The 8th World Workshop on Oral Health and Disease in AIDS

"Improving Health and Well Being"

Bali-Indonesia, 13-15 September 2019

The 8th World Workshop on Oral Health and Disease in AIDS

"Improving Health and Wellbeing"

September 13-15th, 2019 The Trans Resort Bali, Indonesia

Welcoming Message from the International Organizing Committee

I am delighted to welcome all the participants who will be attending the 8th World Workshop on Oral Health and Disease in AIDS: Improving Health and Wellbeing. The Workshop is being held in the beautiful island of Bali, Indonesia, 13-15 September 2019.

This series of workshops began in 1988 as the dedicated conference on oral health and disease in HIV/AIDS. Since then, there have been significant advances in our knowledge, however, HIV remains a significant global public health challenge, with 1.8 million new infections and more than 940,000 HIV-related deaths last year alone. Disparity across the world, in the rate of HIV infection, in the availability of effective management, and in the access to clinical services, continues to be a problem. The plenary talks and workshop debates planned for WW8, will focus on the developments in the scientific and clinical knowledge, with a special emphasis on the wellbeing of people living with HIV globally.

I would like to express my thanks to all the speakers for their outstanding contributions, and in particular to the members of the International and Local Organising Committees and the Scientific and Editorial Committees for their enthusiastic support in putting together such an exciting programme. Professor Irna Sufiawati and her team worked tirelessly to ensure the quality of the conference.

I sincerely wish you all a very enjoyable stay in Bali and fruitful discussions and networking during this unique and exciting meeting.

Thank you for your participation.

Anwar R Tappuni

Chair, 8th World Workshop for Oral Health and Disease in HIV/AIDS

Welcoming Message from the Local Organizing Comittee

Excellencies
Honourable Guest
Distinguished Delegates
Colleagues, Ladies and Gentlemen

On behalf of the Local Organizing Committee, I am honored and delighted to welcome you all to Bali, one of the most beautiful islands in Indonesia, for the 8th World Workshop on Oral Health and Disease in AIDS: 2019. I would like to express my sincere gratitude and appreciation to the International Organizing Committee (IOC) composed of world-class experts in the field of Multidisciplinary Dentistry who have made significant contributions to the science behind our understanding of the various oral health problems arising from HIV/AIDS. My special thanks go to Professor Anwar Tappuni for placing her trust and confidence in our ability to organize this conference. The professionalism, integrity and sincerity of all members of the IOC is admired and beyond question. It has been an honour and pleasure working with you all. A special acknowledgment is extended to my great mentor, Prof. Sharof M. Tugizov for his valuable guidance and continued support. I would not be where I am today without you.

I would like to extend a special welcome to our guest of honour, Professor Paula Moynihan, President of the International Association for Dental Research (IADR). Please accept our sincere gratitude for the excellent support and hard work provided by you and your staff in helping us to organize this conference from start to finish. I would also like to offer our grateful thanks to the National Institutes of Health (NIH)/the National Institute of Dental and Craniofacial Research (NIDCR), and the Ministry of Research, Technology and Higher Education of Republic of Indonesia, for the funding support given to this conference. I cannot finish this paragraph without also acknowledging all the speakers and chairs from different corners of the world for their invaluable contributions to the 8th World Workshop.

After 30 years of these international workshops that have been held in various countries around the world, it is a privilege and honour for Indonesia to be hosting the latest workshop in the series. The conference program is rich and varied with plenary sessions, oral sessions and poster sessions, workshops, and an educational program. Today, we have more than 600 Indonesian attendees and international delegates from across the world, including Australia, Belgium, Brazil, the United Kingdom, India, Mexico, Russia, Romania, South Africa, Vietnam and the USA. We are optimistic that this conference will play a vital role in creating social HIV-awareness, enhancing the knowledge and insights into the disease, reducing HIV-related stigma, and improving the benefits of HIV prevention provided by oral health care professionals in Indonesia and neighbouring countries. We hope that this conference will create an opportunity to build global partnerships for future research collaboration.

Thank you to all our sponsors for supporting this conference which would not have been possible without their generous contributions. I would especially like to thank all of the beloved local committee. We could not have pulled this event off without the dedication of the whole committee whose hard work has made today a reality.

Finally, we hope that everyone attending this conference will have the most fruitful days as well as an enjoyable stay in Bali.

