HIV tests in young adolescents attending a GUM clinic

A pretest counselling session is recommended by the General Medical Council before carrying out an HIV test and it is generally accepted that adolescents deemed competent enough to understand the counselling process can have an HIV test without parental consent. A recent survey in the United Kingdom showed that 79% of clinics were prepared to test for HIV infection in children under the age of 16. We reviewed the characteristics of adolescents between the ages of 13 and 16 seen in the Coventry genitourinary medicine (GUM) clinic for an HIV test between 1990 and 2000 (table 1). This was part of a larger review of GUM attendances by children, the results of which have been published.1 The commonest mode of presentation was a specific request for an HIV test. This was the case in 32 (39.0%) adolescents. Eighteen adolescents (22.0%) coming in requesting a check for HIV infection was diagnosed in five cases, gonorrhoea in two cases, and there was one case each of genital herpes, Trichomonas vaginalis, and genital wart infection. Having a sexually transmitted infection was also more likely to accept it following counselling than those who did not (96.9% versus 78.0%, p = 0.02). Acceptance of HIV test was, however, unrelated to the sex of child, prostitution, more than one partner in the previous year, or being diagnosed with a sexually transmitted infection. There was no statistically significant difference between those claiming rape/assault and those who were not in having an HIV test after counselling (95.7% versus 94.6%, p = 0.16). There is no specific literature regarding the factors associated with HIV testing in young adolescents. A study of sexually active 16–19 year olds in Massachusetts found that infrequent condom use and a history of sexually transmitted disease were not significantly associated with voluntary HIV testing.2 Having had more than one sexual partner in the past year and discussing HIV/AIDS with a doctor were however associated with voluntary HIV testing.3

It has been shown that most adolescents engaging in high or moderate HIV risk behaviour continued to do so into young adulthood. Knowledge about HIV infection and its prevention, estimates of personal risk or exposure to HIV may have been associated with a change in behaviour.4 Effort must therefore be directed at research into adolescent risk behaviour change.

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Table 1 Demographics

<table>
<thead>
<tr>
<th>Total number</th>
<th>82</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>70 (85.4%)</td>
</tr>
<tr>
<td>Accepting to have HIV test</td>
<td>70 (85.4%)</td>
</tr>
<tr>
<td>Median age</td>
<td>15</td>
</tr>
<tr>
<td>Virgins</td>
<td>8 (9.8%)</td>
</tr>
<tr>
<td>Prostitutes</td>
<td>3 (3.7%)</td>
</tr>
<tr>
<td>Injecting drug users</td>
<td>3 (3.7%)</td>
</tr>
<tr>
<td>Positive for HIV antibodies</td>
<td>0</td>
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</tbody>
</table>

References


Sexual and reproductive health among female adolescents: preliminary results

The recognition of adolescence as an essential formative stage of life has implications for programmes, content and approaches. Young people have to be treated as people in their own right, and their individual needs considered on a case to case basis. The realisation that this is a time of significant opportunity and risk highlights the urgency to deal directly with sensitive topics such as sex and drugs.5

The aim of this study was to identify demographic, behavioural and clinical factors for STI and unplanned pregnancy among female adolescents assisted by the family health programme (PSF) of Vitoria Municipality in Brazil. A cross-sectional study was performed among female adolescents (15–19 years old) assisted by the PSF. Participants were screened for Chlamydia trachomatis and Neisseria gonorrhoeae using ligase chain reaction (LCR) applied to urine and answered a face to face questionnaire. Standard descriptive statistical analysis was performed. Prevalence rates were calculated to reflect the relative frequency of each disease with corresponding 95% confidence intervals (CI). The national school of public health (FIOCRUZ) ethics committee approved this study. Written informed consent was obtained by all participants and their parents. The study included 149 adolescents. Mean age was 17.2 (SD 1.5) years; mean education was 8.3 (SD 2.9) years of schooling, and the mean age of the first sexual intercourse was 15.4 (SD 1.6) years. Seventy-four per cent of adolescents had already sexual intercourse. Among those the prevalence rate of CT was 11.4% (95% CI 7.6 to 14.0). 4.0% (95% CI 2.1 to 5.2) of GC. Behaviour and clinical data are reported in table 1. There was statistical significance between chlamydia infection and previous STI (OR = 20.1, 95% CI: 5.9 to 67.9); gonorrhoea and no condom use (OR = 1.2, 95% CI: 1.06 to 1.12); and gonorrhoea and alcohol abuse (OR = 1.3, 95% CI: 1.1 to 2.1). Clinical problems identified were genital ulcer 6.0%, dysuria 15.4%, inguinal lymphadenopathy 12.1%, vaginal bleeding 3.4%, and polyuria 2.1%

