



CLINICAL IMAGES

Misdiagnosed bacillary angiomatosis

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A 46-year-old HIV-positive albino male presented with a 6-month history of a septic, ulcerating mass on his left cheek and pre-auricular area. A chest radiograph suggested pulmonary tuberculosis (PTB), fine-needle aspiration of the lesion was suspicious of mycobacterial infection, and formal biopsy showed spindle cell proliferation only. Computed tomography (CT) of the brain and neck showed a left periorbital ring enhancing, space-occupying lesion, necrotic cervical lymph nodes with patent vessels, and pansinusitis suggestive of squamous cell carcinoma or tuberculosis.

The patient was discharged on TB treatment. He presented 13 months later, having completed 9 months' TB treatment without improvement. The friable, ulcerating and fungating mass, affecting the entire left side of his face, was severely septic and infested with maggots (Fig.1). Formal excisional biopsies of multiple satellite neck lesions were consistent with a benign vasoformative lesion, favouring an ulcerated pyogenic granuloma. Polymerase chain reaction (PCR) was positive for bacillary angiomatosis.

Bacillary angiomatosis (BA) is a systemic, life-threatening but curable infection that causes an eruption of

purple lesions on or under the skin. The lesions resemble Kaposi's sarcoma and almost exclusively occur in patients with AIDS. BA is caused by Bartonella bacteria – small, curved, Gram-negative bacilli, one associated with AIDS patients (especially when CD4<200 µl) and one associated with cat-scratch disease. BA is now considered to be an AIDS-defining illness.¹

BA is characterised by the uncontrolled proliferation of blood vessels that form nodular tumours in the skin and organs. Systemic infection may be accompanied by constitutional symptoms of fever, sweats, chills, poor appetite, vomiting, diarrhoea, abdominal pain and weight loss. The patient may have transaminitis, elevated alkaline phosphatase or pancytopenia.² The infection may be fatal if untreated.

The most sensitive diagnostic tests are tissue culture, which takes 20 - 40 days,⁵ or PCR. Recommended treatment is erythromycin 500 mg qid po/IVI. Alternatives include doxycycline, azithromycin or clarithromycin.³ Duration of treatment is usually as long as the lesions are visible, which typically takes up to 3 months. Lifelong treatment is indicated in relapse. Incision and drainage of lymph node abscesses may be indicated. Paracetamol may be used to relieve pain and fever.⁴

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Fig. 1. A – day 1, B – day 30, C – day 41. The patient was treated with oral erythromycin and dressings.