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TABLE OF CONTENTS

Volume 10, Number 1, 2021

1. Relationship of gallbladder histopathology towards types of stones in cholelithiasis patients at Universitas Sumatera Utara Hospital, Medan, Indonesia 1-3
DOI:10.15562/bmj.v10i1.2128
Adi Muradi Muhar, Denny Rifsal Siregar, Doddy Prabisma
2. Successful total correction of Transposition of Great Artery in Surabaya's rural area experience: serial cases 4-7
DOI:10.15562/bmj.v10i1.2005
Heroe Soebroto, Farhan Danisa, Arief Rakhman Hakim
3. Single Umbilical Artery (SUA) - prenatal sonography diagnosis and vascular imaging features postnatal cord: a case report 8-10
DOI:10.15562/bmj.v10i1.2024
I Nyoman Hariyasa Sanjaya, Cokorda Istri Mirayani Pemayun, Ni Wayan Dewi Purwanti, Made Diah Vendita Sakuntari, Ni Putu Nining Gianni, Ni Luh Made Diah Mas Cahyani Putri, Ni Komang Anik Pirgantari, Ni Luh Md Dwi Laxmi Satriani, Firsta Sesarina Mintariani, Ni Luh Putu Yulia Padmawati, Anak Agung Wahyu Putri
4. Study of neutrophil-lymphocyte ratio (NLR) in recent onset type 2 diabetes mellitus 11-16
DOI:10.15562/bmj.v10i1.1780
Sharmila Dudani, Sanjiti Poodury, Sridhar Mangalesh
5. Mean pulmonary artery diameter in chest CT scan in the Thai population 17-20
DOI:10.15562/bmj.v10i1.1833
Sitang Nirattisaikul, Nuttapat Sunpech, Keerati Hongsakul
6. The relationship between self-esteem and husband support with body image perception in post-vaginal delivery primiparous mother in independent Delima midwife practice in Denpasar 20-25
DOI:10.15562/bmj.v10i1.2069
Ignasius Yulianus Jagkson Bomba, Cok Bagus Jaya Lesmana, Ni Ketut Sri Diniari, Luh Nyoman Alit Aryani, Anak Ayu Sri Wahyuni, Lely Setyawati, Ni Ketut Putri Ariani, Ida Ayu Kusuma Wardani, I Gusti Ayu Indah Ardani

7. **A 3-days old infant with neonatal soft tissue sarcoma: a case report**..... 26-29
 DOI:10.15562/bmj.v10i1.2104
Dwi Feris Sidabutar, Agung Aji Prasetyo
8. **Vitamin D Receptor (VDR) Apa1 gene polymorphism increasing the risk of breast cancer women in Bali, Indonesia**..... 30-34
 DOI:10.15562/bmj.v10i1.2113
I Putu Gede Fajar Mahayasa, I Ketut Widianana, Putu Anda Tusta Adiputra, I Wayan Sudarsa
10. **Right hepatic artery pseudoaneurysm after choledocoduodenostomy: a case report**..... 35-37
 DOI:10.15562/bmj.v10i1.2106
Erik Prabowo, Ahmad Fathi Fuadi, Antonius Gunawan Santoso
11. **Functional assessment of operative and nonoperative management in major pelvic fracture at Dr. Moewardi Hospital, Surakarta, Indonesia**..... 38-42
 DOI:10.15562/bmj.v10i1.2116
Udi Heru Nefihancoro, Muhamad Muamar, Muhammad David Perdana Putra
12. **Delayed laparotomy and gastric repair in gastric perforation: a case report in the neonatal patient**..... 43-46
 DOI:10.15562/bmj.v10i1.2117
Barmadisatrio, Ali Sibra Mulluzi
13. **Liver resection profile in Prof. dr. R.D. Kandou General Hospital: 1-year experience** 47-52
 DOI:10.15562/bmj.v10i1.2118
Michael Iskandar, Michael Tendean, Toar Deliezer Bram Mambu, Ferdinand Tjandra, Jimmy Panelewen, Celine Martino
14. **Sexual satisfaction of Indonesian women with breast cancer in Central Java, Indonesia** 53-57
 DOI:10.15562/bmj.v10i1.2119
Yan Wisnu Prajoko, Tommy Supit
15. **Fractional erbium: YSGG laser compared to the combination of fractional erbium: YSGG laser and topical autologous platelet-rich plasma for treatment of atrophic acne scars: a case report**..... 58-62
 DOI:10.15562/bmj.v10i1.2240
Prasetyadi Mawardi, Adniana Nareswari

16. The role of cholelithiasis risk factors in stone types in cholelithiasis patients at Universitas Sumatera Utara Hospital 63-65
DOI:10.15562/bmj.v10i1.2139
Denny Rifsal Siregar, Adi Muradi Muhar, Doddy Prabisma Pohan
17. Characteristics of non-genital warts in the dermatovenereology department of Mangusada Badung General Hospital during in 2019 66-68
DOI:10.15562/bmj.v10i1.2038
Efbri Chaurasia Dalitan, Anak Agung Ari Agung Kayika Silayukti
18. Intracranial stenosis in patients with post-ischemic stroke: a case-control study 69-73
DOI:10.15562/bmj.v10i1.1989
Rizaldy Pinzon, Andre Dharmawan Wijono
19. The change of cell biometric and its nucleus on cervical-squamous-epithelial-cell with GA genotype of Fas-promoter-670 gene, high-risk human papillomavirus and Candida species infection: a case report 74-75
DOI:10.15562/bmj.v10i1.2138
Edy Parwanto, Raditya Wratsangka, Assangga Guyansyah, Kirana Anggraeni, Reza Aditya Digambiro, David Tjahyadi, Hanslavina Arkeman, Haryo Ganeca Widyatama, Hosea Jaya Edy, Yosua Jaya Edy
19. DNA barcoding in molecular identification and phylogenetic relationship of beneficial wild Balinese red algae, *Bulung sangu* (*Gracilaria* sp.) 82-88
DOI:10.15562/bmj.v10i1.2093
I Gede Putu Wirawan, Maria Malida Vernandes Sasadara, I Nyoman Wijaya, Anak Agung Keswari Krinandika
20. Video-assisted thoracoscopic surgery in the treatment of empyema: a case series... 89-94
DOI:10.15562/bmj.v10i1.2121
Yustinus Rurie Wirawan, Christophores Jonathan Tansil
21. Simultaneous resection on the patient with synchronous colorectal liver metastasis: two cases report 95-98
DOI:10.15562/bmj.v10i1.2122
Celine Martino, Michael Tendean, Toar D. B. Mambu, Ferdinand Tjandra, Michael Iskandar
22. Correlation of CD44 and CD24 expression with the positive response after neoadjuvant chemotherapy in stage IIIB breast cancer patient at Dr. Saiful Anwar Hospital, Malang, Indonesia 99-102
DOI:10.15562/bmj.v10i1.2123
Muhammad Bachtiar Budianto, Artono Isharanto, Andry Haris