Irna Sufiawati

Chair of the Local Organizing Committee

ORGANIZING COMMITTEE

The International Organizing Committee

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09:30-10:00	**Coffee Break**	
	WORKSHOPS	
	Workshop Social Science 2 **Grand Ballroom 1-3**	**Workshop Clinical Science 1** **Boardoom 2-3**
10:00-12:30	**HIV testing: what, where and how?** Chair: Anthony Santella, Hofstra University, New York, USA Co-chair: Mohammad Majam HIV Self-Testing, Wits Reproductive Health and HIV Institute, Johannesburg, South Africa	**HPV and oral cancer in HIV-infected individuals on long-term ART: do the risks exist?** Chair: Newell Johnson Griffith University, Australia Co-chair: Jennifer Webster-Cyriaque University of North Carolina, USA
12:30-13:30	**Lunch**	
13:30-14:00	**SUMMATION OF WORKSHOPS** **Grand Ballroom 1-3** **Chairs** **Anwar R Tappuni** Queen Mary University of London  **Rudi Wisaksana** Faculty of Medicine Padjajaran University 	
14:00-14:15	**Coffee Break**	
14:00-16:30	**EDUCATION PROGRAMME** **Grand Ballroom 1-3**	**POSTER PRESENTATION** **Foyer of Boardroom 1**
19:00-21:00	**GALA DINNER** **Grand Ballroom 1-3**	

13:30-14:30	**Lunch**
14:30-15:00	**SUMMATION OF WORKSHOPS** **Grand Ballroom 1-2** **Chairs** **Christopher Hughes Fox** IADR  **Ketut Tuti Parwati Merati** Faculty of Medicine, Udayana University 
15:00-15:15	**Coffee Break**
15:15-17:45	**EDUCATION PROGRAM** **Boardroom 2-3**
	POSTER PRESENTATION **Foyer of Boardroom 1**

SATURDAY, 14th September 2019

PLENARY SESSION-2
Grand Ballroom 1-3

Chairs

Stephen Challacombe
King's College London

Agnes Rengga Indrati
Faculty of Medicine Padjajaran University

08:00-08:30	**HIV Testing in the Dental Setting: A Global Perspective of Feasibility and Acceptability**	Anthony Santella, Hofstra University, New York, USA
08:30-09:00	**Sexual and Reproductive Health and Human Rights of Women Living with HIV**	Anandi Yuvaraj, International Community of Women Living with HIV, Coimbatore, India
09:00-09:30	**HIV Interaction in Mucosal Epithelium**	Sharof M. Tugizov, University of California, San Francisco, USA

12:30-13:30	Lunch
13:30-14:00	**SUMMATION OF WORKSHOPS** **Grand Ballroom 1-3** **Chairs** **Stephen J. Challacombe** King's College London  **A.A.A. Yuli Gayatri** Udayana University, Bali 
14:00-16:00	**WORKING GROUP** Grand Ballroom 1-3 **Patient and Public Involvement in HIV Research.** Chair: Vaishali Sharma-Mahendra, Independent Consultant, Public Health, India Co-chair: Anandi Yuvaraj, International Community of Women Living with HIV, Coimbatore, India Panel Members: Amitha Ranauta, Queen Mary University London, UK Aditia Taslim, Rumah Cemara Bandung
16:00-16:30	**Setting the Research Agenda and Close** Anwar R.Tappuni and Christopher Fox Grand Ballroom 1-3
16:30-17.00	**CLOSING CEREMONY and GROUP PHOTOGRAPHS**

PRESENTATION SCHEDULE
POSTER PRESENTATION
Friday 13th September 2019
15.00 – 17.30
Foyer Boardroom 1

