her house. It was impossible to accurately quantify the amount eaten. The patient's symptoms slowly responded to intravenous and oral potassium supplementation over 14 days. Her liver function and renal function returned to normal. She was discharged 18 days after admission to hospital. Her care, for the remainder of her pregnancy, was in the community. Further follow-up information is not available. The patient did not have a telephone land line nor a cellphone. A request was made to the community services to follow-up the patient. On receiving the address, we were told that they only went into the patient's district with a police escort and our request was not justified.

DISCUSSION

The aetiology of pica is not known. Theories on pica range from nutritional deficiencies and psychological problems to obsessive-compulsive behaviour and specific brain lesions.[3,4] Pica can cause a number of serious conditions including iron-deficiency anaemia, bowel obstructions and perforations, lead poisoning, and helminthnic infestations.[5] This is only the second report in the literature of geophagia causing hypokalaemic myopathy in pregnancy.[6] The pathophysiology, it is suggested, is that clay binds to potassium in the gut. This leads to increased intestinal excretion of potassium, resulting in hypokalaemia.[7] It appears that the effect is dose dependent on the amount of clay ingested.

Unfortunately, our patient was lost to follow-up. This also occured in the other reported case.[6] The long-term maternal, fetal and neonatal outcomes in the severely hypokalaemic mother, would be of interest.

The author has no conflict of interest.

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REFERENCES

1. American Psychiatric Association. Diagnostic and stastistical manual of mental disorders, 4th revision: DSM-IV. Washington: American Psychiatric Press, 1994.
2. Federman DG, Kirsner RS, Federman GS. Pica: are you hungry for the facts? *Conn Med* 1997; **61(4):** 207-9.
3. Sayetta RB. Pica: an overview. *Am Fam Physician* 1986; **33(5):** 181-5.
4. Lacey EP. Broadening the perspective of pica: literature review. *Public Health Rep* 1990; **105(1):** 29-35.
5. Rose EA, Porcerelli JH, Neale AV. Pica: common but commonly missed. *J Am Board Fam Pract* 2000; **13(5):** 353-58.
6. Ukaonu C, Hill DA, Christensen F. Hypokalemic myopathy in pregnancy caused by clay ingestion. *Obstet Gynecol* 2003; **102(5):** 1169-71.
7. Gonzales JJ, Owens W, Ungaro PC, Werk EE, Wentz PW. Clay ingestion: a rare cause of hypokalemia. *Ann Intern Med* 1982; **97(1):** 65-6.

Atypical presentation of HIV in a pregnant patient

Editor,

We report a case of Kaposi's sarcoma (KS) of the epiglottis in a pregnant lady who presented with stridor. It is very rare for stridor caused by laryngeal KS to be the initial presentation of HIV infection in a pregnant patient that has not been previously reported.

Case Report: A 33-year-old, 13 weeks pregnant lady presented with shortness of breath and noisy breathing. She also had odynophagia, bilateral neck swelling, sore throat and night sweats for the past 3 days. She had a discharging ear and a chronic non-productive cough for 3-6 weeks. Distaclor, commenced initially, was discontinued when she was confirmed to be pregnant. She was on nystatin mouthwashes for her oral thrush. She was a non-smoker and took alcohol occasionally. There was no history of intravenous drug abuse or other risk factors for HIV infection.

On examination she was pyrexic, had inspiratory stridor, tachycardia and tachypnoea. Oral cavity and oropharynx examination revealed extensive candidiasis.

Flexible nasoendoscopy revealed a very large, oedematous and inflamed epiglottis with extensive white patches. The epiglottic swelling was so large that the vocal cords could not be visualized and only the posterior portion of the arytenoids was seen. Neck examination revealed bilateral cervical lymphadenopathy. Lateral soft tissue X-ray of the neck revealed an enlarged epiglottis and a normal trachea. Chest X-ray was clear. Full blood count showed WCC - 6.1×10^9/L, Hb - 13.2 g/dl and platelets – 215×10^9/L. Routine blood tests and viral serology was normal. Her CD4 count was 40/mm^3.