23. Patients' characteristics following reoperation after Modified Blalock-Taussig Shunt (MBTS) in Cardiac Centre National General Hospital Cipto Mangunkusumo from 2018-2020..... 103-107
DOI:10.15562/bmj.v10i1.2124
Suprayitno Wardoyo, Joshua Parsaoran Partogi Pardede, Hari Agung Asari
24. Penile gangrene as a priapism sequele due to Chronic Myeloid Leukemia (CML): the first report in Indonesia..... 108-110
DOI:10.15562/bmj.v10i1.2125
Deddy Rasyidan Yulizar, Eka Putri Maulani, Heru Prasetya, Hendra Sutapa, Eka Yudha Rahman
25. The effects of cyclophosphamide, adriamycin and 5-fluorouracil chemotherapy on blood cells and cardiac hemodynamics in breast carcinoma patients: a case study at Dr. Kariadi General Hospital, Semarang, Indonesia..... 111-118
DOI:10.15562/bmj.v10i1.2126
Sibin Chandra, Djoko Handojo
26. Radiofrequency ablation for management of thyroid nodules: a case report..... 119-121
DOI:10.15562/bmj.v10i1.2150
Kristanto Yuli Yarsa, Monica Bellynda
26. The future of three-dimensional skin graft: a mini-review..... 122-125
DOI:10.15562/bmj.v10i1.2242
Zendio Abednego Santoso
27. The correlation TNF- α gene promoter region-238G, -308G, -857, and -1031 polymorphism with psoriasis vulgaris 126-131
DOI:10.15562/bmj.v10i1.2328
Cashtri Meher, R. Lia Kusumawati Iswara, Irma D. Roesyanto-Mahadi
28. Phytochemical test and identification of active compounds with LC-MS/MS in green meniran leaf (*Phyllanthus niruri* Linn) 132-136
DOI:10.15562/bmj.v10i1.2208
Ni Kadek Eka Widiadnyani, I Nyoman Mantik Astawa, I Wayan Putu Sutirta Yasa, I Dewa Made Sukrama
29. The role of psychosocial stressors, carbohydrate and protein intake on serum serotonin and cortisol levels in patients with depression: a preliminary evaluation 137-141
DOI:10.15562/bmj.v10i1.2315
Alifiati Fitrikasari, Natalia Dewi Wardani, Tanjung Ayu Sumekar, Fanti Saktini, Hang Gunawan Asikin1, Mohamad Sulchan, I Dewa Made Sukrama

30. COVID-19 vaccination in patients with cancer: Position paper from the Indonesian Society of Hematology and Medical Oncology (ISHMO) of Semarang 142-150
DOI:10.15562/bmj.v10i1.2273
Eko Adhi Pangarsa, Budi Setiawan, Santosa, Ridho Monotoc Naibaho, Daniel Rizky, Suyono, Mika Lumban Tobing, Muchlis Achsan Udji Sofro, Catharina Suharti
31. Ergonomic workstation reduces electrical activity of upper trapezius muscles, erector spinae muscles, and musculoskeletal complaints in agel fiber twisting process 151-155
DOI:10.15562/bmj.v10i1.2187
Chandra Dewi Kurnianingtyas, I Putu Gede Adiatmika, Ketut Tirtayasa, I Wayan Surata
32. The ethanol extract of *Garcinia mangostana* L peel reduces the isoniazid-induced liver damage in rats 156-159
DOI:10.15562/bmj.v10i1.2108
Triyanta Yuli Pramana, Brian Wasita, Vitri Widyaningsih, Risya Cilmiaty, Suroto, Ambar Mudigdo, Bambang Purwanto
33. Intravenous Wharton's Jelly stem cell increased the number of β cells pancreas and reduced the fasting blood glucose level in diabetes mellitus Wistar rat male (*Rattus norvegicus*) 160-163
DOI:10.15562/bmj.v10i1.2306
Nadia Permatasari, Wimpie Pangkahila, Anak Agung Gde Budhiarta
34. Pectoralis major myocutaneous flap for head and neck reconstruction: a case report 164-166
DOI:10.15562/bmj.v10i1.2112
Oktahermoniza, Ari Oktavenra, Daan Khambri
35. Primary infertility of male and female factors, polycystic ovary syndrome and oligoasthenoteratozoospermia dominate the infertile population in agricultural and industrial areas in Karawang Regency, West Java Province, Indonesia 167-173
DOI:10.15562/bmj.v10i1.2281
Assangga Guyansyah, Raditya Wratsangka, Denny Dhanardono, Muhammad Farid Ghazali, Hosea Jaya Edy, Haryo Ganeca Widyatama, Dietha Kusumaningrum, David Tjahyadi, Edy Parwanto
36. Does a higher degree of education affect the performance of healthcare leaders? A systematic review 174-18
DOI:10.15562/bmj.v10i1.2014
Awal Prasetyo, Jethro Budiman, Muzakar Isa

37. Management of giant thyroglossal duct cyst in Dr. Moewardi Hospital Indonesia: A case report..... 181-183
DOI:10.15562/bmj.v10i1.2111
Muhammad David Perdana Putra, Joko Purnomo, Kristanto Yuli Yarso
38. Aggressiveness tumor: a case report of recurrent ameloblastoma in the mandible. 184-188
DOI:10.15562/bmj.v10i1.2114
Marjono Dwi Wibowo, Agung Fuad Fathurochman
39. Anti-diabetic properties of *Stevia rebaudiana Bertoni* as sugar substitute: a mini-review..... 189-193
DOI:10.15562/bmj.v10i1.2259
Yudi Kristanto, Angeline Rosa Hartono
40. Comparison of skin hydration degrees based on moisturizing time in children's atopic dermatitis 194-198
DOI:10.15562/bmj.v10i1.2137
Puteri Wulandari, Syahril Rahmat Lubis, Deryne Anggia Paramita
41. Acute kidney injury in patient with djenkolism: a case report 199-201
DOI:10.15562/bmj.v10i1.2146
Yenny Kandarini, Made Edwin Sridana, Gede Wira Mahadita
42. Evaluation of patient's daily activities with Free Non-Vascularized Fibular Head Graft (FNVFHG) as a treatment after resection of proximal humeral tumors..... 202-207
DOI:10.15562/bmj.v10i1.2270
Muhammad Phetrus Johan, Henry Yurianto, Roichan Mochammad Firdaus, Andi Firman Mubarak, Luky Tandio Putra, Tri Kurniawan
43. An overview of overactive bladder 208-210
DOI:10.15562/bmj.v10i1.2266
I Putu Gde Fredy Gunawan, I Nyoman Suarjana, Kadek Frida Wulandari
44. Case report of Laryngeal Amyloidosis: Unusual cause of hoarseness 211-213
DOI:10.15562/bmj.v10i1.1795
Noraimi Khamalrudin, Mohd Razif Mohamad Yunus, Marina Mat Baki, Foong Seong Kin
45. The correlation of blood thiamine concentrations with lactate acidosis in peritonitis patients with sepsis..... 214-218
DOI:10.15562/bmj.v10i1.2237
Maria Meilita Sinaga, Vicky Sumarki Budipramana, Jusak Nugraha
46. Use of smartphone-based self-monitoring blood glucose application in type 2 diabetes mellitus patients in Indonesia: A pre and post-test study 219-224
DOI:10.15562/bmj.v10i1.2181
Ida Ayu Kshanti, Muhammad Ikhsan Mokoagow, Rulli Rosandi, Marina Epriliawati, Jerry Nasarudin, Nadya Magfira