STIs deserve attention not only because of their high prevalence but also because they frequently go undetected and untreated, and often result in serious sequelae and association with HIV infection.6 High prevalence rates associated with high frequency of risk were observed in this ongoing study. These two factors identify female adolescents as an important group to target with STI including HIV prevention efforts.

These data are descriptive and need to be completed but they are in agreement with the last research about Brazilian sexuality. It was reported that adolescents have their first intercourse earlier than the older generation and the knowledge about STI/AIDS does not modify the exposition.7 Eighteen per cent of adolescents in Brazil become pregnant at least once and 54.1% among the married ones use some method of contraception.8 The preliminary results suggest that humane, healthcare based, STI/HIV prevention services in the health family programme can be an acceptable intervention, as well as one that is highly targeted epidemiologically. Screening, treatment and prevention counselling, and support in communities should be considered.
and evaluated as a core component of STI/HIV prevention efforts in many or most places where STIs are public health problems.

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LETTERS

Factors affecting co-infection with genital chlamydia and genital gonorrhoea in an urban genitourinary medicine clinic

Co-treatment for chlamydia is common practice when gonorrhoea is diagnosed in a UK genitourinary medicine setting. In Glasgow, the incidence of gonorrhoea across the city has tripled from 1995 to 2000.1 Given this rise, we investigated whether our practice of co-treatment was of continued benefit. We examined all patients presenting to the Glasgow Royal Infirmary Genitourinary Medicine (GUM) Service (including the Steve Retson Project service for gay men) between 1 April 1997 and 30 September 2000 who had genital gonorrhoea diagnosed on routine culture. We diagnosed genital chlamydia co-infection by ligase chain reaction (LCR) on first pass urine (for men) or endocervical swab (for women). We diagnosed gonorrhoea in 351 attenders (287 men, 64 women), of whom 86 (25%; 95% CI 20% to 29%) were co-infected. Co-infection was significantly more common in women than men (29/64 (48%) vs 26/287 (10%; p = 0.02). Homosexual or bisexual men were significantly less likely to be co-infected than heterosexual men (15/134 (11.0%) vs 42/153 (28%); p = 0.001). Co-infection became less common with increasing age (15–19 years 43%; 20–24 years 34%; >24 years 18%; χ² for trend = 15.4, p <0.0001) (see table w1 on STI website). Logistic regression modelling showed young age and female sex to be independent predictors of co-infection, while homo/bisexuality was protective (see table w2 on STI website).

We recommend continuing co-treatment for chlamydia in all women and heterosexual men presenting with gonorrhoea in our setting. However, in common with other recent findings2 co-infection with genital chlamydia is uncommon in male homosexual or bisexual attenders with genital gonorrhoea, and co-treatment may not be necessary in this group.

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Erythema nodosum induced by chancroid

Erythema nodosum is a type of panniculitis which is often regarded as a complex reaction pattern to various aetiopathological factors of infective and non-infective origin. Infective agents outnumber inflammatory causes and drugs in causation of erythema nodosum in the developing countries. Almost all the infective agents including aerobic and anaerobic bacteria, viruses, fungi, parasites and mycobacteria can induce eruption of erythema nodosum. Among sexually transmitted infections lymphogranuloma venereum has been known to be associated with erythema nodosum not infrequently.

A 23 year old woman presented with genital ulcer disease and painful rash over the legs of 1 week’s duration. There was no history of trauma, fever, or drug intake. She had a single stable sexual partner who was apparently unaffected. Examination revealed a single, 1–1.5 cm size, irregular tender ulcer on the right labia minora with undermined margins and a well defined elevated edge. The regional lymph nodes were firm, moderately enlarged, and tender. Speculum and vaginal examination was normal. Examination of the perianal region, perineum, and other mucosae was also normal.

