Perforating chancre: any cause-effect relation with HIV infection?

Variation in clinical pictures of syphilis, when co-infected with HIV are well known. Normally, a classic Hunterian chancre heals within 1–2 weeks of treatment without scarring. Primary chancre, healing with perforation of the site, does not commonly occur. Here we report four patients with primary syphilis, in whom the chancre healed with perforation of the genitalia. Concomitant infection with HIV is presumed to be responsible for this destructive sequela.

Case 1
A 21 year old woman presented with a painless ulcer on the left labia majora, along with same sided unilateral inguinal lymphadenopathy. Following treatment with penicillin, the ulcer healed at a slower pace leaving a large perforation on the labia majora. The VDRL titre was 1:32. He had a history of genital mollusca contagiosa, and genital warts. Bilateral inguinal lymphadenopathy was present. DGI from the ulcer was negative and VDRL was 1:64. Following penicillin therapy, it healed with perforation of the prepuce.

Case 2
A 20 year old unmarried male patient with high risk behaviour presented with a painless indurated ulcer over the dorsal aspect of the prepuce and unilateral inguinal lymphadenopathy. DGI was positive for T pallidum and VDRL titre was 1:64. Following treatment with penicillin, the ulcer healed slowly, leaving a perforation on the labia majora.

Case 3
A 20 year old unmarried male patient with high risk behaviour presented with a painless indurated ulcer over the dorsal aspect of the prepuce and unilateral inguinal lymphadenopathy. DGI was positive for T pallidum and VDRL titre was 1:32. He had a history of genital ulceration and was treated for suspected lymphogranuloma venereum. Following treatment with penicillin, the ulcer healed at a slower pace leaving a large perforation on the prepuce (fig 1).

Case 4
A 45 year old married man with high risk behaviour presented with a large perforation on the lateral side of the shaft of the penis. He gave a history of a painless ulcer on the same site about 1 month earlier. At presentation, his VDRL was 1:32. He was treated with penicillin.

Comment
Gram stained smears from the ulcers and culture for aerobic and anaerobic organisms were negative in first three cases. In all the four patients, ELISA for HIV was positive.

Immune response to T pallidum is primarily cell mediated. In an immunocompetent host with primary syphilis, CD4+:CD8+ T lymphocyte ratio is high at the site of the chancre, which possibly prevents local multiplication of the organism. Consequently to the loss of local cellular immunity as a result of HIV infection there may be an enhanced ability of the organism to multiply locally, giving rise to larger and deeper ulcers which are slower to heal. This fact has been demonstrated experimentally in animal models.

Studies exploring the correlation of CD4+ T cell count and stage of HIV infection with this altered manifestation of primary syphilis should be undertaken. This might show the impact of HIV infection on the clinical severity of primary chancre.

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Figure 1 Perforation of prepuce.
in cases of severe kyphoscoliosis. Duodenal arteriomesenteric duodenal compression syndrome is a controversial diagnosis synonymous with superior mesenteric artery syndrome, the cast syndrome, chronic duodenal ileus, and Wilkie’s syndrome. First described by Rokitskian in 1842, frequency of reports have recently declined and its existence debated. The syndrome has been ascribed to a reduction in the angle between the aorta and the superior mesenteric artery, scissoring the duodenum in its third part causing obstruction. This is often because of sudden, severe weight loss resulting in a reduction of mesenteric and retroperitoneal fat. Precipitating factors include eating disorders, severe wasting conditions, prolonged immobilisation, previous abdominal surgery, or inflammatory conditions. It has also been reported in cases of severe kyphoscoliosis. It has not previously been reported in AIDS.

Characteristic symptoms, typically intermittent in nature, comprise bloating, nausea, and intractable bilious vomiting relieved by adopting the prone or knee to chest position. A barium meal is the most useful diagnostic investigation. Features of note include dilatation of the duodenum, arteriomesenteric duodenal compression syndrome, characteristic symptoms, typically intermitting in nature, and a study in Brazil found similar results (a 30% decrease in the prevalence of trichomoniasis in Brazil over a 10 year period). As there are no cytological changes do not diagnose a case from one year to the next. Similar observations have been reported elsewhere: the rate of detection of trichomoniasis in Papanicolaou (Pap) smears in Denmark fell from 19% in 1967 to <2% in 1997, and a study in Brazil found similar results (a peak of 17.3% in 1978, falling to 3.4% in 1998).

In the absence of any health promotional activities relating to trichomoniasis and in a setting where the prevalence of another STI, Chlamydia trachomatis, has shown a fourfold increase in notifications in the past 10 years (Communicable Diseases Network Australia, National Notifiable Diseases Surveillance System, personal communication), what can explain the declining prevalence of T vaginalis?

I propose that the change in prevalence is an unintended consequence of the introduction of coordinated Pap smear screening programmes in the 1970s and 1980s. As the Pap screening programmes gained momentum in the urban areas, a positive finding on the Pap smear, which has a sensitivity for the diagnosis of T vaginalis of around 50–60%, would have been conveyed to the referring medical practitioner who would treat the woman with metronidazole or tinidazole. In addition, the increasing use of these antibiotics for the treatment of other conditions, in particular bacterial vaginosis, may have further reduced the prevalence during the same period. As there are no cytological changes that are diagnostic of C trachomatis, Pap screening would be expected to have no effect on chlamydia prevalence.

