A 56-year-old married male, who recently returned from Las Vegas, presented to follow-up for a persistent sore throat and fever of 2 weeks’ duration.

One week prior, he developed flu-like symptoms, initially with sore throat with associated fatigue, anorexia, generalized joint pains, low grade fever, chills and night sweats. He denied nausea, vomiting, diarrhea or urinary symptoms. He took over-the-counter Acetaminophen 1 gram every 8 hours and Ibuprofen 400 mg every 8 hours which provided transient improvement prompting urgent care evaluation. He was thought to have a non-specific acute viral syndrome and underwent several diagnostic tests which were consistent with non-specific acute viral syndrome. Tests included a CBC with total WBC count of 1.1 x10E3/uL and a normal Chest x-ray. He was instructed by urgent care to continue taking acetaminophen and ibuprofen and sent home. Because of persistent flu-like symptoms, patient presented to another urgent care. Labs included CBC with total WBC count of 2.9, x10E3/uL, Hgb 14.1 g/dL, platelet count 166 x10E3/uL. Chemistries included sodium of 129 mmol/L, total bilirubin 0.6 mg/dL, AST 72 U/L, ALT 114 U/L. Tests for rapid flu, rapid strep and monospot were negative. He was again given the diagnosis of non-specific acute viral syndrome, given IV fluids and advised to follow up with a primary care physician.

One week later, he was seen for consultation with significant improvement of clinical symptoms except for persistence of sore throat. Pertinent physical exam findings included a solitary, shallow, non-exudative ulcer on the posterior pharyngeal wall. There was no associated cervical lymphadenopathy or skin rash. Lung and abdomen were normal. Laboratory data included AST 151 U/L, ALT 146 U/L, and 4th generation HIV-1/2 Ag/Ab Screen was positive with negative HIV-1/2 Ab confirmatory tests. HIV RNA Quantitative PCR showed >10 million copies. Hepatitis B and C screening tests were negative.

The patient was informed of the HIV results and reported having multiple episodes of unprotected sexual intercourse with other men.

Discussion

Around 1.1 million people are diagnosed with HIV infection in the United States with nearly one in seven cases unaware that they have HIV infection.¹ Men who have sex with men (MSM) is the group most affected by HIV in the United States, account-
transmission by decreasing viral reservoir but also improves the clinical symptoms related to acute HIV infection. Appropriate initiation of ART has been shown to preserve CD4 cell count and viral set points thereby reducing the likelihood that the infection progresses to a more advanced stage. Prompt referral to an HIV expert ensures that the ART medications are closely monitored for efficacy, tolerability and potential side effects with improved medication compliance.

**Conclusion**

Acute HIV infection poses a diagnostic dilemma because the symptoms are usually transient and very non-specific. However, making the correct diagnosis is critical. Clinicians should have a high index of suspicion in considering the diagnosis and should be familiar with the specific diagnostic tests to correctly establish diagnosis of acute HIV infection. Acute HIV should be considered in the differential diagnosis for sore throat. Early recognition and prompt initiation of appropriate anti-retroviral therapy in patients with acute HIV infection can significantly alter the prognosis and improve clinical outcomes. These include decreased risk of disease transmission and improving the natural course of the infection for the individual patient and from a public health standpoint.

**REFERENCES**


