ng/ml)

Tx21~25 < 96-07-27 > ~ < 97-02-15 > Continue HAART

O

- Skin lesion improve, carbuncle recover, muscle cramping,
- Eye itching

Rx

- Ditto

Examination(96-10-19)

CBC:
WNL

VL<50
copies/ml

CD4:285

Lab data summary

	93/8/11	94/7/13	95/4/19	96/3/21	96/6/29	96/11/16
WBC	5.94	4.25	5.11	3.34	3.53	5.03
RBC	5.06	3.4	3.34	4.58	3.05	3.32
Hgb	15.3	14.3	14.5	14	12	13.8
Hct	46.5	42.1	41.1	42.4	34.8	40.6
HCV	91.9	123.8	123.1	92.6	114.1	122.3
HCH	30.2	42.1	43.4	30.6	39.3	41.6
HCHC	32.9	34	35.3	33.9	34.5	34
PLT	193	213	197	209	309	206
RDW-CV	12.6	12.3	12	12.6	20.6	12.8
RDW-SD	42.0	55.6	54	42.4	81.3	57.5
NEUT	54.1	59.8	65	66.1	65.6	57

	93/8/11	94/7/13	95/4/19	96/3/21	96/6/29	96/11/16
EOSIN	1	3.3	2.7	4.5	1.1	2.2
BASO	0	0.4	0.2	0	0.2	0.4
LYMPH	35	31.6	27	24.9	24.9	35.2
MONO	16	4.9	5.1	4.5	8.2	5.2
HDL-C			75.5	36	51	65
LDL-C			74.4	69	50	52
GPT(ALT)	24	23	28	28	17	22
CHOL	111	134	164	143	130	151
TG	128	98	57	145	62	55
Creatinie	0.81	0.99	1.02	1.1	0.9	0.93
Sugar	80	83	84	84	93	98
TC/HDL			2.2	4	2.5	2.3
LDL/HDL			1	1.9	1	0.8

	93/8/11	93/12/22	94/7/13	95/4/19	96/3/21	96/6/29	96/11/16
CD4 _{27-51%}	9.36%	11.45%	15.37%	22.24%	8.41%	12.70%	16.10%
CD8 _{14-44%}	80.86%	76.54%	71.69%	68.66%	70.62%	78.60%	73.90%
CD4:CD8 ratio _{1.4~2.0}	0.12	0.15	0.21	0.32	0.12	0.16	0.22
HIV-VL	146000	<50	<50	<50	2450	<50	<50
Total T-cell	89.52%	88.69%	85.95%	84.54%	81%	88.80%	
Active T-cell	67.39%	43.64%	43.60%	41.31%	42.32%		
Total B-cell	7.53%	6.98%	10.12%	12.20%	13.57%	4.80%	

Another Two Cases: Case II (96-10-01)

A 46 y/o male complained of pain at lateral tongue, lips and palate for 2 years.

Smoking, betel nut chewing, alcohol consumption for 20~25years.

Denied heart disease, arrhythmia, TB , Thyroid disease, sex transmitted diseases, drug allergy....et al.

Herpes zoster over right back in one year

Oral Examination

- Removable white patches over bilateral BM, upper lip, and tongue dorsum.

Smear cytology: Oral candidiasis over lateral tongue, lips and palate

Lab survey : HIV infection

Refer to Infection Department for further treatment on 96-10-17



Another Two Cases: Case III (96-11-05)

A 31 male comes with multiple white spots over full mouth for 2 months.

Denied any habits and any systemic diseases.

A **syphilis history** [REDACTED] **BUT ! ! !** was found from his previous medical [REDACTED]

Oral Examination

- Removable white patches over bilateral BM, palate, and tongue dorsum.
- Cough, pneumonia for 2months



Smear cytology: **Oral candidiasis** over BM, palate and tongue

🐾 ***Homosexual and one-night stand experience was told in the later treatment courses***

