

CASE REPORTS

i. Persistent cough and haemoptysis in an 8-year old boy

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An 8 yr old boy presented to QECH in September 2004 with a two months' history of cough and haemoptysis. He was well until July 2004 when his mother noted that he developed a non-productive cough which was worse at night and intermittently associated with fever. It was not associated with night sweats, shortness of breath or weight loss and there was no history of TB contact. There was also no history of foreign body inhalation. Review of other systems was normal.

He was treated with several antibiotics at several private clinics under the presumptive diagnosis of pneumonia but there was no improvement. The haemoptysis had worsened from twice or thrice a month to about 7 or 8 episodes a month. This warranted two admissions at QECH for further investigation.

There was nothing significant in the past medical history and no history of chronic illness. He is an only child. Parents are alive and well, and have a good socioeconomic status. He attends school and only missed school during the recent admissions.

On examination he was of good nutritional status. He was not cyanosed and not in respiratory distress. The vital signs were normal. He had finger clubbing. Trachea was midline. Percussion of the chest was normally resonant. On auscultation, he had a few fine basal crackles over right base posteriorly. There were no other abnormalities on examination. No lymphadenopathy, no Kaposi sarcoma lesions, no parotid enlargement and no abdominal abnormalities. Cardiac examination was also normal.

Investigations

A chest X-ray was done which showed some patchy opacities in

the right lower lobe (Figure 1). Mantoux test and HIV spot test was negative. The mother was taught "Chest physiotherapy". The symptoms did not disappear despite two prescribed courses of erythromycin for atypical pneumonia and other antibiotics obtained elsewhere. In April 2005, investigations were repeated as cough and haemoptysis persisted. Mantoux test and HIV test were again negative. CXR was unchanged with persistent RLL opacities.



Case report foreign body Fig. 1

What is your differential diagnosis?

What other investigations would you undertake?

For discussion of this case, see pg. 102

ii. Persistent galactorrhea in a postmenopausal woman with Herpes Zoster and HIV-1 Infection

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We describe a 65-year old postmenopausal woman who has had galactorrhea for 8 years. She presented with cough and chest pain and milk discharge from both breasts. She had had a herpes zoster eruption in 1997 and this healed to leave a hypertrophic scar. Two months later she noticed milk discharge from both of her breasts and this has continued up to now. There is no pain or swelling of the breasts, no color change. No nipple retraction. There were no other symptoms to suggest hyperprolactinemia. She is 12 years postmenopausal, and during her reproductive years she had 6 children between 1966 and 1979. She had had normal menstruation and lactation in the past. She has not had headache or vomiting. She had not taken any anxiolytics, phenothiazines, antihypertensives, H₂ receptor blockers or contraceptives at the onset of her symptoms. Her spouse died four

years before the onset of galactorrhea and since then she has not been sexually active.

She weighed 51.5 kg which was 10% less than her original weight. She had no anemia, jaundice or significant axillary lymph node enlargement.

She had herpes zoster scars on the right side of the chest, level T4. Her breasts were normal in size and had no masses. A milky discharge was expressed from both breasts, but there were no obvious nipple abnormalities or skin changes. ELISA for HIV-1 was positive and she had a CD4 lymphocyte count of 251/mm³. Serum TSH was 0.4mIU/ml (normal range. 0.47-5.01mIU/ml) while prolactin was 22.4ng (normal range. 1.9-25.9ng/ml, for

postmenopausal women).

150mg BID and Efavirenz 600mg nocte.

She has continued to have galactorrhea 3 months after starting antiretroviral treatment with Stavudine 30mg BID, Lamivudine

What are the possible explanations for galactorrhea in this patient? (for discussion see pg. 102)