Number	Presentation Code	Authors	Title
1	AP_01_CC	I Nyoman Gede Juwita Putra, Irna Sufiawati, Yovita Hartantri	Severe Kaposi's Sarcoma Accompanied by Secondary Candida Infection in Patient with AIDS: A Case Report
2	AP_02_CC	Chivita Wulandari Febryna	Oral Manifestation in Pediatric Patients With HIV-Positive: 4 Case Reports
3	AP_03_CC	Etis Duhita Rahayuningtyas, Irna Sufiawati	Squamous Cells Papilloma in an HIV-Infected Woman on Long-Term HAART
4	AP_04_CC	Anzany Tania Dwi Putri, Siti Sarah, Elvina Sutopo	Multiple etiologies of xerostomia in an HIV positive patient: A case report
5	AP_05_CC	Devi Nasution, Tenny Setiani Dewi	The Various Oral Lesion in HIV/AIDS Patient Disease in Wasting Syndrome: A Case Report
6	AP_06_CC	Eko Rotary Nurtito, Riani Setiadhi	Severe Necrotising Ulcerative Stomatitis in HIV Patient: A Case Report
7	AP_07_CC	Dwi Setianingtyas, Nafiah, Cane Iukisari, Kharinna Widowati, Nur Tsuraya, Felicia Eda Haryanto	The successfull palliative care of oral lesion in HIV/AIDS patient with integrated multidisciplinary approach
8	AP_08_CC	Felicia Paramita, Febrina Rahmayanti, Endi Novianto, Endah Ayu Tri Wulandari	Challenge in Management of Stevens-Johnson Syndrome and Oral Pseudomembranous Candidiasis in HIV Patient
9	AP_09_CC	Nur Tsurayya Priambodo, Kharina Widowati, Isidora Karsini Soewondo, Dwi Setyaningtyas, Nafi'ah	Unexpected HIV/AIDS Case on Acute Necrotising Ulcerative Gingivitis Patient
10	AP_11_CC	Nurina Febriyanti Ayuningtyas, Desiana Radithia, Adiastuti Endah Parmadiati	Aphthous Stomatitis and Oral Candidiasis in Patient with HIV infection
11	AP_12_CC	Yuli Fatzia Ossa, Anandina Irmagita Soegyanto, Diah Rini Handjari, Endah Ayu Tri Wulandari	Leukoplakia in HIV Patient and Risk for Malignancy: Case Report
12	AP_13_CC	Rani Handayani, Iwan Purnawan, Tintin Supriantin, Arif Setyobudi, Denti Rahmani Santihe, Anandina Irmagita Soegyanto	The Role of Dentist on Oral Syphilis in MSM HIV Patients with ART (Case Report)

AP_09_CC

Unexpected HIV/AIDS Case on Acute Necrotising Ulcerative Gingivitis Patient

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Abstract

Background: HIV/AIDS is a phenomenon rather like an iceberg, with far fewer people (above the water line) reported to have the disease than is actually the case when the whole of the iceberg becomes visible. About more than 60% of people with HIV and 90% of AIDS have oral manifestations, one of which is Acute Necrotising Ulcerative Gingivitis (ANUG). ANUG causes damage to the gingival margins and interdental papillae that is acute, painful, and bleeds easily as well as creating a distinctive halitosis. The prevalence of ANUG is lower than other oral manifestations, so many health workers pay less attention to it even though oral manifestations can make it easier to spot early clinical signs, determine staging and predict morbidity of people with HIV/AIDS.

Purpose: To discuss oral manifestations of ANUG in HIV/AIDS patients.

Case: Male patient, 37 years old, came to the Oral Medicine Clinic, at The Dr. Ramelan Naval Hospital. His main complaint was an ulcer at the gingival margin, accompanied by bleeding, extreme pain and halitosis. Such patients can have difficulty eating and talking. The patient's general condition was very weak. Low CD4+.

Examination history: Extraorally, examination of the submandibular gland, found it to be palpable, soft and painful. Intra-oral examination of the gingival margin of region 13 there is an ulcer accompanied by spontaneous bleeding, reddish color, clear boundaries, irregular edges, it feels very painful.

Case management: Based on the patient's medical history, clinical examination and a low CD4+ count, the patient was referred for an antibody VCT test because it was suspected that the patient had HIV. The patient was given chlorherxidine gluconate mouthwash 0.2%, to be used four times a day.

Conclusion: ANUG has a close relationship with the development of HIV/AIDS. It is hoped that dentists will pay more attention to oral manifestations, especially ANUG because it can make it easy to show early clinical signs, determine staging and predict morbidity of people with HIV/AIDS.