47. Keloid after orthopedic surgery: prevention, current therapy modalities, and emerging therapies modalities..... 225-228
DOI:10.15562/bmj.v10i1.2264
Andrew Sutheno
48. A new hope of CD133+ bone marrow stem cell for functional exercise capacity improvement in low ejection fraction coronary artery bypass graft patients: a clinical trial 229-223
DOI:10.15562/bmj.v10i1.2264
Tri Wisesa Soetisna
49. A new hope of CD133+ bone marrow stem cell for functional exercise capacity improvement in low ejection fraction coronary artery bypass graft patients: a clinical trial 229-223
DOI:10.15562/bmj.v10i1.2264
Tri Wisesa Soetisna
49. Blood pressure difference between regular hemodialysis and hemodialysis with hemoperfusion at Haji Adam Malik Hospital, Medan-Indonesia 234-237
DOI:10.15562/bmj.v10i1.846
Dedy Shauqi Fachrianda Situmorang, Alwi Thamrin Nasution, Syafrizal Nasution
50. The role of epidermal growth factor receptor as progression factor in cervical intraepithelial neoplasia and squamous cell carcinoma..... 238-242
DOI:10.15562/bmj.v10i1.2349
I Gusti Ayu Sri Mahendra Dewi, Ni Putu Sriwidnyani, Ni Putu Ekawati
51. Purple sweet potato extract and vitamin C increase the proliferation of endothelial progenitor cells from stable coronary artery disease patients..... 243-248
DOI:10.15562/bmj.v10i1.2261
Luh Oliva Saraswati Suastika, Yudi Her Oktaviono, Djoko Soemantri, Ferry Sandra
52. Predicting factors for walking ability of postoperative patients with hemiarthroplasty at Wahidin Sudirohusodo Hospital in Makassar 249-255
DOI:10.15562/bmj.v10i1.2256
Muhammad Sakti, Ruksal Saleh, Khrisna Yudha, Taufiq Akbar
53. Correlation between nail psoriasis severity index score with quality of life in nail psoriasis 256-260
DOI:10.15562/bmj.v10i1.2198
Abdul Arif, Irma Damayanti Roesyanto Mahadi, Ariyati Yosi
54. The dynamic of Soluble Vascular Cellular Adhesion Molecule -1 (sVCAM-1) level in Overnutritious children with Dengue Infection 261-265
DOI:10.15562/bmj.v10i1.2304
Ni Kadek Elmy Saniathi, Mohammad Juffrie, Bambang Udji Djoko Rianto, Soetjningsih

55. **Decision to Delivery Interval in Emergency Cesarean Section at Two Academic Hospitals in Yogyakarta and Central Java, Indonesia**..... 266-272
 DOI:10.15562/bmj.v10i1.2030
Shinta Prawitasari, Doni Widyandana, Mohammad Hakimi, Adi Utarini
56. **Decision to Delivery Interval in Emergency Cesarean Section at Two Academic Hospitals in Yogyakarta and Central Java, Indonesia**..... 266-272
 DOI:10.15562/bmj.v10i1.2030
Shinta Prawitasari, Doni Widyandana, Mohammad Hakimi, Adi Utarini
56. **Evaluation of chronic disease management programs in developed and underdeveloped regions in Indonesia** 273-280
 DOI:10.15562/bmj.v10i1.2099
Ahmad Muhammad Kasim, Yodi Mahendradhata, Laksono Trisnantoro
57. **Evaluation of chronic disease management programs in developed and underdeveloped regions in Indonesia** 273-280
 DOI:10.15562/bmj.v10i1.2099
Ahmad Muhammad Kasim, Yodi Mahendradhata, Laksono Trisnantoro
58. **Criteria for palliative care referral in oncology practice: An instrument development** 281-290
 DOI:10.15562/bmj.v10i1.2099
Maria A Witjaksono, Christantie Effendy, Sri Mulatsih, Iwan Dwiprahasto, Adi Utarini
59. **Correlation of low vitamin D status with atopic dermatitis severity in children** 291-295
 DOI:10.15562/bmj.v10i1.2203
Habibah Hasyim Lubis, Kristo Alberto Nababan, Deryne Anggia Paramita
60. **Analysis of Malondialdehyde (MDA) levels in skin tags patients**..... 296-299
 DOI:10.15562/bmj.v10i1.2214
Muhammad Ridlo, Imam Budi Putra, Nelva Karmila Jusuf

The change of cell biometric and its nucleus on cervical-squamous-epithelial-cell with GA genotype of Fas-promoter-670 gene, high-risk human papillomavirus and *Candida* species infection: a case report

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INTRODUCTION

The ThinPrep Pap test can be used to identify precancerous lesions in patients to facilitate early detection to manage cervical cancer. ThinPrep Pap tests are currently the gold standard in liquid-based cytology testing, and their use is greatly improved compared with conventional Pap technology.¹ It has been demonstrated that the ThinPrep Pap test has high sensitivity and high specificity in

screening for cervical cancer.²

Precancerous cervical lesions are strongly associated with high-risk human papillomavirus (hr-HPV) infection. It has been demonstrated that persistent infection with high-risk types of HPV is the most significant factor for cervical cancer and precancerous lesion manifestation.³ A previous study has reported the incidence and mortality of cervical cancer and their relationship with the human

development index in 185 countries globally. Furthermore, screening methods include cytology (Papanicolaou test) and HPV testing, alone or in combination.⁴ However, HPV infection is not the only factor for the development of cervical cancer.⁵ Genetic and environmental factors are also associated with the development of cervical cancer.

APO-1/Fas (CD95/TNFRSF6) receptor is a type I transmembrane glycoprotein

ABSTRACT

Background: Cervical samples of patients with human papillomavirus (HPV) infections show positive results in HPV DNA testing. HPV infection can alter cervical squamous epithelial cells (CSECs) to be abnormal. Epigenetically, CSECs that change to be abnormal are affected by Fas-promoter-670 gene polymorphism. High-risk HPV (hr-HPV) patients can be infected by other microbes, for example, *Candida species* (*Candida sp.*). The present study's purpose was to show CSEC biometrics based on epigenetics of the Fas-promoter-670 gene polymorphism in Indonesian women with hr-HPV and *Candida sp.* infection. Biometric quantification was performed based on the following analysis of CSECs.

