# Diagnosis at first glance: nodular hepatic lesions in persons with AIDS

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A 38-year-old HIV-infected homosexual man, resident all his life in northern Europe, was admitted with a 2-week history of fever, night sweats, fatigue and weight loss. Nine months earlier, he had been diagnosed with HIV infection while suffering from *Pneumocystis carinii* pneumonia (PCP). He had received the following treatment regimen since the diagnosis of the PCP: indinavir 800 mg three times daily, stavudine 40 mg twice a day, lamivudine 150 mg twice a day and co-trimoxazole. His CD4+ lymphocyte count at the time of PCP diagnosis was $53 \times 10^9$/L, and his viral load 432 000 copies/mL plasma.

On admission, clinical examination revealed an enlarged liver but no polyadenopathy. Laboratory tests revealed anemia (hemoglobin 7.8 g/dL), thrombocytopenia ($69 \times 10^9$/L), leukopenia (leukocytes $1.2 \times 10^9$/L), a CD4+ lymphocyte count of $275 \times 10^9$/L, and an undetectable viral load. The liver tests were abnormal: serum alanine aminotransferase (ALT) 48 U/L, aspartate aminotransferase (AST) 160 U/L (normal value (NV) 17–59 U/L), alkaline phosphatase 804 U/L (NV 38–126 U/L), and lactate dehydrogenase (LDH) 1183 U/L (NV 313–618 U/L). Blood, stool and urine cultures remained negative. A chest X-ray was normal. An

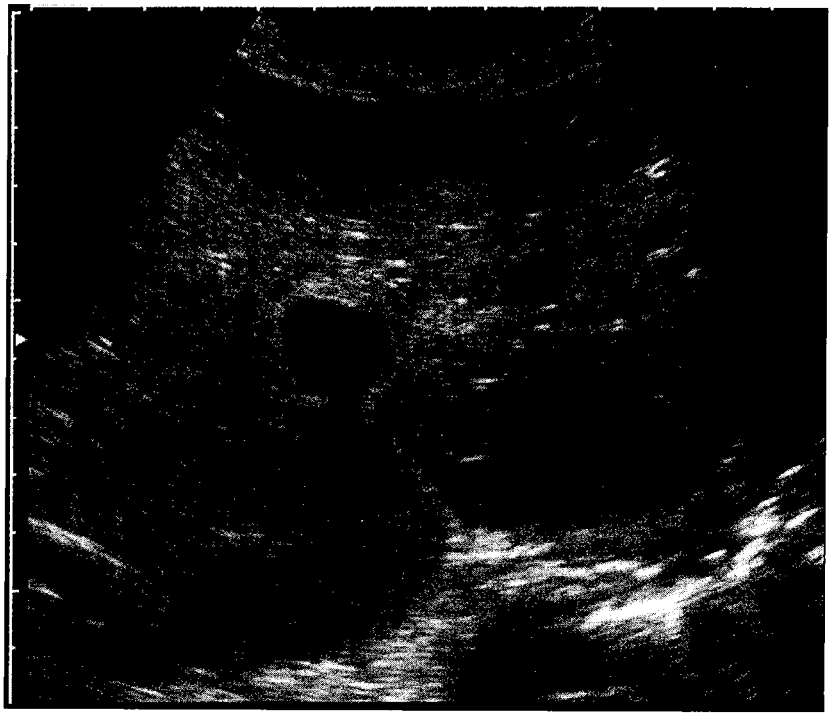

**Figure 1** Transverse section through the liver, showing three hypoechoic lesions with echogenic border. One of the lesions bulges at the liver surface.

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ultrasound examination of the abdomen showed hepatomegaly with multiple hypoechoic lesions (maximal diameter 5 cm) surrounded by a hyperechoic border (Figure 1). Hepatitis B an C serology were negative. Alcohol abuse was denied.

## QUESTIONS

1. What is your clinical diagnosis?
2. How are you going to confirm your diagnosis?
3. How are you going to treat the patient?

# Clinical microbiological case: refractory chest wall infection following reconstructive surgery in a patient with relapsed lung cancer

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## CASE REPORT

A 41-year-old Indian man with recurrent squamous cell lung carcinoma was evaluated for left anterior chest wall fistula tract. Eight weeks earlier, he underwent an extensive excision of the chest wall, 6th and 7th ribs, and prolene mesh placement.

He complained of severe pain extending from the left anteriolateral chest wall and ipsilateral breast area and denied

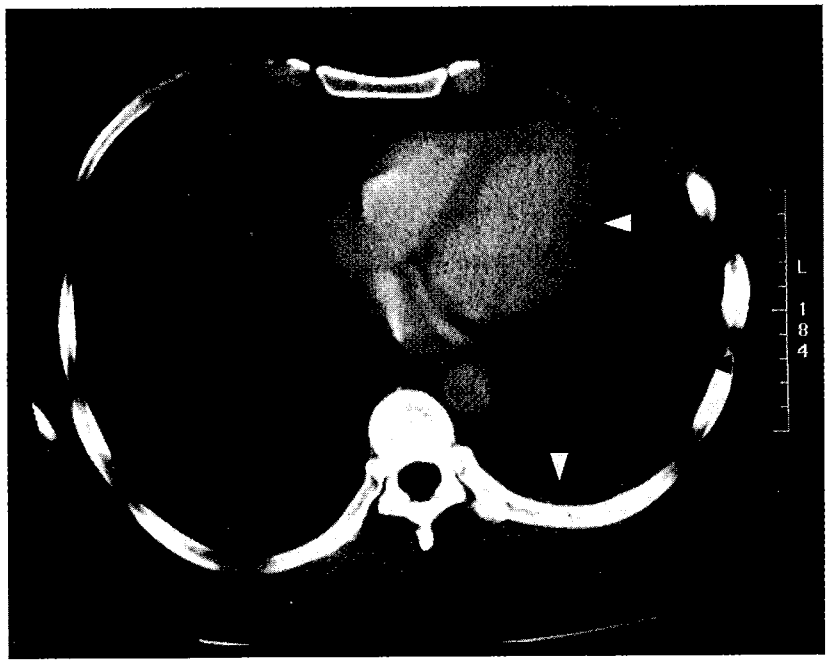


**Figure 1** Computed tomography scan of chest without intravenous contrast shows a circumferential thickening of the left pleura and adjoining pericardium (black arrows). Localised left pneumothorax and pneumopericardium suggest communication with the chest wall fistula tract (white arrow heads).

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