Multiple tender, erythematous nodular subcutaneous lesions with dusky erythema were present over both shins, calves, and ankle joints. Investigations revealed a normal complete blood count, serum biochemistry, serum analysis and blood sugar. VDRL, HIV-1 ELISA, and HBsAg were negative. Dark ground illumination, smears, and cultures from the ulcer did not reveal aetiological diagnosis. Histopathology from the ulcer revealed an ulcerated surface with necrosis and neutrophilic infiltrate deeper to which a zone of new blood vessel formation with marked endothelial proliferation and a lymphoplasma-stylic infiltrate was observed. These findings were consistent with diagnosis of chancroid but histopathology of leg lesions confirmed it to be septal panniculitis consistent with a diagnosis of erythema nodosum. The baby was treated with erythromycin steearate 500 mg hourly for 7 days. The genital ulcer healed completely in 7–10 days but the lesions of erythema nodosum subsided completely in 5–7 days without any other treatment.

Erythema nodosum as a cutaneous reaction pattern was first observed by Willan in 1798. A female preponderance with a ratio of 3:1 is often observed in adults compared to an equal incidence at prepubertal age. Although the exact pathogenesis of erythema nodosum is not known, it has been regarded as a immune complex, deposition disease which prefers the richly supplied vascular adipose tissue of the legs.

In the present patient erythema nodosum and chancroid had a strong temporal correlation as erythema nodosum immediately followed the appearance of the chancroid and resolved completely with its resolution. Although erythema nodosum is known to be associated with innumerable infective agents, to the best of our knowledge chancroid leading to causation of erythema nodosum has not been observed before.
Gonococcal perianal abscess: re-emergence after cessation of co-trimoxazole

We report a case of perianal abscess due to N gonorrhoeae, which appears to have been suppressed but not eradicated by chronic low dose co-trimoxazole for a period of almost 6 months between acquisition and diagnosis. The patient was a 34 year old HIV infected homosexual man treated with didanosine, stavudine, and nevirapine with a viral load of 500 copies per ml and a CD4 lymphocyte count of 280 × 10^3. He was taking co-trimoxazole 400 mg/80 mg once daily to prevent Pneumocystis carinii pneumonia (PCP).

He reported last having receptive anal sex in June 2000. This was unprotected, with a casual partner at a “gay” sauna. Three weeks later he reported a perianal abscess which discharged spontaneously, requiring dressings for a few days. A sinus was observed and he was booked for elective surgery. He remained well for 5 months.

Co-trimoxazole PPy prophylaxis was stopped in November 2000 as his CD4 T lymphocyte count had remained above 200. Two weeks later (and almost 6 months after the last reported anal sex) he presented with purulent discharge emerging from a sinus approximately 3 cm from the anus. N gonorrhoeae (sensitive to penicillin, ceftriaxone, and ciprofloxacin) and Bacteroides species were cultured from this discharge.

The isolation of N gonorrhoeae from a perianal abscess is unusual, especially when the patient has been treated with ciprofloxacin and ceftriaxone. The finding of Bacteroides species raises the possibility that anaerobic organisms were contributing to the formation of the abscess, consistent with animal inoculation experiments. Another possible factor was the moderate immunosuppression (CD4 count of 280) from his HIV infection.

Six months passed from the time of infection to diagnosis, during which the patient was largely free of symptoms which then developed when co-trimoxazole was stopped. The likely explanation is that the co-trimoxazole was suppressing the gonococcal infection without curing it. The failure to detect N gonorrhoeae by PCR from the rectal specimen raises the possibility that co-trimoxazole may have eradicated a rectal infection in this case while only suppressing an extragenital manifestation.

It is now standard practice to stop PCP prophylaxis when CD4 counts rise above 200 × 10^3 in patients taking antiretroviral therapy. This may in turn have contributed to increases in gonorrhoea in HIV infected populations.


table

<table>
<thead>
<tr>
<th>Table 1 Timeliness of HIV testing</th>
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<tr>
<td>Tested for HIV at time of attendance</td>
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<td>Study 34/242 (14%)</td>
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<tr>
<td>Control 25/76 (33%)</td>
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</table>

1 Accepted for publication 5 June 2002


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• Pretest counselling is reserved for high risk groups instead of being required routinely.