Keywords: Acute Necrotising Ulcerative Gingivitis, HIV/AIDS, CD4+

Unexpected HIV/AIDS Case On Acute Necrotizing Ulserative Gingivitis Patient

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ABSTRACT. Background: HIV / AIDS is a phenomenon like an iceberg, with far fewer people reported than is actually the case. About more than 60% of people with HIV and 90% of AIDS have oral manifestations, one of which is Acute Necrotizing Ulcerative Ginggivitis (ANUG). ANUG is damage to the gingival margins and interdental that is acute, painful, halitosis and bleed easily. The prevalence of ANUG is smaller than other oral manifestations, so many health workers pay less attention. Whereas oral manifestations can make it easier to show early clinical signs, determine staging and predict morbidity of people with HIV / AIDS. **Purpose**: Discusses oral manifestations ANUG in HIV / AIDS patients. **Case**: Male patient, 37 years old, came to the Oral Medicine Clinic, Department of Dental and Mouth, Navy Hospital Dr. Ramelan with the main complaint in the form of ulcer at the gingival margin, accompanied by bleeding, extreme pain and halitosis. Patients have difficulty eating and talking. The patient's general condition is very weak. Low CD4 + examination history. Extra Oral examination of sub mandibular gland is palpable, soft and painful. Intra-oral examination of the gingival margin of region 13 appears ulcer accompanied by spontaneous bleeding, reddish color, clear boundaries, irregular edges, it feels very painful. **Case management**: Based on history, clinical examination and a low CD4 + history. So the patient was referred for an antibody VCT test because he suspected the patient had HIV. The patient was given Chlorherxidine Gluconate mouthwash 0.2%, used 4 times a day. **Conclusion:** ANUG has a close relationship with the condition of HIV / AIDS. It is expected that dentist pay more attention to oral manifestations, especially ANUG because it can make it easy to show early clinical signs, determine staging and predict morbidity of people with HIV / AIDS.

Keywords: *Acute Necrotizing Ulcerative Gingivitis, HIV/AIDS, CD4+*

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INTRODUCTION

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) have become global emergency problems. Worldwide, 35 million people live with HIV and 19 million do not know their HIV positive status. Indonesia is the 5th most country at risk of HIV / AIDS in Asia. The Ministry of Health's report that HIV / AIDS has increased in line with the years, in 2016 jumped to 7,491 (Kemenkes, 2017).

The case of HIV / AIDS is a phenomenon like an iceberg, with far fewer people reported than is actually the case. HIV / AIDS sufferers often show oral manifestations. About more than 60% of people with HIV and 90% of AIDS have oral manifestations (Nugraha et al., 2015).

Oral manifestations in HIV patients that commonly occur include Candidiasis, Oral Hairy Leukoplakia, Acute Necrotizing Ulcerative Ginggivitis and Linear Gingival Erythema and Kaposi's Sarcoma. The prevalence of oral manifestations in HIV patients is 29% with a composition of 9% LGE, 3.6% ANUG & ANUP, 7% oral candidiasis and 3.6% OHL (Kroidl, 2015).

Acute Necrotizing Ulserativ Ginggivitis has a small prevalence compared to others, so that many dentists pay less attention. Whereas oral manifestations can make it easier to show early clinical signs, determine staging and predict morbidity of people with HIV / AIDS. Therefore this case will discuss oral manifestations especially ANUG in HIV / AIDS patients who previously did not know that they were HIV / AIDS.

CASE REPORT

On May 28, 2018, a male patient, 37 years old, came to the Oral Medicine Clinic, Department of Dentistry, Dr. Ramelan Navy Hospital with the chief complaint of injury accompanied by spontaneous bleeding in the gums. Complaints were felt since 3 days ago. The gums bleed continuously and are accompanied by intense pain, so that patients find it difficult to eat and talk. This causes the General Condition / KU of the patient to be very weak.

There is a history of CD4 + blood examination in February 2017 related to general weakness, with a CD4 + result of 8 cells / mm3 and the last performed in August 2017 was 7 cells / mm3. But not followed up by the patient because the patient still feels healthy.

On Extra Oral examination in sub mandibular gland area felt, soft and sore. Patients also have difficulty opening their mouths, accompanied by bad breath.

On Intra Oral examination on the gingival margin region 13, Ulcer was accompanied by spontaneous bleeding, reddish color, clear boundaries, irregular edges, it was very painful. In the anterior mandible gingiva there is spontaneous bleeding.

Figure. 1a. Region 13 right above there is a white ulcer on

1b & 1c. In the right and left posterior regions there is a blood cloth

Based on the history and clinical examination, the provisional diagnosis is ANUG. The treatment plan will be a panoramic photo. Due to a suspected ANUP diagnosis. But considering the patient's condition that is not possible, then the patient is referred for hospitalize. With history taking, clinical examination and a low CD4 + history. So the patient was referred for an antibody VCT test because he suspected the patient had HIV.

On May 29, 2018 an antibody VCT test was carried out, with the final result reactive. This means that the patient has HIV / AIDS.

The patient was given Chlorherxidine Gluconate mouthwash 0.2% therapy, used 4 times a day.

