A Case Report

By

María Teresa Martínez Rísquez
Lucía Ramos Merino
Patricia Vázquez Rodríguez

CASE PRESENTATION

A 61 year-old man was admitted to the Emergency Department with fever and abdominal pain. The fever started two weeks ago and was well tolerated, with no predominant pattern. The abdominal pain started two days ago; it developed suddenly, was located in the right upper side and it was not radiated. He reported nausea and two episodes of bilious, non-bloody emesis this morning. No diarrhea nor other symptomatology

PATIENT´S FILE

Social History

· Smokes approximately one and a half packs of cigarettes a day and has done so for the past 40 years
· Does not consume alcohol nor other drugs

Medical History

· Depressive syndrome
· Appendix surgery

Medications

· Paroxetine 20 mg/d, Diazepam 5 mg/d

Allergies

· None

PHYSICAL EXAMINATION

Temperature 37.7 ºC.
Pulse, regular at 80 beats per minute
Blood presure, 120/70 mmHg

Skin and mucosal jaundice.
No other signs in the physical examination

FEVER

+

RIGHT UPPER SIDE ABDOMINAL PAIN

+

JAUNDICE

DIFFERENTIAL DIAGNOSIS

- Chronic or Acute Hepatitis
- Hepatic occupant lessions
- Acute cholangitis/cholecistitis
- Acute pancreatitis
- Hematologyc malignancies
- Bilio-pancreatic neoplasms

BLOOD TESTS

LABORATORY TESTS

Variable	Result	Normal Range
White-cell count (per mm^3)	8,510	4,000-10,000
Hemoglobin (g/dl)	13.4	13-18
Hematocrit (%)	45	41-50
Platelet count (per mm^3)	280000	130,000-450,000
Total bilirubin (mg/dl)	**2.91**	0.1-1.3
Direct bilirubin (mg/dl)	**2.45**	
Alkaline phosphatase (UI/L)	171	91-258
Alanine aminotransferase (ALT) (UI/L)	99	5-45
Aspartate aminotransferase (AST) (UI/L)	74	5-40
Gamma-glutamyl transpeptidase (GGT) (UI/L)	508	8-61
Lactate dehydrogenase (LDH) (UI/ml)	272	105-333
Total Proteins (g/dl)	5.6	6-8
Urea nitrogen (mg/dl)		
Creatinine (mg/dl)		
Erythrocyte sedimentation rate (mm)	30	0-20
C-reactive Protein (mg/dl)	53.7	0-1

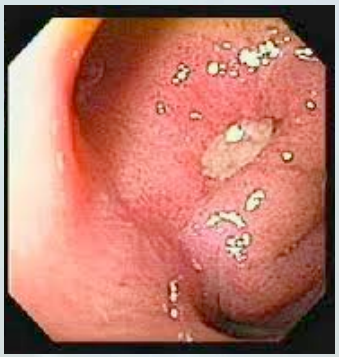
SEROLOGY TESTS

HBs – Ag Negative
Total Ab-HBc Negative
Ab – HBs Positive
HCV Ab Negative
CMV IgG Positive
VCA IgG, EBV Positive
VCA IgM, EBV Negative
HIV 1/2 Ac Negative
Brucella Negative
Leptospira negative

Antimitochoncrial Ab Negative

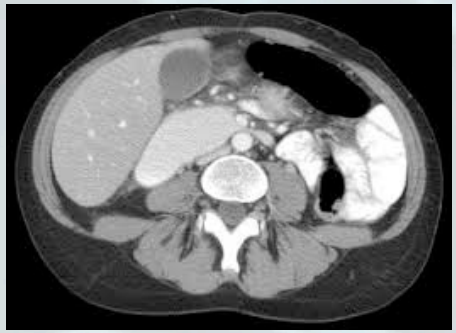
EVOLUTION

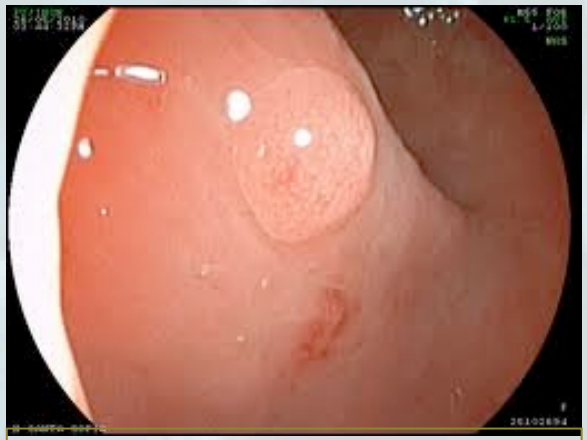
- On treatment with Amoxicillin/Clavulanic acid 1 g/8h
- During his stay in the ward the patient suffered an episode of upper gastrointestinal bleeding and haemoglobin decreased 4 g/dl