In Australian urban populations the proportion of women undergoing Pap screening in the 20–40 year age group is approximately 70%. On the other hand, in some remote Aboriginal populations the introduction of coordinated screening has lagged behind urban areas and trichomoniasis remains hyper endemic (prevalence of approximately 25%). (Of course these observations could be confirmed by a number of factors: Pap screening rates correlate with socioeconomic status and the rate of partner change could be different between these groups. However, it has been shown that access to services is more important than differences in the rate of partner change when comparing STI rates in Indigenous and non-Indigenous populations in Australia.)

The Pap smear hypothesis could be tested by correlating the prevalence of trichomoniasis with the rate of cervical cancer screening in selected populations and through clinic based case-control studies. The virtual absence of trichomoniasis in urban Australia means that this work must be performed in other populations. If the prevalence of T vaginalis is related to Pap screening, a shifting approach to chlamydia control—that is, routinely linking nucleic acid amplification testing for Chlamydia with the Pap smear, could also be considered.

Conflict of interest: None.

References

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The HIV/AIDS epidemic in Ukraine: stable or still exploding?

A recent article published in Sexually Transmitted Infections present evidence suggesting that the HIV/AIDS epidemic in Ukraine had peaked in 1997 and has since declined. The world has only recently awoken to the threat of a widespread HIV/AIDS epidemic in eastern Europe, including projections of an
epidemic in Russia of between 6–11% by 2010, and the potential for economic decline and geopolitical instability. HIV trends in Ukraine, with many of the same socio-economic characteristics and risk factors found in Russia—namely, large numbers of injecting drug users (IDUs), an expanding sex industry, internal and external migration, poor access to health care, sexual and domestic violence, and a recent explosive syphilis epidemic—must therefore be examined closely. Could Ukraine present a model for Russia in terms of controlling the HIV epidemic? Ukraine in fact represents an epidemic in Russia—namely, large numbers of injecting drug users (IDUs), and the potential for economic decline and social upheaval, and a recent explosive syphilis epidemic—must therefore be examined closely. Could Ukraine present a model for Russia in terms of controlling the HIV epidemic in Ukraine in fact reflect an ongoing epidemic inadequately described by official statistics? The first indication that perhaps the data presented by Mavrov and Bondarenko might not reflect the ongoing HIV epidemic in Ukraine is the apparent contradiction in table 1, which reports the prevalence of HIV among select groups in 1998 and 1999. While HIV prevalence for “all populations” declined, every subpopulation increased, except for a decline from 0.07% to 0.06% among blood donors. Prevalence among pregnant women, who reflect the likely future of the epidemic, increased by 33%. Current official statistics in Ukraine simply do not reflect the current status of the epidemic, and, importantly, do not reflect the likely future course of the epidemic. As Mavrov and Bondarenko report, the majority of new HIV cases continue to be among IDUs. This population is wary of the healthcare sector, as the acknowledgement of drug use to a healthcare provider leads to obligatory registration and confinement for treatment. Possible job loss, loss of one’s driving licence, and criminal prosecution. Kobyshecha reported that only 5% of IDUs were covered by the current system of HIV surveillance. Rather than the 8.6% prevalence reported by Mavrov and Bondarenko among IDUs, cross sectional studies have shown prevalence of between 18% and 64% (table 1). In 1997 and 1999, the percentage of FSWs reporting always using condom declined (from 49% to 40%). A 1999 national reproductive health survey found that 27% of women reported condom use at the time of first sexual experience. The recent attention to model the future course of the HIV/AIDS epidemic in Ukraine, developed an “optimistic” scenario, where HIV prevalence increased to 2% of the adult population by 2010, and a “pessimistic” scenario, where HIV prevalence increased to 5%. While official statistics might indicate a stable epidemic, after more than two decades of global experience, no one should mistake the clear evidence that an explosive epidemic is ongoing in the Ukraine. Failing to acknowledge the true nature of an epidemic has yet to save any nation from its consequences.

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Genitourinary Medicine, while 17.3% specified an inadequate course. Dosage or duration could not be ascertained in 12.7% of responses. This suggests substantial improvement in the past few years, although our study probably over-represents GPs already taking time, since those who do so and may exaggerate the extent of good practice.

Our study suggests that GPs already willingly take on an important role in diagnosing and managing genital chlamydia infection. They agree overwhelmingly that partner notification is the main difficulty in managing these patients. However, there is little evidence of follow up strategies designed to minimize re-infection risk, as in previous studies, and the majority of GPs consider that partner notification is not their role. The latter view probably explains why the majority manage partner notification by simply telling the patient to deal with it, without support or follow up.

If testing in primary care continues to increase without adequate support for partner notification, much of the resource used in testing women will be wasted. The announcement of pilot sites for chlamydia testing in primary care is to be welcomed. However, support for GPs in partner notification should not wait for the roll out of a national programme, since many patients diagnosed in primary care are already at risk of re-infection and onward transmission.