Refer to Infection Department for further treatment on 96-11-22

	<i>Our Case</i>	<i>Case I</i>	<i>Case II</i>	<i>Normal range</i>	
WBC	8	3.28	2.39	4.0-10.0	x1000/ <i>ul</i>
RBC	4.84	4.79	3.6	4.5-6.0	x10*6/ <i>ul</i>
Hgb	14.7	13.6	10.6	13-17	<i>g/dl</i>
Hct	45.2	41.8	31.5	40-53	%
CRP	5.26	1.41	11.9	<5	<i>ug/ml</i>
HDL-C	-	27	24	29.0-85.0	<i>mg/dl</i>
LDL-C	-	94	151	0.0-130	<i>mg/dl</i>
HIV 1+2(ELISA)	+	+	+		
HIV 1,2 (WB)	HIV 1(+)	HIV 1(+)	HIV 1(+)		
HIV-VL	146000	184000	813000	<50	<i>copy/mL</i>
HA IgG	-	-	-		
HBsAg	-	-	-		
HBsAb	+	+	+		
HCV Ab	+	-	-		
CD4	9.36	6.21	10.7	27-51	%
CD8	80.86	67.4	51.2	14-44	%
HLA-DR positive	74.92	78.4	-	28.36-46.1	%
STS	-	-	+		
Amoebiasis test	-	-	-		
Chlamydia(Sero)	-	+	+		
Toxoplasmosis	-	-	-		
IgM	-	-	-		
Cryptococci	-	-	-		
neoformans(S)	-	-	-		
CMV(sero)	-	-	-		
CMV IgG(B)	-	-	+		
CMV IgM(B)	-	-	-		
AFB	-	-	-		

Discussion

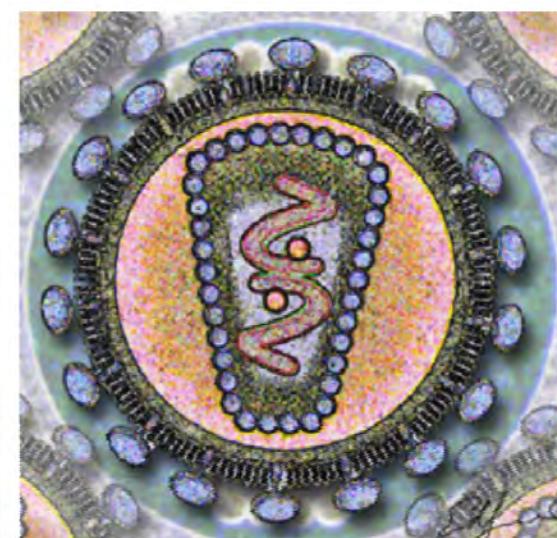
HIV

- Oral clinical features
- Other clinical features
- The relationship between the oral pathosis and HIV

HIV P' t in dental treatment

HIV (Human Immunodeficiency Virus)

- ✿ Identified in 1983(AIDS)
- ✿ Previous names
 - Immune Deficiency-Associated Virus(IDAV)
 - Human T-lymphotropic virus-III (HTLV-III)
- ✿ Designated in 1986



Classification

HIV-1 (Chimpanzee)

- Initially discovered and termed LAV
- More virulent, relatively easily transmitted
- Cause of the majority of HIV infections globally

HIV-2 (Sooty Mangabey)

- Less transmittable than HIV-1
- Largely confined to West Africa

Transmission

Sexual route

- The majority of HIV infections
- Contact with the genital, oral, or rectal mucous membranes of another

Blood or blood product route

- Intravenous drug users
- Recipients of blood transfusion
- Reuse of needles
- Health care workers

Mother-to-child transmission (MTCT)

- Pregnancy
- Intrapartum at childbirth

Disease staging system for HIV infection and disease (sep 2005, WHO)

Stage I:

- Asymptomatic, not categorized as AIDS

Stage II:

- Minor mucocutaneous manifestations, recurrent upper respiratory tract infections

Stage III:

- Unexplained chronic diarrhea for longer than a month, severe bacterial infections, pulmonary tuberculosis

Stage IV: **→ INDICATORS OF AIDS**

- Toxoplasmosis of the brain, candidiasis of the esophagus, trachea, bronchi or lungs and Kaposi's sarcoma.