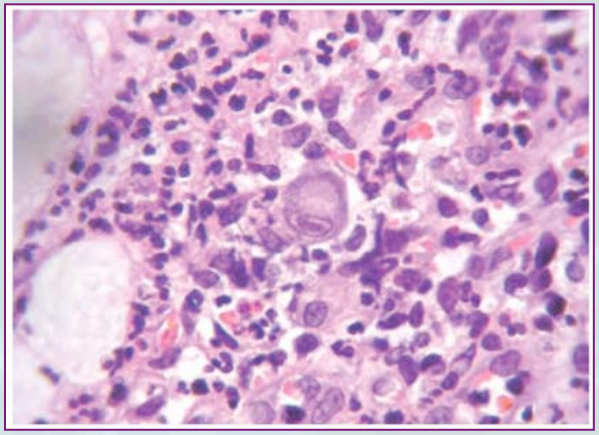
Antral and cardia ulcers. Antral gastric mucous atrophy. Negative urease testing.
They took ulcer biopses to rule out
Ulcer Gastric Lymphoma

Splenomegaly. Stomach, Sigma and Rectal thickening. No other relevant disorders.





Mucosal polyp from 45 cm to anal bank



Histological findings: We can see in the stomach and duodenum, the CMV nuclear expression in ephitelial cells:
CMV ULCER GASTROENTERITIS

Blood CMV PCR: 2080 copies/ml

CMV IgM Positive
CMV IgG Positive 1/512
Two weeks later: CMV IgG Positive 1/1024

DIAGNOSIS

HEPATOSPLENIC
AND
GASTROINTESTINAL
ACUTE CMV INFECTION
IN AN APPARENTLY IMMUNOCOMPETENT
HOST

EVOLUTION

- On treatment with valganciclovir during 2 weeks
- Clinically asymptomatic
- Blood test were normal
- Immunodeficiency study was negative

CMV INFECTION

- The spectrum of human illness caused by cytomegalovirus (CMV) is diverse and mostly dependent on the host

- CMV infection in immunocompromised patients cause substantial morbidity and mortality, especially among transplant recipients and those infected with the human immunodeficiency virus (HIV).

- In these patients the indication for treatment is well established.

CMV INFECTION

- Infection in the immunocompetent host is generally asymptomatic or may appear as a mononucleosis syndrome but occasionally primary CMV infection can lead to severe organ specific complications with significant morbidity and mortality .

- Although these cases are rare, gastrointestinal, cardiovascular, neurologic, hepatic and hematological disorders have been reported.

CMV INFECTION

- Little is known about the severity of symptoms and the clinical course in immunocompetent patients, CMV plays an important role in these patients due to its high seroprevalence and life-long persistence.

- The illness is generally self-limited, with complete recovery over a period of days to weeks. Antiviral therapy is not usually indicated.

- The clinical utility of antiviral agents in the immunocompetent host remains unproven

Case Report

Singapore Med J 2011; 52(9) : e170

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1130-0108/2011/103/3/154-156
Revista Española de Enfermedades Digestivas

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CLINICAL NOTE

Cytomegalovirus ileitis in an immunocompetent patient

Journal of Clinical Virology 55 (2012) 187–190

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VIROQAS

Colitis in an elderly immunocompetent patient

Elena Seminari[a,*], Elisa Fronti[a], Giada Contardi[a], Francesco Broglia[b], Daniele Scevola[a], Loretta Fiorina[c], Fausto Baldanti[c]

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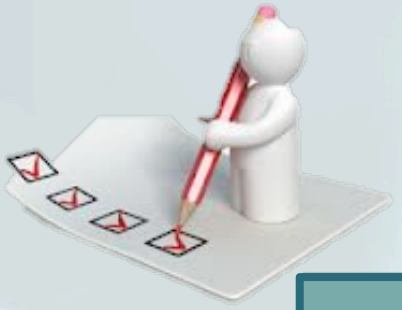
December 2012, Vol. 44, No. 12 , Pages 987-991 (doi:10.3109/00365548.2012.697637)



MAIN LEARNING POINTS

- CMV disease in immunocompetent patients may not be as rare as previously thought, above all in the elderly, so it must be taken into account.

- Primary CMV infection can lead to severe life-threatening organ specific complications.

- Treatment should be initiated early regarding the severity of the illness, regardless of the immunological status of the patient.

[1] Epidemiology, clincal manifestations, and treatment of cytomegalovirus infection in immunocompetent hosts. UpToDate. Last review Nov 2013
[2] Severe primary cytomegalovirus infection in the immunocompetent adult patient: A case series. Scandinavian Journal of Infectious Diseases, 2012; 44: 987-991
[3] Severe cytomegalovirus infection in apparently immunocompetent patients: a systematic review..