Fighting HIV and Acute Leukaemia Five Years On

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Summary:
We report a case of a 19 year old university student diagnosed with HIV and acute lymphocytic leukaemia 5 years ago. He presented with severe anaemia necessitating multiple transfusions at theageof fourteen. Bone marrow aspirate confirmed ALL-L2 and HIV infection was confirmed by ELISA at the same time. He completed his induction, consolidation and maintenance courses successfully with only essential hospital admissions. HAART was initiated soon after initiation of chemotherapy. Initial HAART regimen was D4T/3TC/EFV. He was later changed to TDF/3TC/EFV following D4T lipoatrophy. Clinically he has done well; current CD4 409cells/mm3(25%), VL- 89cp/ml. Bone marrow shows remission for the last 12months.

Key messages:

Acute leukaemia in HIV is rare; There have been reported cases of Bcell ALL and T cell ALL in HIV with poor outcomes. HIV in addition to being neurotropic and a tropic virus to CD4 also affects other cell lines. It has also been implicated in enhancing release of leukemogeniccytokines from monocytes and macrophages amidst low or absent Tcellimmune surveillance. The virus oncogenic nature is been demonstrated in T cell lymphomas albeit controversies.

Earlier cases reports indicated a rapid progression and high case fatality rates. However, with advent of HAART, there is considerable improvement on morbidity and survival.Close monitoring and prompt management of opportunistic infections is invaluable. Possible drug interactions include use of AZT and bone marrow suppressive chemotherapeutic agents. Other considerations include concomitant use NVP with methotrexate due to hepatotoxicity. Overall, the case we are presenting did well in contrast to earlier case reports. The management required a multidisciplinary team including, paediatric HIV specialists, Heamatoncologists,psychosocial and family support.