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Systemic Symptoms of AIDS

Fevers

Sweats (particularly at night)

Chills

Swollen lymph nodes

Sore throat

Weakness

Weight loss

Diarrhea

Joint and muscle aches

Oral and Oropharyngeal Infections

- Oral candidiasis
- Periodontal disease
- Gingival bleeding
- Aphthous stomatitis
- Herpetic stomatitis



ENT Symptoms

- ⊕ Otitis media
- ⊕ Otomycosis
- ⊕ Sensory neural hearing loss

Neck Infections

- ⊕ Cervical lymphadenopathy
- ⊕ Deep neck space infections



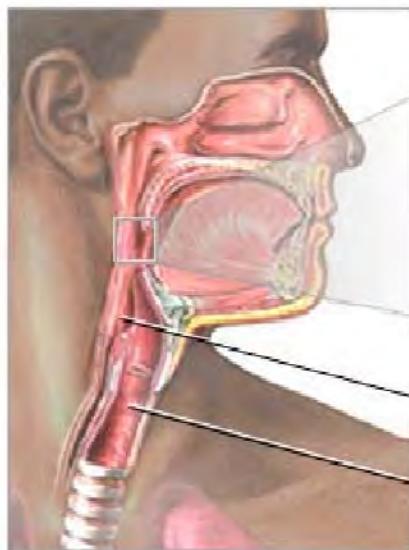
Pulmonary Infections

- ⊕ Pneumocystis pneumonia
- ⊕ Tuberculosis

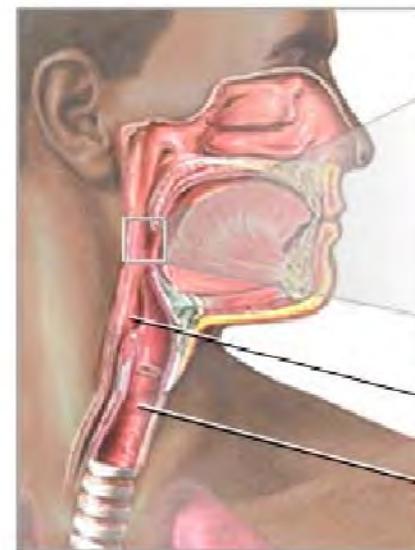


Gastrointestinal Infections

- ❖ Esophagitis
- ❖ Chronic diarrhea



Ulcers in esophagus



Candida (yeast) infecting esophagus



Esophagus

Trachea

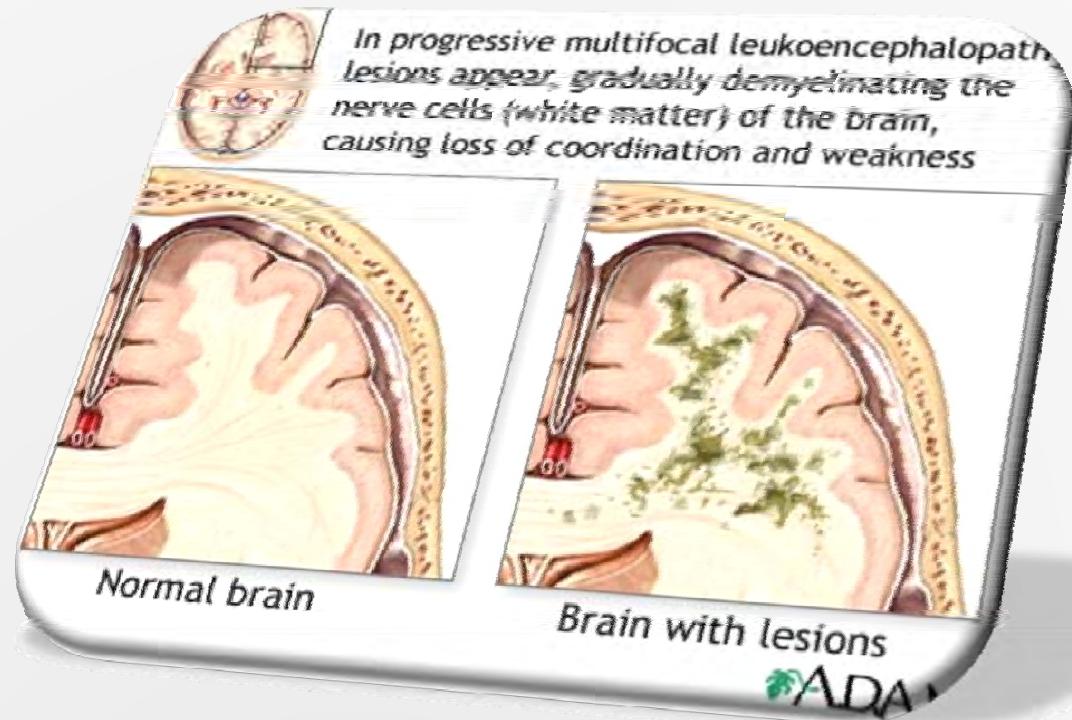
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Neurological Diseases