Case report: Indonesian hr-HPV women at the age of 28 years, with *Candida sp.* infection, underwent a Pap smear examination on April 21st, 2016, using the ThinPrep method, and a blood test was also performed using the cubital vein. Blood and ThinPrep samples were examined for the Fas-promoter-670 gene polymorphism. Epigenetically, the subjects had the GA genotype of the Fas-promoter-670 gene in the blood and ThinPrep samples. Patients with *Candida sp.* infection in the early stages were characterized by the appearance of polymorphonuclear leukocytes (PMN), whereas those in advanced stages presented without PMN on the hyphae. CSEC biometric measurements were performed quantitatively using mononuclear CSECs (mn-CSECs) and binucleated CSECs (bn-CSECs).

Conclusion: Biometric measurements of the CSECs were performed quantitatively and assessed the length, width, area and perimeter of the cell and its nuclei. Cell length, cell width, nucleus area, nucleus perimeter and nucleus length index were significantly different between the mn-CSECs, the 1st nucleus of bn-CSECs and 2nd nucleus of bn-CSECs ($P < 0.05$).

Keywords: Epigenetics, Fas promoter-670 gene, *Candida sp.*, cervical-squamous-epithelial-cells, cell biometrics.

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that belongs to the tumor necrosis factor (TNF) or neuronal growth factor receptor superfamily.⁶ The human Fas-promoter-670 gene has been mapped and is located at chromosome 10q24.1⁷ or 10.23.⁸ This gene consists of 9 exons and eight introns. Exon 1 comprises the 5'-untranslated region (UTR) and DNA sequence for the first ten amino acids. Exons 2-5 encode the extracellular region, while exon 6 encodes the transmembrane region. Exons 7 and 8 encode the 36 amino acids of the membrane-proximal cytoplasmic receptor. Exon 9 encodes the remaining 109 amino acids, including the 'death domain' and the 3'-UTR.⁶

The Fas-promoter-670 gene plays a central role in programmed cell death's physiological regulation (also termed apoptosis). Failure of this gene's regulation produces a death signal reported in several types of cancer.^{9,10} It has been reported that a single nucleotide polymorphism at site 670 in the Fas gene's enhancer region is associated with tumorigenesis.¹¹ A study has demonstrated an association between Fas-promoter-670 gene polymorphism and cervical cancer. A statistically significant correlation was identified between the susceptibility for cervical cancer and the GA and combined GA+GG genotypes in a study focused on an Indian population.¹² An association between Fas-promoter-670 gene polymorphism and HPV infection has also been shown in Japan's cervical cancer.¹³ Another study in Asia has also demonstrated a positive association between Fas-promoter-670 gene polymorphism and cervical cancer.¹⁴ Additionally, a previous study has reported a case of a high-risk Indonesian mother, whose Fas-promoter-670 gene in normal CSECs was mutated from AA to GA, whereas in the lymphocyte cells, the genotype was AA.¹⁵

A previous study has reported that the *Candida species* (*Candida sp.*) is of great concern due to its human hosts' infection, particularly patients with cancer.¹⁶ Invasive candidiasis is a serious infection that predominantly affects critically ill and immunocompromised patients. In general, *Candida albicans* is a species that is involved in this infection.¹⁷ Furthermore, it has been stated that cancer patients have a greater risk for serious infections, such as

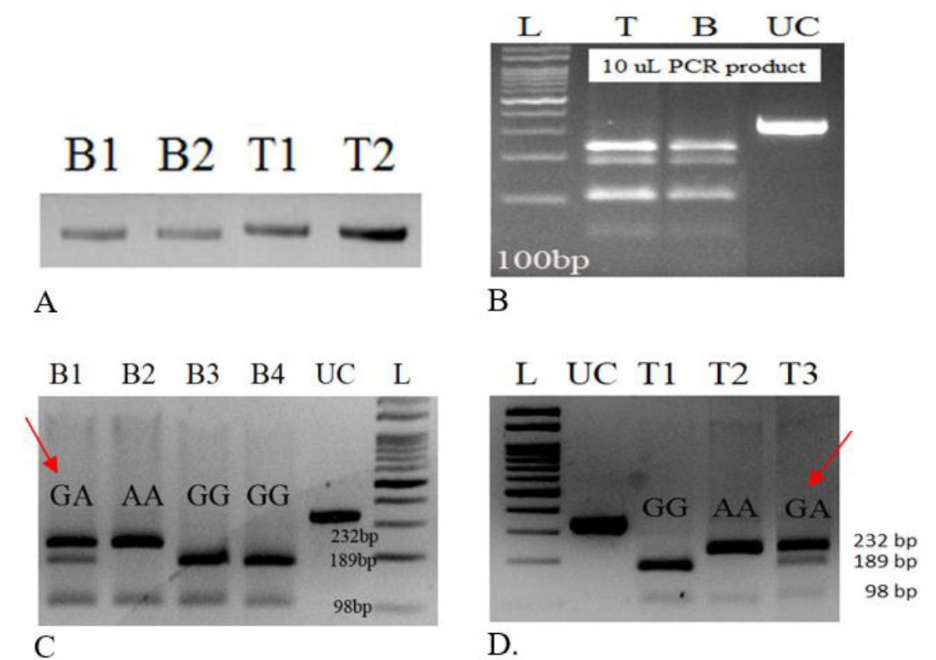


Figure 1. Detection of Fas-promoter-670 gene G/A polymorphism in blood and CSECs. (A) DNA extraction from blood and CSECs samples. (B). Optimization of restriction fragment length polymorphism from the ThinPrep Pap test of CSECs and blood samples with BstN1 enzyme. L, molecular weight marker; T, ThinPrep CSEC sample; B, blood sample; UC, running sample without BstN1 enzyme. (C) Genotyping of the Fas-promoter-670 gene from the blood sample. B1-B4, sample number; UC, running sample without BstN1 enzyme; L, molecular weight marker. The three possible genotypes were defined by three distinct patterns: AA (232, 98 bp), GA (232, 189, 98 bp), and GG (189, 98 bp). The subject, in this case, had the GA genotype of the Fas-promoter-670 gene (red arrow, B1 sample). (D) Genotyping of the Fas-promoter-670 gene from the ThinPrep CSEC sample. L, molecular weight marker; UC, running sample without BstN1 enzyme; T1-T3, sample number. The three possible genotypes were defined by three distinct patterns: AA(232, 98 bp), GA(232, 189, 98 bp), and GG (189, 98 bp). The subject, in this case, had the GA genotype of the Fas-promoter-670 gene (red arrow, T3 sample). CSEC, cervical squamous epithelial cell; PCR, polymerase chain reaction; bp, base pair.