A provisional diagnosis of severe fungal / bacterial epiglottitis was made. The treatment regime included high dose of intravenous fluconazole, cefuroxime, metronidazole and nystatin mouthwashes. An HIV test was positive which was again confirmed on retesting.

An ultrasound scan revealed an anembryonic and nonviable pregnancy. After discussion with the patient she had a medical evacuation of the pregnancy with mifepristone.

Anti-retroviral therapy and prophylaxis with co-trimoxazole, azithromycin and dapsone was commenced. Two weeks later on review with flexible nasoendoscopy, the epiglottis still appeared inflamed and grossly swollen. A CT scan of the neck and upper thorax showed a 4 cm swelling of the epiglottis extending down into the aryepigolttic folds and into the vestibule. Bilateral cervical lymphadenopathy was also noted on the CT (*Fig 1*).

In view of her slow recovery, a microlaryngoscopy and biopsies of the epiglottis were performed to reach a firm diagnosis. The histopathology revealed necrotic inflammatory tissue with ulceration and dense proliferation of anastomosing vascular channels. A tentative diagnosis of KS was made. The specimen was sent to a tertiary referral centre for human herpes virus 8 (HHV8) staining which proved positive. The diagnosis was finally confirmed when the samples were sent to the national center of KS pathology.

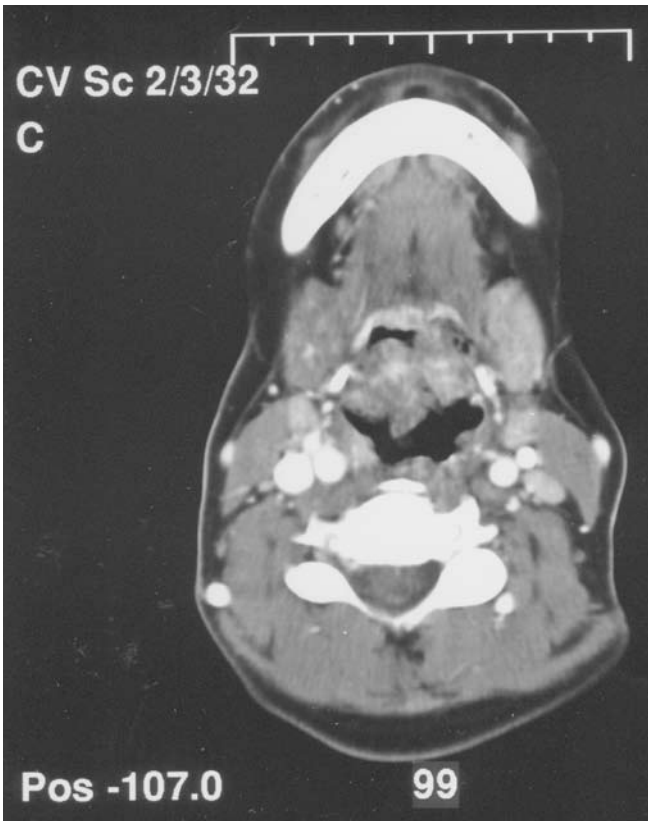

Fig 1. Axial CT scan of the neck showing the grossly enlarged and irregular epiglottis with bilateral cervical lymphadenopathy.

Antiretroviral medical therapy, consisting of efavirenz and zidovudine, was commenced and the patient's symptoms regressed. Eight weeks after her initial presentation the larynx appeared normal, her viral load was undetectable and her CD4 count was raising.

DISCUSSION

The diagnosis was difficult as the patient had no risk factors for HIV infection. Extensive oropharyngeal candidiasis and the fungal appearance of the epiglottitis should alert the clinician to the likelihood of immunosuppression. In such cases a HIV test and an examination and biopsy under general anaesthetic is necessary for histological diagnosis.

This case is noteworthy in three aspects: first – KS of the epiglottis is itself very rare, second – the patient was pregnant, and third – KS with stridor is an atypical initial presentation of HIV infection. Clinicians should be aware of this rare condition as a cause of airway obstruction in the immunocompromised.

The authors have no conflict of interest.

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