Changes of Opportunistic Infection Pattern in Patients with AIDS in Jakarta

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The outpatient clinic of special study group on AIDS (POKDISUS) FKUI/RSCM provides health service for most of patients with HIV infection/AIDS in Jakarta. According to information center currently there are approximately 1800 cases and most of them (67%) are intravenous drug users.¹

The study to obtain the profile of opportunistic infection in hospital had been initiated by Aida et al (1999). The pattern of opportunistic infection reported by Aida was the 1st report on opportunistic infection pattern in Indonesia. Aida et al reported fungal infection of gastrointestinal tract was the most frequent infection followed by tuberculosis. Cytomegalov retinitis was also an important opportunistic infection reported by Aida. Compare to opportunistic infection pattern in developed countries, in Cipto Mangunkusumo hospital, however, Pneumocystic Carinii Pneumonia (PCP) was not common. Case series reported by Aida were HIV patients who were infected likely due to sexual transmission because intravenous drug user was still uncommon phenomenon in Indonesia.²

Maulana et al (2002) reported the opportunistic infection pattern in Cipto Mangunkusumo hospital and showed that fungal infection of gastrointestinal tract was still the most frequent infection. At that time, most of cases were intravenous drug users.³ Yunihastuti reported 698 cases in 2004 and found that fungal infection of gastrointestinal tract was 48% of all cases followed by lung tuberculosis (36%) and chronic diarrhea. Case series by Yunihastuti demonstrated relatively high incidence of lung tuberculosis infection (17%) and if it were put together with extra-lung tuberculosis infection accounted for 50% of all cases. Thus, according to this report, tuberculosis was the most common opportunistic infection. However, it reported cytomegalov retinitis less then those reported by Aida.⁴

The diagnosis of opportunistic infection is important because anti retroviral treatment (ARV) should be given between 2 weeks and 2 months after giving anti tuberculosis treatment. Concomitant treatment of anti tuberculosis and ARV would increase risk of nausea, hepatotoxicity and immune reconstitution syndrome/ immune restoration disease). Immune reconstitution syndrome is a syndrome which occurs due to inflammation process because of immune system restoration. One of etiology of immune reconstitution syndrome is tuberculosis.⁵,⁶

Diagnosis of opportunistic infection in most of the case was still a presumptive diagnosis. Confirmation of diagnosis is certainly necessary to find the cause of opportunistic infection.

Karyadi et al reported that parasite infection was the cause of chronic diarrhea in HIV-infected patients. The study reported 150 cases and the most common parasite found was Blastocytis hominis. As the etiology of chronic diarrhea, the role of B hominis was still controversial whether this parasite was commensally or pathogenic. However, one case reported by Karyadi found B hominis in ascitic fluid and the patient was die.⁷

Sahbandar reported in this journal that colonization of Candida in the oropharynx in patients with AIDS. It revealed that C albicans was the most commonly found species in this study. In this case series, subjects were either hospitalized or outpatient clinic, so the median of CD4 was still high 100 cell/μL.⁸ In fact, CD4 of hospitalized patients was far lower than outpatient subjects. Mahdi found median of CD4 count of hospitalized patient in Dharmais hospital was 36 cell/μL.⁹ A study by Sahbandar showed the strong negative correlation between intensity of Candida colonization in oropharynx of HIV patients and their CD4 count. Unfortunately in this study, pattern of Candida resistant to fluconazole was not investigated. The data is important since fluconazole is the main drug used for Candida opportunistic infection in Indonesia.

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