Candida sp. Patients with candidemia have a serious problem due to high mortality, particularly if resistant *Candida spp.* cause it.¹⁸

Binucleation of CSECs in patients with *Candida sp.* infection has been reported. It has been stated that binucleation is a reactive cellular change in Pap smears due to *Candida* infection.¹⁹ A study result previously indicated an effect of HPV infection on the number of nuclei in CSECs. Following HPV infection, the appearance of CSECs on the ThinPrep Pap slide demonstrates a different number of nuclei, exhibiting ≥ 1 nucleus. In the

cells with >1 nucleus, if the nuclei pressed against each, they were defined as positive compression. The nuclei contacting but not pressing against each other were defined as negative compression.²⁰ It has been reported that positive compression of binucleated cells may be present due to hr-HPV infection, which is caused due to inflammation in intraepithelial lesions or malignancy cases infected with *Candida sp.*¹⁹ The present report evaluates CSEC biometrics' performance and its nuclei with a GA genotype of the Fas-promoter-670 gene in who has hr-HPV and *Candida sp.* infection.

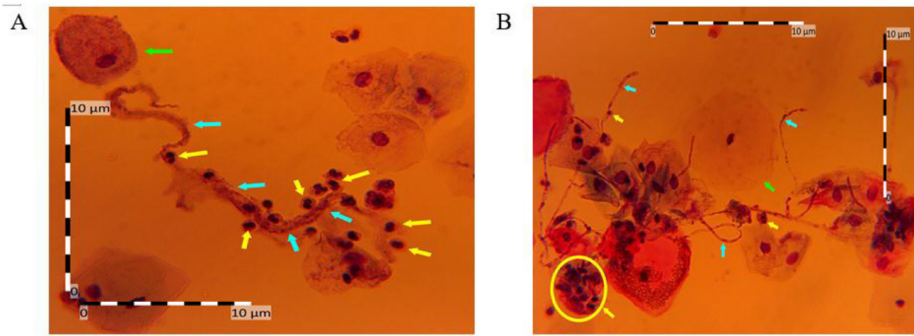


Figure 2. The appearance of CSEC and hyphae of *Candida sp.* in the subject with high-risk HPV and *Candida sp.* infection. (A) mn-CSEC (lime arrow) in the subject with high-risk HPV and *Candida sp.* infection in the early stage. The aqua arrow indicates hyphae and the yellow arrow indicates the polymorphonuclear leukocyte. Magnification, 400x. (B) mn-CSEC (lime arrow) in the subject with high-risk HPV and *Candida sp.* infection in the advanced stage. The aqua arrow indicates hyphae and the yellow arrow indicates a spore. Magnification 400x. mn-CSEC, mononucleated cervical squamous epithelial cell; CSEC, cervical squamous epithelial cell.

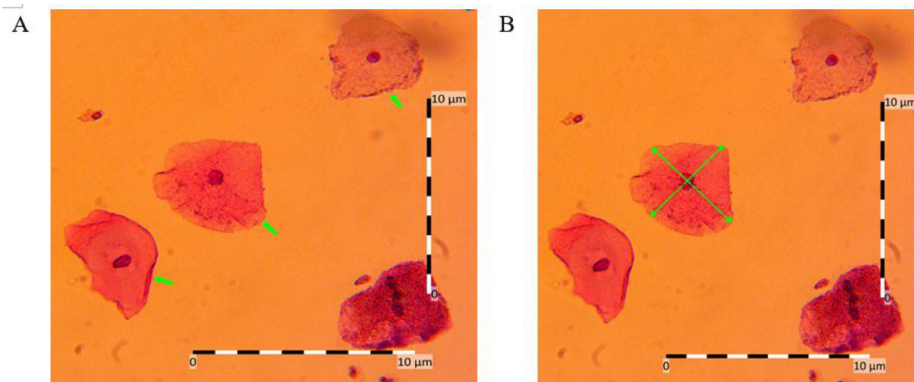


Figure 3. The appearance of mn-CSECs in the subject with high-risk HPV and *Candida sp.* infection. (A) The appearance of mn-CSECs available for measurement (lime arrow). Magnification, 400x. (B) Cell length and cell width measurements result of mn-CSECs. Magnification 400x. mn-CSEC, mononucleated cervical squamous epithelial cell.

CASE REPORT

A 28-year-old Indonesian woman living with hr-HPV and *Candida sp.* infection on April 21st, 2016, underwent a Pap smear examination and a blood test. Before participating in this study, the participant provided informed consent. Ethical approval for the study was obtained from the “Komisi Etik Riset Fakultas Kedokteran, Universitas Trisakti, Indonesia” (approval no. 60/KER/FK/05/2013). Informed written consent was obtained from participants before data collection. The subject concerned was included in

the community of Indonesian women living with hr-HPV based on laboratory examinations. In this case, the subject first has coitus at the age of 16 years, had free sex, and never received HPV vaccination.

Blood samples (~10 µl) were taken from a cubital vein and inserted into an ethylene diamine tetraacetate (EDTA) tube. The Pap smear examination was performed according to the ThinPrep method to collect cytological material. Whole blood in the EDTA tube and cytological material in the ThinPrep solution was analyzed for Fas-promoter-670 gene polymorphisms by restriction fragment

length polymorphism (RFLP) *Bacillus stearothermophilus* N1 (BstN1) enzyme. DNA extraction from the blood and ThinPrep samples was performed using chloroform. In addition, the forward primer, 5’CTACCTAAGAGCTA TCTACCGTTC3’ and reverse primer, 5’GGCTGTCCATGTTGTGGCTGC3’ were used. Epigenetically, the subject, in this case, had the GA genotype of the Fas-promoter-670 gene both in the blood and ThinPrep samples (Figure 1).

In addition to analyzing the Fas-promoter-670 gene polymorphism, cytological material in the ThinPrep solution was also analyzed cytologically. ThinPrep 2000 was used to create slides automatically based on liquid-based cervical cytology. Three observers used Optilab Advance Plus and Image Raster 3 programs (PT MICONOS, Daerah Istimewa Yogyakarta, Indonesia (<https://miconos.ac.id/new/support/download>)). The presence of *Candida sp.* was based on the observation of hyphae under the microscope. *Candida sp.* infection can be divided into two stages, termed the early and advanced stages. *Candida sp.* infection in the early stage is characterized by polymorphonuclear leukocytes (PMNs), whereas at the advanced stage, no PMNs are observed on the hyphae of *Candida sp.* The spores of *Candida sp.* were observed qualitatively (Figure 2).

