Case report

HHV8 +VE multicentric Castleman's disease (MCCD)

A 29-year-old man presented with night sweats, loss of appetite and fevers for about a week. Two sputa samples taken at the day hospital had been direct smear-negative for acid-fast bacilli (AFBs). Clinically he presented with undulating high fevers, tachycardia and was markedly pale, with generalised shotty cervical lymphadenopathy and mild splenomegaly. Chest X-ray showed bilateral hazy infiltrates and hilar adenopathy. Laboratory tests showed: haemoglobin 3.6, mean corpuscular volume 68.3, white cell count 7, platelets 121, renal function normal, protein 67 and albumin 14. The rest of the liver function tests were normal. He tested HIV positive with a CD4 of 80. Four blood cultures showed no growth.

He was started on a broad-spectrum antibiotic followed by empiric tuberculosis treatment, but continued to be very unwell with high swinging fevers.

A bone marrow showed a hypercellular smear with plasmacytosis and increased erythropoiesis with severe megaloblastic features. A lymph node biopsy showed prominent dysplastic dendritic cells with the occasional 'lollipop' lesions, interfollicular plasma cells and prominent small vessel vascularity confirming multicentric Castleman's disease (MCCD).

The patient was started on highly active antiretroviral therapy (HAART) and transferred to the haematology department. He was noted to have Kaposi's sarcoma (KS) lesions on his soft palate. HHV8 PCR was positive, He became pancytopenic and septic. After treatment with broad-spectrum antibiotics he was started on chemotherapy. Blood counts started to pick up; he was discharged and had another 6 courses of chemotherapy (CHOP) as an outpatient. A CD4 count after 9 months of treatment was 228. He continues to do well after 15 months.

HHV8 is universally associated with MCCD in HIV. It is known to have a poor outcome. The symptoms are suggestive of an inflammatory illness due to the cytokine response. It is associated with KS, Hodgkin's, non-Hodgkin's lymphoma and polyneuropathy, endocrinopathy, M-protein band, skin hyperpigmentation (POEMS) syndrome. HAART and chemotherapy can give partial response and symptomatic relief.

BARBARA SCHOLZ
Department of Medicine
University of Cape Town

single suture

COX-2 inhibitors last choice in heart patients

Cyclo-oxygenase-2 (COX-2) inhibitors should be used only as the last choice after other types of non-steroidal anti-inflammatory drugs (NSAIDs) to relieve chronic pain in people with heart disease or at high risk of it, the American Heart Association has recommended.

The Association has recommended a stepped approach to treatment. The first step should be non-pharmacological approaches, such as physical therapy and weight loss, for patients with known cardiovascular disease or with risk factors for ischaemic heart disease. Drug treatment should start with agents with the lowest reported risk of cardiovascular events, before other agents are prescribed, and at each step account should be taken of the risk-benefit balance.

First-line drug choices include paracetamol, aspirin, tramadol, and short-term use of other narcotic analgesics. If these fail to achieve adequate pain control, the next option is non-acetylated salicylates, such as naproxen.

The expert committee recommended NSAIDs that aren't COX-2 inhibitors if pain is still inadequately controlled, then NSAIDs with some COX-2 activity as the next step, and then COX-2 selective NSAIDs as the last choice. The committee considered the risk of all three of these classes to be sufficiently high to require that patients taking them should be monitored regularly for sustained hypertension (or worsening of prior blood pressure control), oedema, worsening renal function, or gastrointestinal bleeding. They found several studies showing an increased risk of cardiovascular complications with COX-2 selective NSAIDs, particularly in patients with prior cardiovascular disease or risk factors for that disease. The complications included myocardial infarction, stroke, heart failure, and hypertension.

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