HIV epidemic in context of STI declines: a telling discordance

Decosas and Padian report, but do not discuss, a noteworthy disassociation in epidemic trajectories between human immunodeficiency virus (HIV) and sexually transmitted infections (STI) in Zimbabwe. They cite estimates that, between 1990 and 1999, HIV prevalence increased linearly from 9% to 25%, while STI syndrome reports declined substantially, from 963 436 cases to 727 788. The authors not only believe that observed STI declines are real, but cite increases in reported condom use by high-risk people (for example, prostitute women, truck drivers, miners, and young people) as supporting evidence. What is not clear is why HIV prevalence would increase markedly coevally with increasing condom use in high-risk populations and with decreasing STI incidence. Assuming synergism between STI and HIV transmission, one would expect that a burgeoning and sexually mediated HIV epidemic would be accompanied by corresponding increases in STI transmissions. An estimated increase in HIV prevalence from 9% to 25% in a decade, implying a 12% annual epidemic growth rate, is not likely to be due to differences between HIV, a chronic infection that accumulates in a reservoir, and STI, which tend not to. Does this anomaly require clarification?

Recent analyses suggest that a large proportion of HIV infections, especially in sub-Saharan Africa, may be a consequence of unsafe medical infections. This under-suspected and scientifically underexplored transmission vector is overlooked by the authors as well (exception: “blood safety” in fig 1). Theirs is not the first report of an epidemiologically suspicious anomaly between STI and HIV trends in Africa and, if others’ suspicions are correct, it is unlikely to be the last.

J J Potterat
Independent consultant, Colorado Springs, CO, USA

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5. Stellman JD, Alcabes PS, Marx PA. The injection century: massive unsterile injections with Enterobacter sakazakii are known. No cultivation from environmental sources (surface water, animals, raw cow’s milk, etc) has been successful, except recently from the gut of fruit flies. The rare case of Enterobacter intermedium causing urinary tract infection, was found in drinking water and soil. Our case strongly suggested that warm surface water was the source of infection. The unusually high thermal resistance of E sakazakii might contribute to its survival during the manufacture powdered milk batches. It is important to remember that the stomach of adults ingested milk preparations remaining neutral or slightly alkaline in their stomach ensure survival and subsequent infection in the alkaline intestine. This pathomechanism is similar to pH increase in vaginal infections in the lack of Lactobacillus flora. The detrimental effect of E sakazakii infection is also reflected by the fact that re-colonisation by the normal flora and a pH shift towards physiological level could be achieved only gradually in our patient.

J Ongrádi
National Institute of Dermato-Venereology, Budapest, VIII, Mária utca 41, Hungary 1085, ongradi@hotmail.com

Successful use of valaciclovir in a case of recurrent urticaria associated with genital herpes

Urticaria is a common skin condition but the symptoms and signs can be extremely distressing. The condition is often idiopathic. The management of urticaria can be frustrating even when triggers are identified. We describe a case of recurrent urticaria associated with genital herpes attacks and a successful use of suppressive therapy with valaciclovir.

A 35 year old white woman presented in March 2000 to a genitourinary medicine (GUM) clinic with 5 year history of recurrent lesions typical of genital herpes simplex virus (HSV) infection occurring almost every month. She had also been developing physical urticaria manifesting as itchy weals on pressure areas of the body, approximately 24 hours before the onset of genital HSV attacks. The lesions showed no characteristics of erythema multiforme or vasculitis. Each urticarial attack lasted from 20–30 minutes and had a cholinergic element being exacerbated by exercise and heat. Antihistamines were not effective. She had contact sensitivity to perfumes, make up, and coloured bath products. There was no history of angioedema, other atopic disease, or drug allergies. She was otherwise well and on no medication.

Culture for HSV was negative. However, serology was positive for HSV type 1 IgG antibody. HSV type 2, hepatitis B and C serology were negative. Her IgE level was normal. Immunological investigations including CD4/CD8 count showed no evidence of immunodeficiency.

Her HSV attacks were frequent and distressing. She began suppressive therapy with valaciclovir 500 mg twice a day and antihistamines in March 2000 and the symptoms were well controlled. Both urticaria and herpes recurred when the valaciclovir therapy was discontinued after 6 months. She recommenced her therapy in October 2000 but required higher doses of valaciclovir to control her symptoms. She is currently taking valaciclovir 1 g twice daily and cetirizine 10 mg daily. She has had a single episode of urticaria associated with genital herpes precipitated by intense sunlight exposure in September 2001 which is more difficult to insert and causes damage to the vulva. She is currently taking valaciclovir 1 g twice daily and cetirizine 10 mg daily. She has had one episode of urticaria associated with genital herpes; none had genital herpes. In our patient, control of both genital herpes and recurrent urticaria with valaciclovir therapy suggests a close temporal association between the onset of urticaria and development of herpetic lesions. The exact role of HSV in the pathogenesis of urticaria is unknown but it may be related to hypersensitivity reaction to viral antigens. Antiviral agents may be effective by suppressing these antigens.

This case demonstrates the importance of early recognition of urticaria associated with HSV infections in order to avoid delay in instituting antiviral treatment in GUM clinics or other settings for this disabling skin condition.

A Khunda, M Kawser, J M Parkin, G E Forster
Infection and Immunity Clinical Group, Barts and The London NHS Trust, London E1 1BB, UK
Correspondence: Dr A Khunda, Ambrose King Centre, Royal London Hospital, Whitechapel, London E1 1BB, UK; khunda@btinternet.com

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Inhibition of Neisseria gonorrhoeae by vaginal lubricants

Microbiology culture remains the diagnostic standard for gonococcal infection. Isolation of the pathogen confirms the clinical diagnosis and allows assessment of the antimicrobial susceptibility of the gonococcal strain, guiding effective therapy. The sensitivity of endocervical swabs has been reported as 80–90% but this varies with the quality of culture media and adequacy of the specimen. The gonococcus is a nutritionally demanding bacterium, readily inhibited by adverse culture conditions.

For decades, doctors in genital urinary medicine have been advised to lubricate metal vaginal specula with water only. With the increasing use of disposable vaginal specula, which are more difficult to insert, some workers have promoted the use of vaginal lubricants, such as KY jelly, to reduce patient discomfort during clinical examination and specimen collection.

Figure 1 Five randomly selected clinical strains of Neisseria gonorrhoeae growing on gonococcal sensitivity agar. Note the central region of the plate where a line of KY jelly has inhibited growth.

Figure 1 shows five randomly selected clinical strains of Neisseria gonorrhoeae inoculated by swab (10^5/ml) and growing readily on gonococcal sensitivity agar except in the central region of the plate where a line of KY jelly has inhibited growth. Some studies have demonstrated the inhibitory actions of various vaginal lubricants, including KY jelly, against N gonorrhoeae, while others have found KY jelly to be relatively non-toxic to both chlamydia and gonococci.

In view of these conflicting findings, prospective studies are required to assess the clinical significance of using vaginal lubricants when collecting specimens for gonococcal culture. Pending the completion of such studies, we recommend that vaginal lubricants should not be used when obtaining endocervical samples for microbiological investigation.

Contributors
REH, design of practical work, literature review, production of first draft of manuscript; JDJ, performance of practical work, literature review, critical comment on draft manuscript; FD identification of clinical issue, literature review, critical comment on draft manuscript.

R E Holliman, J D Johnson, F Davidson
St George’s Hospital, Blackshaw Road, London SW17 0QT, UK
Correspondence to: Dr Holliman; rhollima@sghms.ac.uk

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R E Holliman, J D Johnson and F Davidson

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