The biometric measurements of CSECs were performed quantitatively, focusing on the length, width, area and perimeter of the cell and its nuclei. Optilab plus and Image Raster 3 programs were used to analyze the biometric measurements by three observers. The measurements of the mononucleated-CSECs (mn-CSECs) (Figure 3) and binucleated-CSECs (bn-CSECs) (Figure 4) were as follows: Cell length (CL), cell width (CW), cell area (CA), cell perimeter (CP), nucleus length (NL), nucleus width (NW), nucleus area (NA), nucleus perimeter (NP), nucleus length index (NLI), nucleus width index (NWI), nucleus area index (NAI) and nucleus perimeter index (NPI). Based on the results of biometric measurements, CSECs in these cases were divided into three groups: i) mn-CSEC; 1st nucleus of bn-CSEC (1st-bn-CSEC); and iii) 2nd nucleus of bn-C2SEC (2nd-bn-CSEC),

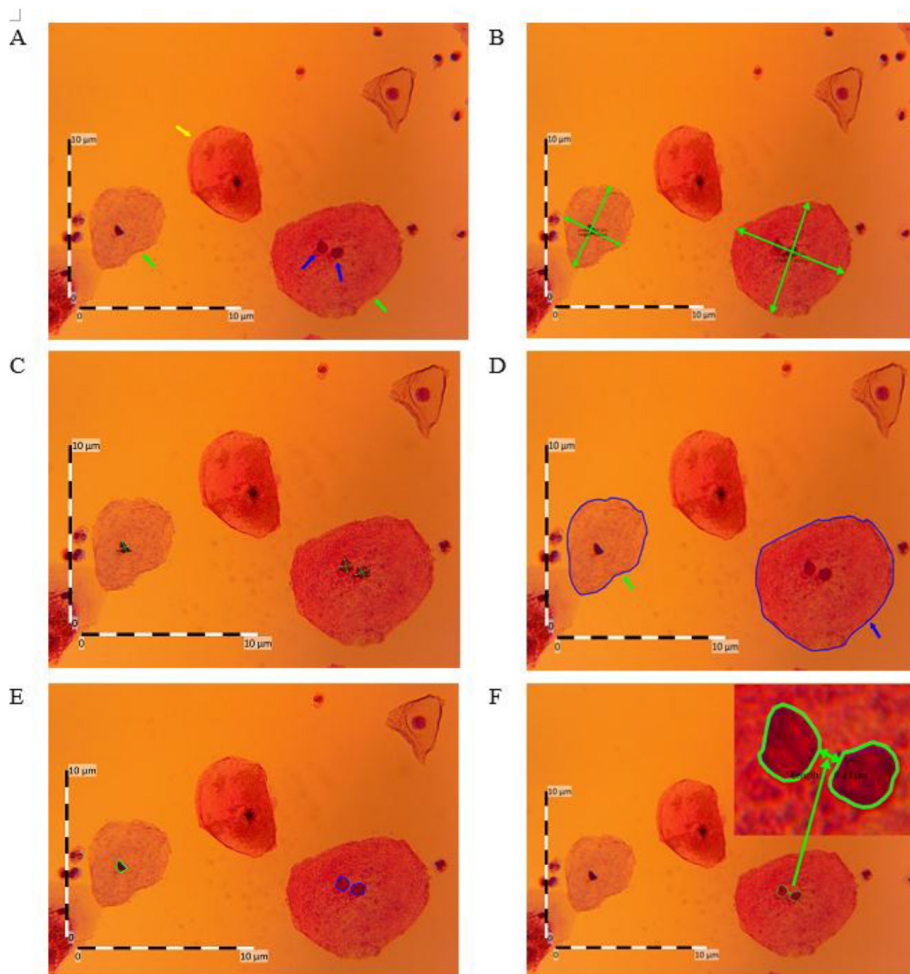


Figure 4. Comparison between mn-CSECs and bn-CSECs in the subject with high-risk HPV and *Candida sp.* infection. (A) The appearance of mn-CSECs available for measurement (lime arrow) compared with mn-CSECs not available for measurement (yellow arrow) and bn-CSECs available for measurement (blue arrow). Magnification, 400x. (B) Comparison of cell length and cell width between mn-CSECs and bn-CSECs. Magnification 400x. (C) Comparison of nucleus length and nucleus width between mn-CSECs and bn-CSECs. Magnification, 400x. (D) Cell area and cell perimeter of mn-CSECs (lime arrow) and bn-CSECs (blue arrow). Magnification 400x. (E) Nucleus area and nucleus perimeter of mn-CSECs (lime polygon) and bn-CSECs (blue polygon). Magnification 400x. (F) Compression of bn-CSECs demonstrated that nuclei are not pressing against each other. Magnification 400x. mn-CSEC, mononucleated cervical squamous epithelial cell; bn-CSEC, binucleated cervical squamous epithelial cell.

which are presented in Table 1. The CL, CW, NA, NP and NLI were not significantly different between the mn-CSECs, 1st-bn-CSECs and 2nd-bn-CSECs ($P>0.05$); however, CA, CP, NL, NW, NAI, NPI and NWI were significantly different ($P<0.05$). Multiple comparisons between the mn-CSECs, 1st-bn-CSECs and 2nd-bn-CSECs are presented in Table 2. The CA

and CP in mn-CSECs, 1st-bn-CSECs and 2nd-bn-CSECs were significantly different ($P<0.05$); however, 1st-bn-CSECs was not significantly different compared with 2nd-bn-CSECs ($P>0.05$). The NL and NW of mn-CSECs were significantly different compared with those of the 1st-bn-CSECs, as well as for 1st-bn-CSECs compared with 2nd-bn-CSECs ($P<0.05$), while mn-CSECs

were not significantly different compared with 2nd-bn-CSECs ($P>0.05$). The NAI and NPI were significantly different between the mn-CSECs and 1st-bn-CSECs or 2nd-bn-CSECs ($P<0.05$); however, they were not significantly different for the 1st-bn-CSECs compared with the 2nd-bn-CSECs ($P>0.05$). The NWI of mn-CSECs was significantly different from that of the 1st-bn-CSECs, and the NWI of 1st-bn-CSECs was significantly different compared with that of the 2nd-bn-CSECs ($P<0.05$). Simultaneously, mn-CSECs did not significantly differ compared with 2nd-bn-CSECs in terms of NWI ($P>0.05$).

DISCUSSION

DNA extraction from CSECs and leukocytes is useful for the genotyping of the Fas-promoter-670 gene and electrophoresis optimization. Genotyping of the Fas-promoter-670 gene in CSECs and leukocytes reveals that both have a GA genotype. To evaluate the exposure of HPV infection on the Fas-promoter-670 gene in CSECs, genotyping is necessary for both CSECs and leukocytes. The genotyping result of the Fas-promoter-670 gene in both CSECs and leukocytes of the present case demonstrated the same result, suggesting that the Fas-promoter-670 gene in CSECs does not mutate due to HPV infection. That is in contrast to a previous case in which the Fas-promoter-670 gene in the CSECs had a GA genotype, whereas had an AA genotype in the leukocytes. Therefore the Fas-promoter-670 gene in CSECs had mutated.¹⁵ This demonstrates that the Fas-promoter-670 gene in CSECs mutates due to the effect of HPV infection (local infection). We know that HPV infection is a local infection that is in the cervix.

