

Case 19

Caso 19

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CASE REPORT

Female patient, 23-year-old, previously healthy, without comorbidities, sought medical care at a basic health unit by presenting sore throat and whitish lesions as a creamy film covering tongue and palate for two weeks ago.

The risk factors for the injuries presented in this report are, EXCEPT:

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- unprotected oral sex;
- chronic inhaled corticosteroid therapy;
- acquired immunodeficiency syndrome;
- broad-spectrum antibiotic therapy.

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ANALYSIS OF IMAGES



Figure 1 - Analysis: whitish plates like “curd”, under the tongue; teeth presenting setting irregularities in the arcade, with precarious conservation and some exposing their roots in addition to some tooth loss.

DIAGNOSIS

Whitish lesions covering the mucosal surface are often associated with oral candidiasis determined by *Candida sp.* This type of lesion is most common in infants and immunocompromised adults. The way it was presented in this patient, however, because of its intense dissemination, denounces immunodeficiency, especially of helper T lymphocytes, which are associated with granulomatous response and involved mainly in protection processes toward viruses, Mycobacterium, spirochetes, fungi, and protozoa.^{1,2}

Chronic inhaled corticosteroid therapy, acquired immunodeficiency syndrome, and broad-spectrum antibiotic therapy are risk factors for the development of candidiasis by reducing the defense capability against *Candida sp.* Unprotected oral sex, even exposing partners to potentially contaminated secretions, is not a strict risk factor for oral candidiasis; it can happen only if the individual being contaminated by mouth is in a state of immune suppression.³

DISCUSSION OF THE CASE

The causative agent of Candidiasis is fungi of the genus *Candida*, especially the species *Candida albicans*, which commonly colonizes humans especially in the digestive, respiratory, and female genital tracts, and skin. Oral candidiasis can be seen in infants and adults under immunosuppression against *Candida sp.*,

as in broad-spectrum antibiotic therapy, chemotherapy, radiation therapy in the head and neck, chronic inhaled corticosteroid therapy, or acquired immune deficiency syndrome. The mechanism of tissue invasion by the microorganism is unclear, and four factors that interfere in this process are known as:

- adhesins that assist the binding of the fungus to host cells;
- formation of hyphae that penetrate the epithelium;
- secretion of fungal enzymes;
- the fungus' ability to adapt to the host's microenvironment.

In oral candidiasis, the mucosa surface presents formation of whitish plaques, creamy or membranous.^{2,3}

Oral candidiasis should be distinguished from:

- lichen planus in its mucosal form, which presents whitish lesions, differing from oral candidiasis for causing burning;
- oral hairy leukoplakia, whose agent is the Epstein-Barr virus, usually affecting patients with acquired immunodeficiency syndrome and manifesting with whitish plaques on the tongue side, differentiating from oral candidiasis because they are not removable with a scraping of the tongue;
- oral neoplasia, which can present white lesions, however, their growth is slower compared with oral candidiasis.^{2,3}

The diagnosis of oropharyngeal candidiasis is confirmed by scraping the suspicious lesions with a spatula, staining by the Gram or KOH method, and examination under a microscope. The culture of lesions is usually not indicated, except in its recurrence. Treatment may be topical, with nystatin, ketoconazole, and clotrimazole; or orally, ketoconazole, fluconazole and itraconazol.²

RELEVANT ASPECTS

- **immunosuppression:** a condition where the immune system is unable to counteract an infectious process in a particular host;¹
- patients diagnosed with the acquired immunodeficiency syndrome have a deficiency in cellular response, especially that of helper T lymphocytes;¹
- oral candidiasis presents with adherent white plaques on the oral mucosa and tongue and when removed reveal intense and painful enanthema.¹

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