

Letters to the Editor

Aphthous stomatitis in a patient with Behçet's disease and HIV was associated with an increased HIV load

Sirs,

Rare cases of Behçet's disease (BD) in HIV-infected patients have been reported (1-5). Oral aphthous also occur in HIV infection. We describe a patient whose pattern of BD crises suggests a clear-cut relationship between the sudden appearance of oral aphthae and polyarthralgia, and the virological escape from antiretroviral therapy control.

A 41-year-old homosexual man has been followed in our clinic for asymptomatic HIV infection since 1986 (CDC A). He had a prior history of cured hepatitis B. This patient related in his clinical history before the HIV seropositivity that he had experienced 5 to 6 annual crises of severe aphthous ulcers oral since childhood and 2 episodes of genital and mouth ulcers highlighting a BD. In 1992 he was treated with zidovudine and zalcitabine and complained of moderate headaches and the sudden appearance of oral severe aphthous ulcers. At this time, zalcitabine was stopped.

Ophthalmological examination did not detect uveitis. A pathology test was negative. A diagnosis of incomplete BD was made. The CD4⁺ T-cell count was 332/mm³ (22%). Cerebrospinal fluid was normal. HLA-B51 was present. Colchicine and mouth washes prescribed for 1 year were not completely effective; thalidomide was added (100 mg/day) and the mouth ulcers disappeared in few days. During this time, the antiretroviral therapy was regularly modified, combining various nucleoside reverse transcriptase inhibitors. When thalidomide was lowered

to 50 mg every two days (d) the oral ulcers reappeared, and the dose was raised to 100 mg/d. In 1996 he experienced a BD crisis with inflammatory polyarthralgias of the shoulder and small and intermediate joints (for which a non-steroidal anti-inflammatory drug was unsuccessfully prescribed) associated with an aphthous stomatitis (Fig. 1). Simultaneously, the HIV infection escaped bitherapy control with nucleoside inhibitors (viral load: 13,000 copies(c)/ml).

A triple therapy was initiated. Polyarthralgia and the mouth ulcers disappeared in few days. In 1997, after 1-year thalidomide-free period, polyarthralgia and giant oral aphthous ulcers reappeared. The HIV viral load was high (10,200 c/ml). Thalidomide was reintroduced but this time induced only a partial regression of the joint pain and oral ulcers. Saquinavir was replaced by indinavir. One month later the viral load fell to below 500 c/ml and the clinical symptoms of BD disappeared. In 1999 the joint pain and mouth ulcers suddenly reappeared and persisted despite thalidomide (100 mg/d). HIV monitoring showed a dramatic rise (38,035 c/ml). One month after starting a new drugs regimen viral load was 313 copies/ml, and the patient became completely asymptomatic.

BD is clinically defined as oral and buccogenital aphthosis associated with systemic manifestations that satisfy certain internationally established criteria (6). Some rare cases of vasculitis occurring during HIV infection have been described. Many viruses can cause vasculitis, e.g. hepatitis B and C viruses (7), cytomegalovirus, parvovirus B19 and HIV (8). HIV infection and diverse viruses can be responsible for vasculitis exacerbations. In certain cases of vasculitis of viral origin, the antiviral treatment can help to control the vascular disease (7, 9). Three cases of BD in HIV-infected patients were published before plasma HIV-load determination was possible (1-3). Two principle hypotheses were evoked, such as a cellular immunodeficiency and a probable relationship between HIV infection and the concomitantly observed BD or other vasculitides (2). The aphthous-like ulcerations seen in association with HIV disease represent a challenging differential diagnosis with other 'non viral' vasculitides (10).

Despite the use of thalidomide, our patient's increased viral load was accompanied by the sudden appearance of mouth ulcers and diffuse polyarthralgia. Many case reports and small series have suggested that thalidomide is effective against aphthous ulcers in HIV-infected patients without impairing immunocompetence (11). Thalidomide's effects on immune function

associate anti-inflammatory and immunomodulatory activities. In addition, the anti-retroviral therapy-induced decrease in the viral load was followed by attenuation of the BD clinical symptoms and allowed the discontinuation of specific BD therapy. This observation suggests that HIV replication may trigger a vasculitis crisis as has been observed with other viruses.

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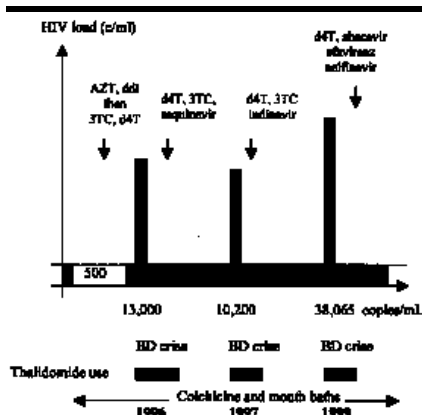


Fig. 1. Behçet's disease (BD) crises and variation of HIV load. Influence of antiretroviral therapy on the sudden rise of vasculitis. AZT: zidovudine, d4T, stavudine, 3TC: lamivudine, ddI: didanosine.