The previous study results indicated that persistent HPV infection is necessary for the development of cervical cancer. Furthermore, it stated that genetic and epigenetic alterations in host cell genes are crucial for preventing cervical precancerous lesions to invasive cancer.²¹ A recent study has reported that samples collected from patients with cervical cancer tested positive for HPV DNA.²² Additionally, a study in Western Kenya also demonstrated associations between vaginal infections and potentially high

Table 1. Comparison of cell biometric and its nuclei between mn-CSEC and bn-CSEC in Indonesian women living with high-risk HPV and *Candida sp.* infection

Variable	mn-CSEC mean ± SD (n cell=27)	1 st nucleus of bn-CSEC mean ± SD (n cell=6)	2 nd nucleus of mn-CSEC mean ± SD (n cell=6)	P value
CL (µm)	5.44±0.31	5.72±0.61	5.73±0.26	0.900
CW (µm)	4.49±0.29	4.47±0.28	4.76±0.13	0.930
CA (µm ²)	20.45±1.23	25.45±2.78	25.61±0.71	0.000
CP (µm)	16.67±1.09	18.64±1.72	19.30±0.96	0.000
NA (µm ²)	0.47±0.05	0.45±0.04	0.45±0.03	0.403
NP (µm)	2.50±0.26	2.44±0.29	2.46±0.10	0.835
NL (µm)	0.83±0.08	0.76±0.09	0.89±0.05	0.034
NW(µm)	0.63±0.06	0.72±0.05	0.62±0.09	0.014
NAI	2.31±0.24	1.79±0.14	1.74±0.11	0.000
NPI	15.05±1.78	13.11±1.28	12.77±1.03	0.003
NLI	15.36±1.83	13.50±2.26	15.59±1.08	0.074
NWI	14.20±1.68	16.17±2.12	12.98±1.92	0.012

Abbreviations: mn-CSEC, mononucleated cervical-squamous-epithelial-cell; bn-CSEC, binucleated cervical-squamous-epithelial-cell; 1th nucleus of bn-CSEC, first nucleus of binucleated-cervical squamous epithelial cell; 2nd nucleus of bn-CSEC, second nucleus of binucleated cervical-squamous-epithelial-cell; SD, standard of deviation; n, sample size; p, significant level; CL, cell length (the longest cell diagonal that passes through the nucleus); CW, cell width (cell diagonal perpendicular to the diagonal of CL); CA, cell area; CP, cell perimeter; NA, nucleus area; NP, nucleus perimeter; NL, nucleus length (the longest cell nucleus diagonal); NW, nucleus width (cell nucleus diagonal perpendicular to the diagonal of NL); NAI, nucleus area index (nucleus area:cell area)x100; NPI, nucleus perimeter index (nucleus perimeter:cell perimeter)x100; NLI, nucleus length index (nucleus length:cell length)x100; NWI, nucleus width index (nucleus width:cell width)x100; µm, milli-micron; µm², milli-micron square.

risk and hr-HPV genotypes. In detail, of the free sex workers analyzed, 33.3% had HIV, and 57.7% harbored a potential hr-HPV and hr-HPV genotype.²³ Based on numerous studies worldwide, the epidemiology of HPV infection and the oncogenic properties of HPV type are different from HPV genotypes. However, there are still many countries where population-based prevalence has not yet been identified. Furthermore, cervical cancer screening strategies are different between countries.²⁴

The results presented in the present case report are consistent with the results of recent research in Indonesia, which shows that HPV vaccination is not yet a priority for adolescents. This result is due to a lack of education and the cost of HPV vaccination. Therefore a program is required to provide accurate information regarding HPV vaccination to the public, particularly teenagers.²⁵

This case is consistent with studies of the Japanese population, which demonstrated that a GG genotype is associated with an increased risk for cervical cancer development, with an odd ratio (OR) of 2.56 compared to the AA genotype. Furthermore, the G allele in the GA or GG

genotype also increased the risk of cervical cancer, with an OR of 1.60.²⁶ Other studies investigating females in Northern India demonstrated that a GA genotype and a combination of GA and GG genotype significantly increased the risk of cervical cancer compared with an AA genotype.¹² Also, a study of Brazilian females <48 years old also reported that a GA genotype increases the risk of cervical cancer 5-fold compared with an AA genotype.²⁷

Research of a Greek population demonstrated no significant association between EVER1/2 polymorphisms (rs2290907 and rs16970849) and cervical cancer. However, the study provided additional data that suggested no association between the FAS polymorphism (rs1800682) and the susceptibility to persistent precancerous lesions and cervical cancer. Current literature for EVER1/2 polymorphisms and cervical cancer is very limited worldwide. Therefore, prospective studies are needed to clarify this point further.²⁸

Candida sp., the most common *Candida albicans*, plays an important role in the vaginal and vulvar epithelium's secondary infections. *Candida sp.* is part of the normal flora in women and is

often asymptomatic.²⁹ In a study based in Brazil, which investigated 633 pregnant women, 158 specimens (24.1%) exhibited pathogenic infections, while 22.9% were infected with *Candida spp.*³⁰ A subsequent study in Brazil demonstrated that of the 263 patients analyzed, *Candida spp.* was isolated in 27%, and >60% of the isolates were identified as *Candida albicans*. Also, *Candida non-albicans* were isolated at 8.6% in symptomatic patients and 14.3% in asymptomatic patients.³¹ Another study in Ethiopia reported a high prevalence rate of vulvovaginal candidiasis and *Candida non-albicans*. Therefore it is important to conduct continuous epidemiological surveys to measure species distribution changes from *C. albicans* to *Candida non-albicans*.³² A study in West Kenya demonstrated that bacterial vaginosis was the most common infection (48.3%), followed by *Trichomonas vaginalis* (31.4%) and *Candida spp.* (19.9%). Significant associations between bacterial vaginosis and HPV 58 and between *Candida spp.* and HPV 16 and HPV 53 suggest the need for sexually transmitted disease management in a cervical cancer prevention program.²³

The appearance of PMN on hyphae of *Candida sp.* in the early stage indicates an

Table 2. Multiple comparisons between mn-CSEC, 1stn-bn-CSEC and 2ndn-bn-CSEC in Indonesian women living with high-risk HPV and *Candida sp.* infection