The first control, on June 1, 2018 the patient seemed to improve, not weak. The patient can already eat and talk. HIV/AIDS is treated by internist.

Extra Oral Examination normal. Intra-oral examination of the right upper gingiva is normal. ANUG healed, the patient remains educated to improve oral hygiene and orderly to carry out treatments related to HIV / AIDS.

HASIL TES VCT ANTIBODI

LAPORAN LABORATORIUM

NAMA REAGENSIA		HASIL PEMERIKSAAN
1. [illegible]	○ Non Reaktif	✓ Reaktif
2. [illegible]	○ Non Reaktif	✓ Reaktif
3. [illegible]	○ Non Reaktif	✓ Reaktif

HASIL AKHIR

○ NON REAKTIF ✓ REAKTIF ○ INDETERMINATE

CATATAN

Figure 2. Result VCT antibody

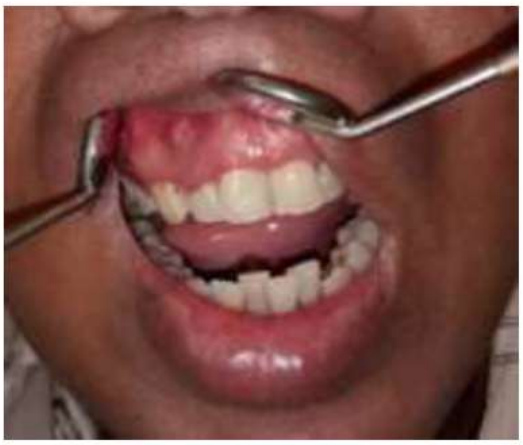


Figure 3. Ulcer in the right upper gingival margin healed

DISSCUTION

Human Immunodeficiency Virus (HIV) is an immunodeficient disease in the presence of retroviruses that infect cells and the immune system. There is a disruption in T cells so the body becomes vulnerable to various kinds of infections, especially infections of microorganisms (Scully, 2010). The HIV virus belongs to the family Retroviridae and the genus Lentivirus. This virus has two types of serotypes, namely HIV-1 and HIV-2. HIV 1 is the most infective HIV virus, has a higher virulence, and is a cause of global HIV infection. HIV-2 is a virus that has lower infectivity and virulence (Yesufu OTC & Gandhi RT, 2011)

This disease is caused by the HIV virus which is an RNA retrovirus that is transmitted through blood and body fluids. Transmission of the disease can be through sexual contact, blood donation that has been contaminated with the HIV virus, the use of alternating syringes, vertical transmission from mother to child (Scully, 2013). From the patient's acknowledgment, sexual transmission of the HIV virus was suspected.

The HIV virus can only survive and multiply in cells. Thus the life cycle of the HIV virus can be divided into 4 stages, namely the entry phase of the virus in the host cell, the transcription stage backwards from the integration of the genome, the replication stage and the stage of assembling and maturing the virus (Services, 2005).

Immediately after HIV infection, some of the free viruses and those that are in infected CD4 T cells will reach the regional lymph nodes and will stimulate cellular and humoral immunity by among other things recruiting lymphocytes. This collection of lymphocytes will actually cause more CD4 cells to become infected. Finally, infected monocytes and lymphocytes will circulate throughout the body and spread the virus throughout the body. HIV can also enter the brain through monocytes that are present and circulate in the brain or through infection of endothelial cells in the brain. During the acute phase, most cases show symptoms of acute viral infections in general which are fever, lethargy, myalgia and headaches as well as other symptoms in the form of pharyngitis, lymphadenopathy and rash (Ratnam, 2018; Klatt R, 2018)

After being attacked by an acute phase, it will then enter the asymptomatic phase which will gradually decrease CD4 levels. This can occur for months or years depending on the immune condition of the infected person. A decrease in a person's immunity can be seen from the level of CD4 in the blood. Therefore, in this asymptomatic phase the number of viruses in the blood and peripheral cells can be detected in a low condition. A decrease in CD4 cell count in the blood averages 65 cells / ul each year. Damage to the immune system is obtained but is not latent and can still be improved, especially in lymph nodes. A decrease in the number of CD4 T cells during HIV infection can directly affect several immunologic reactions played by CD4 T cells (Sudoyo A.W. et.al., Internal Medicine Teaching Book, 2009). This is consistent with the patient's history of having had a very low CD4 + and the same symptoms as fever, sore throat and rash. But the patient returned to feeling healthy and did not follow up on treatment.