- Toxoplasmosis
- Progressive multifocal leukoencephalopathy (PML)



Tumors and Malignancies

- ❖ Kaposi's sarcoma
- ❖ Burkitt's lymphoma
- ❖ Hodgkin's disease
- ❖ Anal and rectal cancer



Kaposi's sarcoma

Oral Features of HIV/AIDS

Oral Lesion of HIV Positive Patients

- Oral lesions in *symptomatic stage* or *pre-AIDS stage* when CD4+ lymphocyte counts are reduced and range from 200~800 per μl

Hairy leukoplakia

Pseudomembranous candidiasis

Diffuse herpes simplex
orogivostomatitis

Gingivitis/periodontitis

Acute nonspecific ulcers

Diffuse varicella-zoster lesion

Hairy
leukoplakia



Pseudomembranous candidiasis



Acute nonspecific



Necrotizing ulcerative
gingivitis



Herpes simplex virus
infection



Varicella zoster virus
infection



Oral Lesions of AIDS Stage

Infection

- Candidiasis - intra oral , esophageal
- Diffuse herpes simplex gingivostomatitis
- Diffuse varicella-zoster lesion
- Cryptococcosis
- Histoplasmosis
- Herpes simplex infection
- Cytomegalovirus ulcer
- HIV gingivitis/periodontitis

Oral Lesion of AIDS Stage

Neoplasm

- Kaposi's sarcoma
- Non-Hodgkin's lymphoma

Non-Hodgkin's lymphoma



Are oral candidiasis and hairy leukoplakia related to the CD4 and viral load kinetics during HIV infection?

The onset of OC and/or OHL is heralded by the sequence of a sustained *reduction of CD4+*, with an associated *sharp increase of VL*.

After adjustment for clinical stage and antiretroviral use, the main factor associated with the development of either oral lesion and OC was *CD4+ count*

Oral Candidiasis or oral hairy leukoplakia can predict CD4⁺

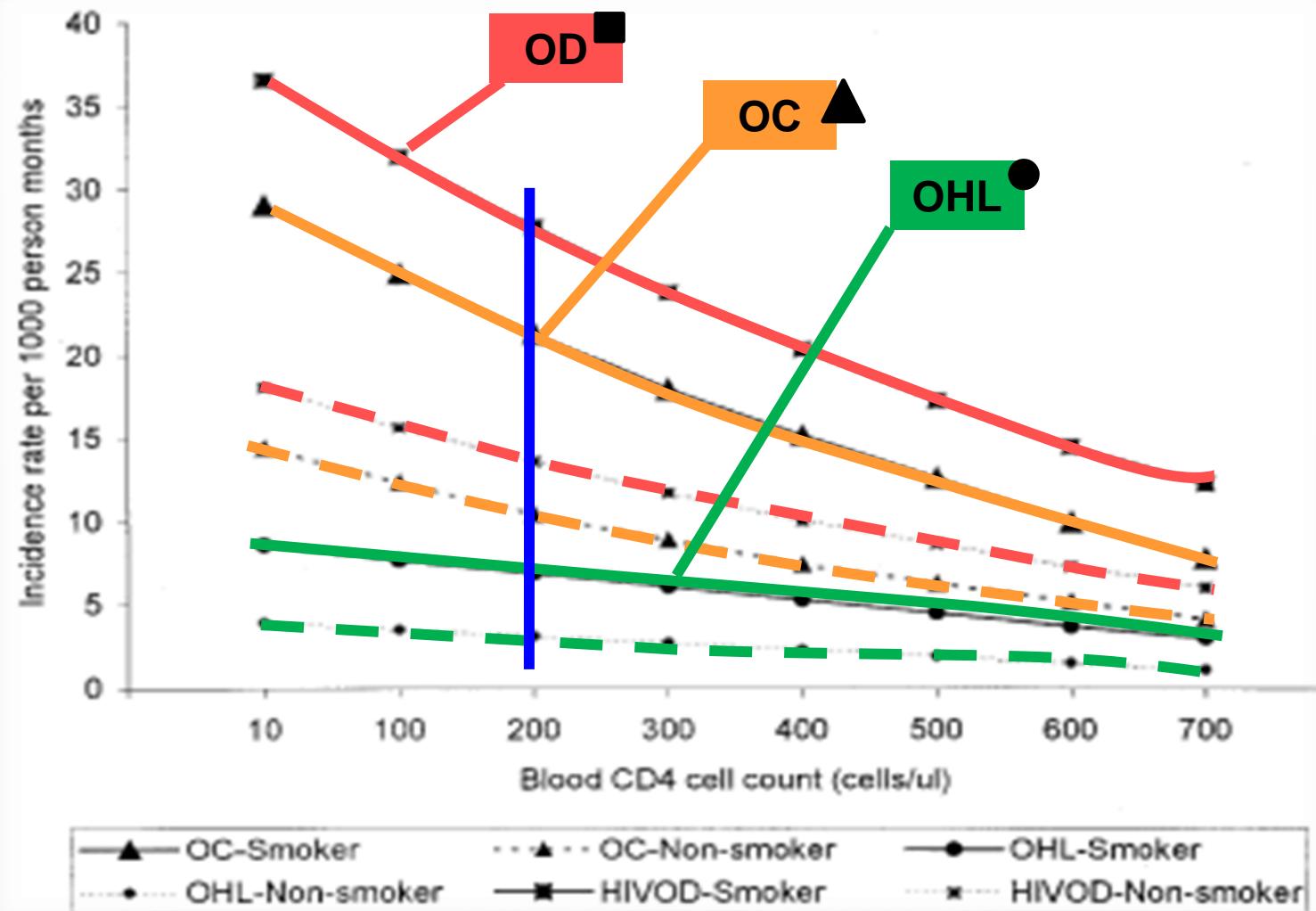
OC predicted CD4⁺ counts, changes in CD4⁺ counts, and AIDS-defining disease occurrences after adjustment for VL.