• Patients are able to obtain their HIV results while they wait to be seen explaining the natural history, treatments available, benefits of early diagnosis, and mechanisms of reducing transmission. This enhances patient education and may expedite consultation length and waiting times for patients with restricted “time off” and/or other more pertinent issues to discuss.

Additional waiting room posters and a new patient information leaflet about HIV is given to all patients at registration to read while they wait to be seen explaining the natural history, treatments available, benefits of early diagnosis, and mechanisms of reducing transmission. This enhances patient education and may expedite consultation length and waiting times for patients with restricted “time off” and/or other more pertinent issues to discuss.

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www.sextransinf.com
Although the title of this volume reflects the general sense that the face of the pandemic has indeed changed in many ways—not least the global spread, and the impact of antiretroviral therapies where they are available—the overwhelming impression I had was how similar are the issues and perspectives it covers. This is partly a reflection of the extraordinary hothouse atmosphere of the early pioneering years, when we climbed the steep part of the learning curve with unparalleled speed. The subsequent years have been ones of consolidation, during which the detail has been explored and the basic ideas refined. This book reflects that, where the change in the face is in part a shift from an impressionistic image to a more fully representational portrait, evidently from the same original.

The chapters provide a balanced and compact, yet thorough, assessment of the main issues. The authors are active in the field; they have an appropriately British background for this series, yet their perspective is unequivocally global. The accounts are worthy, reliable, and authoritative. If this conveys the impression that they are rather dull to read, that was indeed my feeling. There was generally and disappointingly little sparkle or originality in the concepts or the writing. Where there was, it derived from a narrow focus on a small part of the canvas rather than any broader insight. Who will use this volume? I would recommend it as a reliable and thorough review for a new entrant to the field. Those who work adjacent to it and who would like a compact, up to date summary would also be well served. Some of the chapters are an excellent springboard for detailed exploration of their topic. But those who already work on HIV/AIDS will find little to engage or excite them. They would probably feel, as I did, that the fascinating wider changes in the actual face of HIV/AIDS, which are palpable in their work, have scarcely been touched upon.

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26th National Conference of the Indian Association for the Study of Sexually Transmitted Diseases & AIDS

18–20 October 2002, All India Institute of Medical Sciences, New Delhi, India

The last date for submission of abstracts for free papers is 1 September 2002. The registration fees for foreign delegates is $50 (SAARC countries) and $100 (other countries).

Further details: Indian Association for the Study of Sexually Transmitted Diseases & AIDS (fax: (0)91 011 686 2663; email: iasstd2002@tly.com).

European Society for Gynaecological Endoscopy
Expert Meeting on Pelvic Floor Disorders

28–30 November 2002, Centro Médico Teknon, Barcelona, Spain

Further details: ESGE central office, Orga-Med, Essenerstraat 77, B-1740 Ternat, Belgium (tel: +32 2826 0852; fax: +32 2826 1913; email: orgamed@village.uonet.net; web site: www.ESGE.org).

Royal Society of Medicine Conference on Men’s Sexual Health

13 December 2002, The Royal Society of Medicine, 1 Wimpole Street, London, W1G OAE, UK

Is Viagra really the answer to impotence, or are men and their doctors relying on prescription pills and avoiding tackling the psychological causes behind the problem? Besides impotence and other sexual dysfunction, this meeting also looks a range of male sexual problems from STDs to prostate cancer, the effect of sex on the heart to the male menopause. Registration costs: Fellow: £105; Non-Fellow: £175; Student: £20. CPD: 5 credits; PGEA Applied For.

Further details: Ms Georgina Brodie, RSM Administration (tel: +44 (0) 20 7290 3856; fax: +44 (0) 20 7290 2977; email: georgina.brodie@rsm.ac.uk).

XIX International Congress of the Society of The Fetus as a Patient

1–4 May 2003, Gran Hotel Sitges, Barcelona-Sitges, Spain

Further details: (fax: +34 93 418 7832; email: bcn2003@iudexeus.uab.es).
Erythema nodosum induced by chancroid

C Kaur and G P Thami

*Sex Transm Infect* 2002 78: 388-389
doi: 10.1136/sti.78.5.388-a

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