Variable	Group	p-value
CA (μm^2)	mn-CSEC - 1 st n-bn-CSEC	0.000
	mn-CSEC - 2 nd n-bn-CSEC	0.000
	1 st n-bn-CSEC - 2 nd n-bn-CSEC	0.848
CP (μm)	mn-CSEC - 1 st n-bn-CSEC	0.001
	mn-CSEC - 2 nd n-bn-CSEC	0.000
	1 st n-bn-CSEC - 2 nd n-bn-CSEC	0.336
NL(μm)	mn-CSEC - 1 st n-bn-CSEC	0.069
	mn-CSEC - 2 nd n-bn-CSEC	0.115
	1 st n-bn-CSEC - 2 nd n-bn-CSEC	0.010
NW(μm)	mn-CSEC - 1 st n-bn-CSEC	0.007
	mn-CSEC - 2 nd n-bn-CSEC	0.527
	1 st n-bn-CSEC - 2 nd n-bn-CSEC	0.009
NAI	mn-CSEC - 1 st n-bn-CSEC	0.000
	mn-CSEC - 2 nd n-bn-CSEC	0.000
	1 st n-bn-CSEC - 2 nd n-bn-CSEC	0.714
NPI	mn-CSEC - 1 st n-bn-CSEC	0.012
	mn-CSEC - 2 nd n-bn-CSEC	0.004
	1 st n-bn-CSEC - 2 nd n-bn-CSEC	0.724
NWI	mn-CSEC - 1 st n-bn-CSEC	0.019
	mn-CSEC - 2 nd n-bn-CSEC	0.141
	1 st n-bn-CSEC - 2 nd n-bn-CSEC	0.004

Abbreviations: mn-CSEC, mononucleated cervical-squamous-epithelial-cell; 1st n-bn-CSEC, first nucleus of binucleated cervical-squamous-epithelial-cell; 2nd n-bn-CSEC, second nucleus of binucleated cervical-squamous-epithelial-cell; p, significant level; CL, cell length (the longest cell diagonal that passes through the nucleus); CW, cell width (cell diagonal perpendicular to the diagonal of CL); CA, Cell area; CP, Cell perimeter; NA, nucleus area; NP, nucleus perimeter; NL, Nucleus length (the longest cell nucleus diagonal); NW, nucleus width (cell nucleus diagonal perpendicular to the diagonal of NL); NAI, nucleus area index (nucleus area:cell area)x100; NPI, nucleus perimeter index (nucleus perimeter:cell perimeter)x100; NLI, nucleus length index (nucleus length:cell length)x100; NWI, nucleus width index (nucleus width:cell width)x100; μm , milli-micron; μm^2 , milli-micron square.

infection and allergic reaction. By contrast, in the advanced stage of the infection, *Candida sp.*'s hyphae do not present with PMN. It has also been reported that *Candida sp.* infection produces a peptide toxin called candidalysin. The peptide toxin is produced by hyphae of *Candida albicans* and is characteristic of fungal pathogenesis. Besides, candidalysin is important for *C. albicans* mucosal infections. Candidalysin is known to activate epithelial cells to induce downstream innate immune responses associated with protection during vaginal infections. It has been reported that candidalysin plays an important role in stimulating a strong pro-inflammatory response by neutrophil recruitment. Conversely, if candidalysin is not present, the inflammatory response decreases due to a lack of neutrophil recruitment.³³

Previous studies have shown that *Candida sp.* infects humans, particularly patients with cancer. The present study demonstrated that of the 68 blood samples, 5 (7.35%) were positive for the presence of *Candida spp.*, 2 (40%) identified to be positive for *Candida albicans*, and 3 (60%) were contained *Candida non-albicans*.¹⁶ The results of another study demonstrated that 8.7% of 150 samples were infected with *Candida sp.*³⁴

A recent study reported that ThinPrep cervical cytology samples could be used in cervical cancer screening. There have also been reports of Indonesian mothers with hr-HPV and the Fas-promoter-670 gene in CSECs, mutated from AA to GA, and had normal CSEC characteristics.¹⁵ Based on mn-CSEC and bn-CSEC's appearance, mn-CSEC characteristics, in this case, were normal, while bn-CSECs were

abnormal. This result is consistent with the fact that the abnormality of bn-CSECs is due to cytokinesis failure. Furthermore, cytokinesis failure has the potential for proliferation.³⁵ Based on the results of biometric cell measurements (Tables I and II), there was a change in the size and shape of CSECs. The CA, CP, NL, NW, NAI, NPI, NWI measurements between mn-CSECs, 1st-bn-CSECs and 2nd-bn-CSECs were significantly different ($P < 0.05$); however, CL, CW, NA, NP and NLI were not significantly different ($P > 0.05$). The present results and recent studies suggest that the growth rate of precancerous cells is significantly faster compared with normal cervical cells. However, the proliferation capacity of precancerous cells is similar to cervical cancer cells at the molecular level.³⁶

In the Pap smear method, the determination of CSEC characteristics can be used to reference cervical cancer diagnosis. A light microscope and Image Raster 3 are used to analyze CSEC morphology and assess the cell's measurements and its nuclei. Most hospitals in Indonesia have facilities, such as the light microscope. The Image Raster 3 program is easy to obtain. This method may be simplest; however, cervical cancer can also be detected using a more sophisticated tool. The present study, which focused epigenetically on the Fas-promoter-670 gene and two contrasting pathogens, HPV and *Candida sp.*, may improve early screening methods of cervical cancer. Furthermore, the principles of CSEC measurements in this study can be used to develop cervical cytopathology examinations based on 'biometric artificial intelligence'.

CONCLUSION

Biometric measurements of the CSECs were performed quantitatively and assessed the length, width, area and perimeter of the cell and its nuclei. In the case investigated, cell length, cell width, nucleus area, nucleus perimeter and nucleus length index were significantly different between the mn-CSECs, the 1st nucleus of bn-CSECs and 2nd nucleus of bn-CSECs ($P < 0.05$).

DISCLOSURE

Acknowledgments

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Availability Of Data And Materials

The datasets generated and analyzed in the present study are included in this published article.

Authors' Contributions

Mauritius Lambertus Edy Parwanto, Raditya Wratsangka, Assangga Guyansyah and Reza Aditya Digambiro designed the study, collected the samples, carried out the ThinPrep, genetic and cell imaging analysis, participated in the collecting and interpretation of data, wrote the manuscript, and gave the final approval of the version to be published. David Tjahyadi, Hanslavina Arkeman, Kirana Anggraeni, Haryo Ganeca Widyatama, Hosea Jaya Edy and Yosua Jaya Edy carry out the collected and analyzed the data, performed the literature review and wrote the manuscript. All authors read and approved the final manuscript.

Ethics Approval And Consent To Participate

The authors declare that they have obtained written informed consent to publish the details relating to the patient in this report. All possible steps have been taken to safeguard the identity of the patient. This study has ethical clearance by the 'Komisi Etik Riset Fakultas Kedokteran, Universitas Trisakti, Indonesia'.

Patient Consent For Publication

Not applicable.

Competing Interests

The authors declare that they have no competing interests.

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