

SPONTANEOUS ENTEROCUTANEOUS FISTULA IN AN HIV POSITIVE PATIENT

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SUMMARY

A 35 years old woman presented with a periumbilical abscess that later developed into an enterocutaneous fistula. She was found to be HIV positive and responded promptly to antibiotics and antiretroviral drugs. We conclude that in situations where there is enterocutaneous fistula of unknown aetiology, HIV screening should be strongly recommended.

KEY WORD: Spontaneous enterocutaneous fistula, HIV seropositivity.

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INTRODUCTION

Human immunodeficiency virus was first isolated in institute Pasteur in Paris by Luc Montagnier in 1983.¹ It is the causative factor of acquired immune deficiency syndrome (AIDS) which is characterized by a range of immune dysfunction.² AIDS is a dreaded disease assuming an epidemic proportion in most parts of the world. It was first reported in the United State of America in 1981.³ Following infection with the virus there is rapid and widespread dissemination of the virus which attack T lymphocyte cells leading to a drop in the CD4 lymphocyte counts and thus immunodeficiency and proneness to the development of opportunistic and other infections.^{4,5} AIDS has been implicated in the causation of various

infections such as pharyngitis, abscess and warts.⁶⁻⁸ However there is paucity of reports on the incidence of enterocutaneous fistula in HIV seropositive patients. The purpose of this study is to present a rare case of spontaneous enterocutaneous fistula in an HIV seropositive patient.

Case Report: Mrs. A.I is a 35-year-old housewife who presented with a discharging sinus from the umbilical cicatrix of two weeks duration. She was apparently well until about four weeks before presentation when she noticed a painful umbilical swelling. Swelling was initially small in size, but got bigger and more painful with time. There was associated fever and rigors. The swelling finally ruptured spontaneously and drained purulent materials at first and later faecal matter. She was said to have used various antibiotics before presentation to the hospital. The patient also had a history of weight loss and general feeling of unwell.

On examination she was chronically ill looking, depressed, pale and slightly febrile. Her weight was 55kg, there was no peripheral lymphadenopathy. She had a full abdomen, mild generalized abdominal tenderness, no guarding and no organomegally. She had a sinus on the unmbilical cicatrix surrounded with some sloughs and was discharging purulent and faecal materials. See figure-1. Debridement was

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Figure-1

done and wound swab specimen sent for microscopy, culture and sensitivity. Blood was also sent for full blood count and HIV screening. She was admitted and commenced on wound dressing as often as necessary. She was also placed on Gentamycin, Metronidazole and Cefuroxime. The packed cell volume was 10% and she subsequently had four units of whole blood. HIV test was positive using the Western blot technique. She was then placed on antiretroviral drugs including stavudine, nevirapine and lamivudine. The culture yielded growth of coliform organism, which was sensitive to gentamycin and cefuroxime, amongst others. She was placed on antiretroviral drugs and antibiotics. The patient did well on the above management as the fistula closed up on conservative measures after ten weeks after admission. She was subsequently discharged to be followed up in the clinic.

DISCUSSION

Enterocutaneous fistula simply means an abnormal communication between gut and skin. It may be congenital but it is usually acquired. Acquired enterocutaneous fistula usually occurs as a complication of intestinal operation or following criminal abortions.¹ Leakage of faecal material from the intestine leads to abscess formation, which finally drain out through the wound resulting in the formation of enterocutaneous fistula.

Spontaneous enterocutaneous fistula is not a common entity. Our patient did not have any surgical procedure. She however developed an abscess in the umbilical region that eventually

got complicated by an enterocutaneous fistula. There have been some reports of spontaneous rectal fistulae in children who were later diagnosed to be HIV positive.^{9,10} However, these were cases of rectovaginal and rectovesical fistulae as against the case being presented here who had enterocutaneous fistula. Generally, HIV positive patients are more prone to various forms of infections because of the compromised immunity.

The response of the patient to antiretroviral drugs and antibiotics was quite remarkable. This strongly suggests that the immunodeficiency caused by the HIV virus in this patient was probably responsible for the abscess that led to the enterocutaneous fistula.

In conclusion therefore HIV infection should be suspected in cases of spontaneous enterocutaneous fistula. Such cases respond to antiretroviral drugs and antibiotics without necessarily resorting to surgical intervention.

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