Microsporidia: a new sexually transmissible cause of urethritis

Microsporidia are worldwide ubiquitous intra-cellular protozoan parasites, which have recently emerged as a significant cause of morbidity in immunocompromised patients, particularly in those with AIDS.1 Multiorgan microsporidiosis is well described in these individuals, which underscores the severity of immunodeficiency in patients with microsporidial infection.2,3 In 15–30% of patients with advanced AIDS, Encephalitozoon bieneusi is the causative agent of major chronic diarrhoea.4 Many such patients have shown dramatic responses when treated with albendazole.4

The first case of urethritis associated with microsporidiosis has recently been reported in a 36 year old AIDS patient with urethritis, sinusitis and diarrhoea.5 Encephalitozoon-like spores were isolated in a smear of expressed urethral pus. Microsporidial spores were also isolated from faeces, nasal discharge, sputum and centrifuged urinary deposit. We now report a similar case of microsporidiosis in a 35 year old homosexual patient with AIDS, who presented with sinusitis, urethritis and diarrhoea.

Our patient had multiple episodes of gross urethritis with a profuse brown urethral discharge, which was only partially responsive to antibiotics. His urethritis persisted despite courses of doxycycline, erythromycin, azithromycin, rifampicin and ciprofloxacin. Clindamycin, chloramphenicol and metronidazole produced some improvement, but had to be stopped owing to the development of drug related rashes.

Our patient initially presented with urethritis at the same time as hispartner had diarrhoea due to intestinal microsporidiosis. We believe he was persistently infected, or reinfected, by his partner during regular unprotected sexual intercourse. Four months later our patient developed diarrhoea and microsporidium was detected in his stool. He received a four week course of albendazole 400 mg bd. It was this course of therapy that finally cleared his symptoms of urethritis. It is likely that the urethritis responded to the albendazole, which is known to treat successfully microsporidal infections.6,7 However, it was at this time that his partner died, so it is possible that his lack of relapse was partially due to the fact that he was no longer being sexually exposed to microsporidia. Our patient died from multiple opportunistic infections three months later, but the urethritis never recurred.

We suggest that microsporidia represents an unlooked for cause of sexually transmissible urethritis. Microsporidia should be looked for actively in all non-responsive cases of urethritis in the immunocompromised. A study to this effect is currently underway.

KARL BIRTHistle
PHILIPPA MOORE
Department of Medical Microbiology,
Tooting Public Health Laboratory,
PHILIP HAY
Department of Genito-urinary Medicine,
St George’s Hospital Medical School,
London, SW17 OQT, UK

Correspondence to: Dr K Birthistle


Accepted for publication 3 October 1996

Vertical transmission of human papillomavirus in cytologically normal women

The sexual transmission of genital type human papillomavirus (HPVs) has been recognised since 1971, but clinical, epidemiological and laboratory evidence suggests that other ways of transmission can be important especially in children.2 In our department we conducted a polymerase chain reaction (PCR) based study with the following aims: (1) to evaluate the prevalence of HPV DNA in vaginal swabs of pregnant women clinically and cytologically free from HPV; (2) to evaluate the prevalence of HPV DNA in nasopharyngeal aspirate of newborns and the frequency of perinatal transmission of HPV; (3) to evaluate the reliability of a single-point PCR test to predict the risk of perinatal transmission in clinical practice. For this purpose vaginal swabs were obtained from 124 pregnant women during the last three months of pregnancy and nasopharyngeal aspirates were collected, immediately after vaginal delivery, from 109 neonates born in the same hospital. All samples were coded and processed without knowing the presence and/or identity of mother/baby pairs. For HPV identification and identification the protocol described by Bauer et al was used.3 Briefly, HPV DNA was amplified with consensus primers MY09-MY11 and the presence of amplified DNA was checked by Southern blot hybridisation with a generic and type specific probes for HPV 6, 11, 16, 18, 31 and 33.3 Hybridisation analysis of the PCR products with the generic probe was positive in 15/124 (12%) vaginal swabs and 10/109 (9%) nasopharyngeal aspirates. HPV typing of vaginal swab amplificates disclosed HPV6/11 in two cases, HPV16/18 in one, HPV31/33 in two and was negative in the remaining ten cases (unidentified HPV) (table). HPV typing of nasopharyngeal aspirates amplificates disclosed HPV6/11 in two cases, HPV16/18 in one case and HPV31/33 in one case. The other 6 samples positive with the generic probe were negative with the type specific probes (unidentified HPV) (table). On opening the code, we found 47 mother-baby pairs. Among this subgroup, HPV DNA was
HPV identification in vaginal swabs and nasopharyngeal aspirates

<table>
<thead>
<tr>
<th></th>
<th>HPV positive</th>
<th>HPV 6/11</th>
<th>HPV 16/18</th>
<th>HPV 31/33</th>
<th>Unidentified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal swabs</td>
<td>15/124</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>(12.1%)</td>
<td></td>
<td></td>
<td></td>
<td>(66-6%)</td>
</tr>
<tr>
<td>Nasopharyngeal</td>
<td>10/109</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>aspirates</td>
<td>(9-1%)</td>
<td></td>
<td></td>
<td></td>
<td>(60%)</td>
</tr>
</tbody>
</table>

Correspondence to: Prof Michele Fimiani, Department of Dermatology of Siena University, Policlinico Le Scotte, Viale Bracci, 53100 Siena, Italy.


5 Schiffman MH. Epidemiology of cervical human papillo-


7 Center for Disease Control. 1989 sexually transmitted dis-


Accepted for publication 7 August 1996.

Cytomegalovirus retinitis in a healthy antiretroviral naive HIV positive male with a CD4 count of 277/mm³

Cytomegalovirus (CMV) retinitis is a common sight threatening complication of late HIV disease, occurring rarely with CD4 lymphocyte counts above 100/mm³ and most frequently when the CD4+ lymphocyte count falls below 50/mm³. Four cases of CMV retinitis occurring in HIV patients with CD4 counts greater than 200/mm³ have been described. In three of these cases, the CD4 counts were 255/mm³ and 235/mm³ and 355/mm³ at the time of CMV diagnosis. However, these patients were receiving zidovudine antiretroviral therapy which may complicate interpretation of CD4 counts. As demonstrated by Concorde, zidovudine may sustain CD4 counts without translating into clinical benefit. Although the reason for this is unclear, one suggestion was that zidovudine may alter the proportion of poorly functioning CD4 cells in the peripheral blood. In the fourth case, the patient had a CD4 count of 366/mm³ and although he had not previously had antiretroviral therapy, his CD4 count and immune function may have been altered by a previous splenectomy.

We report a case of CMV retinitis occurring in a 42 year old HIV seropositive homosexual man, who was antiretroviral naive, in good health with no prior AIDS defining diagnosis and no other immunocompromising condition. He presented with a history of “floaters” preceding the development of a shadow in the vision of his right eye. He had a relatively stable
Vertical transmission of human papillomavirus in cytologically normal women.

C Mazzatenta, M Fimiani, P Rubegni, L Andreassi, P Buffi and C Messina

Genitourin Med 1996 72: 445-446
doi: 10.1136/sti.72.6.445-a

Updated information and services can be found at:
http://sti.bmj.com/content/72/6/445.2.citation

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/