OHL predicted CD4⁺ counts but not a change in CD4⁺ count .

Number of OC episodes was the most significant predictor for change in CD4⁺ count after adjustment for antiretroviral medications.

The relationship of smoking and CD4 counts, OC, OHL, or HIV-OD

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MSASMS(Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2005;99:39-47)



What is more important in the development of oral candidiasis in HIV-infected patients, low CD4 counts or high viral load?

CD4 hallmark predictor : 200 cells/L.

VL < 36000 copies/ml → no confounding effects of CD4

VL > 36000 copies/ml

- CD4 → < 45 cells/L -- 100% OPC+
- 45 ~ 150 cells/L -- 20% OPC+
- 150 ~ 500 cells/L -- 100% OPC+

Viral load was more important than CD4 cell number as a predictor of OPC

Oral Care and Treatment Protocols in HIV

Current Esthetic Issues

Consent:

- Based on a patient's voluntary authorization

Confidentiality:

- Not absolute

Dental duty of care:

- Unethical to refuse

Does an oral health care worker have a professional obligation to disclose their own HIV ?

Modify the dental care?

ADA 1994:

- “It was both safe and desirable to make regular dental care available to HIV-positive patients.”

Circumstances when routine dental treatment may need to modified:

Low CD4 lymphocyte levels predispose to oral lesions requiring specific treatment

Reduced platelet levels below 60,000 cells mm^3 -
(normal 150,000~400,000) effect clotting time

Reduced neutrophil levels below 500 cells mm^3 -
(normal 2500~7500) may require antibiotic prophylaxis

Patients with late stage AIDS may require a rolling treatment plan with regular reviews of ability to attend and withstand treatment

Preventive Approach

Consensus guidelines:

- Screen for HIV-related oral lesions and treat if necessary
- Screen for xerostomia as a possible symptom of HIV or as side-effect of HAART

Blood analysis~ assist in planning treatment

- Prevent further disease

Local anesthetic :

- Patients with HAART medications (breakdown in liver function)

Antibiotic Prophylaxis

- ✿ No evidence-based data support the need for routine antibiotic to prevent bacteremia and septicemia

Indications:

- CD4+ ≤ 200 per μl
- PMNL ≤ 500 per μl , before oral surgery (antibacterial mouthrinse and scaling)
- Patients infected HIV via IV drug use
→ at risk for developing endocarditis

Conclusion

Oral candidiasis can be the first manifestation of HIV infection.

OC present → VL ↑

Aggressive dental procedure could be delayed if oral candidiasis present

Consent was not absolutely right

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Thank you for your kind attention