Patients who are infected with HIV if not followed up will enter the final stage, namely Acquired Immune Deficiency Syndrome (AIDS). AIDS is a collection of symptoms or diseases caused by decreased immunity due to HIV

virus infection (Mindel, A and Flowers, M, 2001). A collection of symptoms often shows oral manifestations, around more than 60% of HIV and 90% of AIDS (Nugraha et al., 2015). Oral manifestations in HIV / AIDS patients include oral candidiasis, Oral Hairy Leukoplakia, Acute Necrotizing Ginggivitis, Linear Gingival Erythema, and Kaposi's Sarcoma. Acute Necrotizing Ginggivitis has a small prevalence compared to others, so it rarely has special attention, in this case will be discussed about oral manifestations, especially ANUG in HIV / AIDS patients who previously did not know that positive for HIV / ADS.

Acute Necrotizing Ulcerative Gingivitis is damage to the gingival margins and interdental caused by a collection of microbes such as Treponema, Prevotella intermedia, Fusobacterium nucleatum, Peptostreptococcus micros, Porphyromonas gingivalis, Selenomonass, and Campylobacter. These bacteria produce a variety of destructive metabolites, such as collagenase, fibrinolisin, endotoxins, hydrogen sulfide, indole ammonia, fatty acids, proteases that can degrade immunoglobin, inhibit neutrophil chemotaxis and proteolytic enzymes all of which lead to tissue damage (Folayan, 2004; Glick, 2015).

Before it became known that this patient was HIV / AIDS positive, the factors that influenced the occurrence of ANUG were the stress experienced by the patient. psychological stress can activate sympathetic nerves and reduce blood flow to the gingiva by systemic adrenaline secretion and peripheral noradrenaline production in the walls of the gingival blood vessels. These vasoconstrictors combine with endotoxins from gram-negative microbes that cause them to be ANUG (Malek R et al., 2017). Besides stress there are also various predisposing factors to ANUG namely nutritional deficiency and immune system dysfunction, especially HIV infection is a major role in the pathogenesis of ANUG (Malek R et al., 2017)

The reported prevalence of ANUG patients infected with HIV reached 4.3% from 16.0% (Hirofumi Kato H and Imamural A, 2017). The prevalence report reinforces that there is a link between ANUG and HIV / AIDS. This linkage appears in HIV sufferers, the immune system will experience a disturbance where T cell function is disrupted and the T cell ratio decreases resulting in decreased phagocytic function of PMN. This is what makes it easier for micrombes to proliferate (Glick, 2015).

The diagnosis in this case is ANUG with a differential diagnosis of acute herpetic gingivostomatitis and recurrent intraoral herpes. The diagnosis of ANUG based on clinical appearance is usually acute with typical characteristics of rapid onset, reddish gingiva accompanied by the appearance of ulceration in the interdental papillary region where this ulceration can extend to the marginal gingival area of the ulcer in the interdental gingival papillae, pain, bleeding, and

halitosis. There are systemic symptoms such as lymphadenopathy, fever and malaise. The clinical appearance is appropriate for patients (Malek R et al., 2017).

In this patient there was no investigation because the general condition of the patient was very weak but the patient had a VCT antibody examination to detect HIV / AIDS. The examination confirmed that the result was HIV / AIDS positive. It was previously known that the patient had a history of very low CD4 + results, but the patient did not follow up. CD4 + is the best parameter for measuring immunodeficiency. Used in conjunction with clinical assessment. CD4 + can be an early indicator of disease progression because CD4 + values decline earlier than clinical conditions. CD4 + monitoring can be used to start treatment with ARVs or drug replacement (Langford SE, Anaworanich J dan Cooper DA, 2007).

Local treatment in the oral cavity is given mouthwash Chlorhexidine Gluconate 0.2% used 10ml, gargle is applied 4 times a day. Chlorhexidine Gluconate 0.2% is one of the antimicrobial agents that it has Long-lasting antibacterial activity with broad spectrum action and has been shown to reduce plaque accumulation, gingival inflammation and bleeding. Chorhexidine is a positively charged cation molecule that is easily and quickly attracted to the wall of negatively charged bacteria. The bond becomes stronger because the bacterial cell wall can be strong adsorption for compounds containing phosphate. This interaction changes the integrity of the bacterial cell membrane and Chlorhexidine is increasingly drawn towards the inside. On the inside of the membrane Chlorhexidine bacteria will bind to phospholipids so that there will be an increase in permeability and leakage of potassium ions that cause damage to bacterial cells (Kwon et al, 2016; Prasanna1, SGV and Lakshmanan R, 2016)

Systemic care and treatment of HIV / AIDS are referred to doctors sp. Internal disease. After using mouthwash and intensive care (hospitalization) for 5 days, recovery from ANUG was apparent. While HIV / AIDS is still being treated.

