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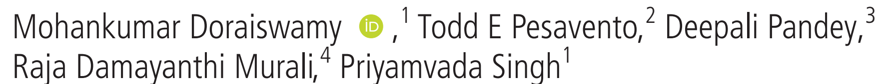
Rare oral lesions from cytomegalovirus in kidney transplant



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Received 1 June 2021
Accepted 13 June 2021
Published Online First 30 June 2021

Check for updates

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To cite: Doraiswamy M, Pesavento TE, Pandey D, *et al*. *Postgrad Med J* 2022;**98**:e32.

CASE PRESENTATION

A 47-year-old man with a history of deceased donor kidney transplant in May 2019 was admitted with odynophagia, pancytopaenia and neutropaenic fever. He had new tongue lesions ongoing for 2 weeks. Examination showed a 3×3 cm elevated, adherent plaque (figure 1). He has a history of resistant cytomegalovirus (CMV) viraemia with failed therapy to low-dose valganciclovir, ganciclovir and letermovir. Foscarnet led to undetectable CMV viral load, but the treatment was complicated with acute renal injury, and he was transitioned to a high-dose valganciclovir. We held his valganciclovir on admission as his CMV PCR was <50 IU/mL and he was pancytopaenic. He did not respond to the empiric fluconazole, and hence biopsy of the tongue lesion was done, which revealed a positive immunohistochemical stain for CMV. CT chest also showed a ground glass pulmonary nodule (figure 2, 1.8×1.9 cm, solid component measuring 1.1×1.2×1.3 cm). A CT-guided biopsy showed organising pneumonia and CMV-positive cells. His pancytopaenia improved with filgrastim. Repeat CMV PCR increased to 17 000 IU/mL. He refused foscarnet and was restarted on oral valganciclovir (1350 mg two times a day) and topical cidofovir. Even with undetectable CMV at presentation, he was noted to have disseminated infection. His mycophenolic acid was already held as outpatient, and we further stopped his cyclosporine. He was discharged only on prednisone for immunosuppression. At the 2-week follow-up, the lesion and its associated symptoms had resolved. The presentation of oral CMV infection is highly variable with mucosal erythema, painful deep ulcers, erosions, but elevated tongue lesions have rarely been reported in the literature to our knowledge.[1] We, through our case, want the medical community to be aware of this rare presentation. Treatment options includes ganciclovir, valganciclovir, foscarnet, letermovir and cidofovir. Early diagnosis is important because CMV increases the risk for rejection, graft loss and all causes mortality.[2] Saliva and periodontal packets serve as reservoirs for CMV infection, and frequent monitoring of periodontal health is needed post-transplant.[3 4]

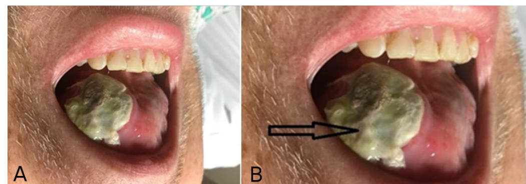

Figure 1 (A, B) showing 3×3 cm elevated, adherent tongue lesions. (A) unmarked, (B) marked.

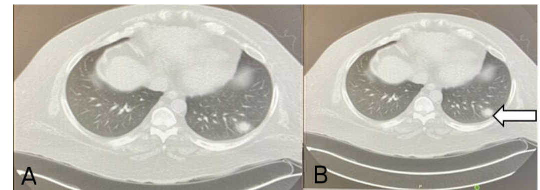

Figure 2 (A, B) showing 1.8×1.9 cm ground glass lung nodule. (A) unmarked, (B) marked.

Contributors MD, PS, DP and TEP identified the case and helped in writing case presentation. MD, RDM and PS authored the manuscript. MD submitted the abstract to the Journal.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

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