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A 35-Year-Old Human Immunodeficiency Virus-Infected Male With Abdominal Pain and a Knot in His Abdomen

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A 35-Year-Old Human Immunodeficiency Virus-Infected Man With Abdominal Pain and a Knot in His Abdomen

(See pages 151–2 for the Answer to the Photo Quiz.)

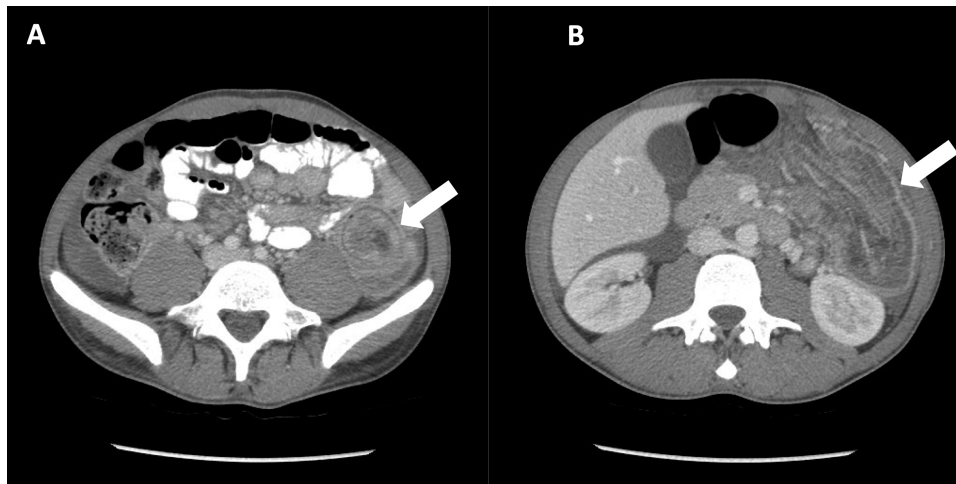


Figure 1. Abdominal-pelvic computer tomography in the axial view. *A*, Round mass (arrow) with alternating hypo- and hyperdense layers resembling a “target pattern” when the bowel was viewed transversely. *B*, Sausage-shaped mass (arrow) with a well-enhanced portion, both indicative of intussusception in the descending colon with no definite signs of a lead point when viewed longitudinally.

A 35-year-old man had AIDS diagnosed when he was admitted with disseminated varicella zoster infection and diarrhea. At the time of this diagnosis, his CD4 cell count was 64/mL, and his human immunodeficiency virus (HIV) viral load was 735 189 copies/mL. His condition improved rapidly with intravenous acyclovir treatment. He had a normal abdominal-pelvic computed tomographic (CT) scan, examination of his stool samples was unrevealing, and his diarrhea resolved. After 1 week of hospitalization, antiretroviral therapy (ART) was started, with coformulated abacavir, lamivudine, and dolutegravir. The patient was discharged to complete a 21-day course of oral valacyclovir and continued taking his ART and daily trimethoprim-sulfamethoxazole prophylaxis against *Pneumocystis jiroveci* pneumonia.

Nine weeks after starting ART, the patient presented for a routine HIV primary care appointment and reported a 1-week history of abdominal cramping and a lump that formed in his stomach accompanied by nausea, not relieved by a bowel movement and unrelated to his ART intake. His symptoms had happened almost every evening to the point that he had to “work out the knot by pushing it in” to relieve symptoms. At examination, his abdomen was soft, nontender, and without focal masses or hernias. Given the benign abdominal examination

findings at this time and a normal CT scan during his recent hospitalization, the decision was to perform blood tests, including lipase measurement (all results were unrevealing) and reassess the patient clinically in 2 weeks.

One week after his outpatient visit (approximately 10 weeks from ART initiation), the patient presented to the emergency room, complaining of 3 days of progressive lower abdominal pain and constipation without nausea, vomiting, or fever. The patient was afebrile and normotensive but diaphoretic and he had abdominal tenderness without guarding in the left lower quadrant. Abdominal-pelvic CT was ordered and showed the findings depicted in [Figure 1](#). Flexible sigmoidoscopy was performed, which demonstrated a large friable mass 50 cm from the anal margin; the patient underwent exploratory laparotomy, his sigmoid colon was partially resected, and the preliminary pathologic findings were consistent with lymphoma.

What is your diagnosis?

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