BIBLIOGRAPHY

Folayan MO. 2004. The Epidemiology, Etiology, and Pathophysiology of Acute Necrotizing Ulcerative Gingivitis Associated with Malnutrition. J Contemp Dent Pract 2004 August:(5)3:028-041. https://pdfs.semanticscholar.org/f0a2/17d6319f3e6090583c5efa5dd4f4094c229e.pdf

Glick, M. (2015) *Burket's Oral Medicine 12th edition*. 12th editi. Edited by M. Glick. Shelton, Connecticut: People's Medical Publishing House—USA.

Kementrian Kesehatan RI .2017. SITUASI UMUM HIV/AIDS dan TES HIV

Kroidl, Schaeben, Oette, Wettstein, Herfordt, Haussinger. 2005. Prevalence of oral lesions and periodontal diseases in hiv-infected patients on antiretroviral therapy a. Eur J Med Res (2005) 10: 448-453. https://www.researchgate.net/publication/7480104_Prevalence_of_oral_lesions_and_periodontal_diseases_in_HIV-infected_patients_on_antiretroviral_therapy

Langford, SE., Ananworanich J and Cooper DA. 2007. Predictors of disease progression in HIV infection: a review. AIDS Res Ther. 2007; 4: 11.. Published online 2007 May 14. doi: 10.1186/1742-6405-4-11

Malek, Rayhana., Gharibi A, Khlil, Kissa J. 2017. Necrotizing Ulcerative Gingivitis. Contemp Clin Dent 2017;8:496-500.

Kwon,Young eun., Youn-Kyung Choi1, Jeomil Choi2, Ju-Youn Lee2, Ji-Young Joo. 2016. Effective Management of Acute NecrotizingUlcerative Gingivitis with Proper Diagnosis and Immediate Treatment. J Korean Dent Sci. 2016;9(2):81-89. https://doi.org/10.5856/JKDS.2016.9.2.81

Kato, Hirofumi dan Imamura, Akifumi. 2016. Unexpected Acute Necrotizing Ulcerative Gingivitis in a Well-controlled HIV-infected Case. Intern Med 56: 2223-2227, 2017. DOI: 10.2169/internalmedicine.8409-16

Klatt, Edward C. Pathology Of Hiv/Aids Version 29. 2018. MD Professor of Pathology Department of Biomedical Sciences Mercer University School of Medicine Savannah April 16, 2018 Copyright © by Edward C. Klatt, MD All rights reserved worldwide

MVR Ratnam, MVR ., Nayyar, AS., Reddy DS., Ruparani., Chalapathi KV dan Azmi S. 2018. CD4 cell counts and oral manifestations in HIV infected and AIDS patients. J Oral Maxillofac Pathol. 2018 May-Aug; 22(2): 282.

Mindel, A and Flowers, MT .2001. ABC of AIDS Natural history and management of early HIV infection. BMJ. 2001 May 26; 322(7297): 1290–1293. doi: 10.1136/bmj.322.7297.1290

Nugraha, AP, Djamhari M, Endah Adiastuti, Soebadi B, Triyono EA, Prasetyo BA, Budi S. 2017. Profil Angular Cheilitis pada penderita HIV/AIDS di

UPIPI RSUD Dr. Soetomo Surabaya 2014. Majalah Kedokteran Gigi Indonesia. Juni 2015; 1(1): 12-20

Prasanna1, SG V dan Lakshmanan R. 2016. Characteristics, Uses and Side effects of Chlorhexidine- A Review. IOSR Journal of Dental and Medical Sciences (IOSR-JDMS) e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 15, Issue 6 Ver. III (June. 2016), PP 57-59 www.iosrjournals.org

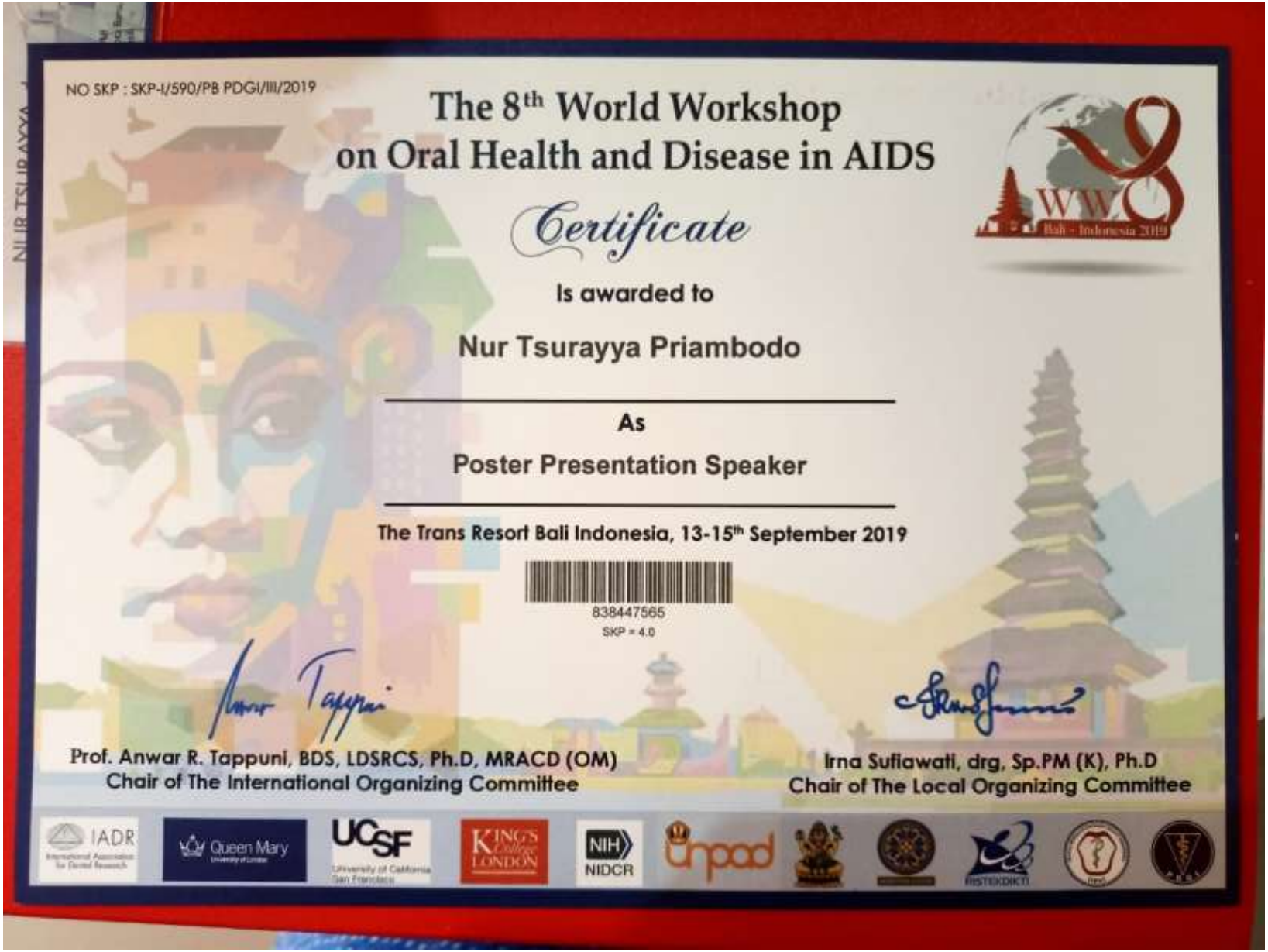
Ruslie, R.H., 2009. DIAGNOSIS DAN TATALAKSANA INFEKSI HIV. , pp.11–22

Scully, C. .2013. *Oral and Maxillofacial Medicine The Basis of Diagnosis and Treatment*. third. Churchill Livingstone ElSevier. Available at: www.elsevier.com.

Sudoyo,A.W.dkk.2009. Buku Ajar Ilmu Penyakit Dalam. Jakarta : Fakultas Kedokteran Universitas Indonesi

Services, U.. D. of He. and H., 2005. The HIV Life Cycle. , (May), p.2005. Available at: http://aidsinfo.nih.gov.

Yesufu, Omobolali T Campbell and Gandhi Rajesh T. 2011. Update on Human Immunodeficiency Virus (HIV)-2 Infection. Clinical Infection Disease. 2011 Mar 15; 52(6): 780–787. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3106263/



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