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References

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Circumcision in genital warts—let us not forget!
Patients with genital warts present to the healthcare professional with two major problems of persistence and recurrence. These problems are particularly 25% of the time. Circumcision is recommended for religious, cultural, medical, or parental choice reasons. However, controversies surround its benefits and protective effects against STDs. Although it may be debatable to recommend circumcision to reduce the risk of acquiring any one of the other STDs/HIV infection in isolation, taken together however the psychological and sexual discomforts for the patients and their sexual partners with recurrent/persistent extensive prepuce warts, circumcision should be tried.

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Treatment of Candida glabrata using topical amphotericin B and fluconosine
We read with interest the article by White and colleagues on the treatment of Candida glabrata using topical amphotericin B and fluconosine because this infection can prove difficult to treat. We have since used this treatment on a 28 year old woman with a 10 year history of recurrent candida.

The woman first attended our department complaining of a recurrent itchy white discharge. She had received numerous courses of antifungals including topical clotrimazole, oral itraconazole, and fluconazole with no relief. Vaginal swabs were positive for C glabrata and she was treated with nystatin pessaries 200 000 units at night for 14 nights. Culture was still positive for C glabrata at follow up 4 weeks later so she was advised to continue with nystatin pessaries for a further 4 weeks. On review she felt her symptoms were slightly better but she found the pessaries were not dissolving so she was switched to nystatin cream 200 000 units by
vagina for 28 nights. After this course of treatment she remained asymptomatic and positive on culture for C. glabrata. Following the success with topical fluconazole and amphotericin B in the above article our pharmacist obtained this preparation. The patient was given amphotericin 100 mg plus fluconazole 1 g in Aquigel in a total 8 g dose, which was given by vaginal applicator nightly for 14 nights. She was reviewed 2 and 6 weeks after finishing treatment, her symptoms had greatly improved and cultures for yeast were negative on both occasions.

White’s paper described the successful treatment of three patients with candidiasis using topical amphotericin B and fluconazole. Our patient makes up the fourth case of successful eradication of refractory vaginal C. glabrata using this combination which, like the other cases, was very well tolerated.

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Reference

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BOOK REVIEW


I judge this is a jewel of a book, although you would not think so from my comments in the next paragraph.

My initial reaction was one of intense irritation. The preface stated that the intention was to “review the state of the art...of this rapidly emerging...field.” A bold promise for which tight editorial time lines and up to date references would be essential. Yet, even though the book was published in 2002, there were very few references from 2001 or even from 2000 in some chapters. To take as one particularly bad example, the chapter dealing with the immunotherapy of HIV had only one reference as recent as 2000, and all the rest were from the last millennium.

It is a credit to the book’s other talents that my bad humour was rapidly dissipated. The introductory chapters were, quite simply, a pleasure. The basis of humoral immunity was a clear rendition of the area, and the chapter on the principles of cellular immunology was as good, and as enjoyable an introduction to the field as you could get. The final introductory chapter, on mucosal defences, maintains the high standards set by the first two.

The remainder of the book is divided into three sections covering the molecular basis for immunotherapy, immunotherapy for HIV infection, and immunotherapy for other infectious diseases. Each of these three sections provides a good review of the major issues. The molecular basis of for immunotherapy contains an excellent chapter on the role of dendritic cells, and usefully explains how their crucial role in immune defences might be utilised for immune therapy. The chapter on cytokines sheds light on an area which is too complex or obtuse for many.

The section on immunotherapy for HIV infection covers in turn the basis for immunotherapeutic HIV vaccines, passive immunotherapy, and gene therapy. There are some notable omissions dictated by the presumed delay between the research for each chapter, and publication of the book. For instance, RNA interference, sometimes known as post-transcriptional gene silencing, is currently being investigated as a possible major therapeutic strategy for the future. True, the problem of delivery to the target cells still has to be solved, but for RNA interference to be left out dates the book already. Similarly many of the viral and bacterial vectors for vaccine delivery worked on the past few years, such as adenovirus, and salmonella, to name just two, are not included. Even those that are, such as canarypox, are not included in the index.

Which leads to my final criticism before summing up—the index is entirely inadequate and mitigates strongly against using this as a book of reference.

So in conclusion, this book represents a flawed gem. Viewed from a certain light it is illuminating, a joy to behold. From other angles, the imperfections are all too obvious. None the less, for a physician or scientist working in the field of infectious diseases or related areas such as STDS or HIV, it provides an introduction to the field of immunotherapy which is both accessible and enjoyable. Read it within the next couple of years as good, and as enjoyable an introduction to the field as you could get. Then, there really will be a precious jewel.

Barry S Peters

INTERNATIONAL HERPES ALLIANCE AND INTERNATIONAL HERPES MANAGEMENT FORUM

The International Herpes Alliance has introduced a web site (www.herpesalliance.org) where patient information leaflets can be downloaded. Its sister organisation the International Herpes Management Forum (web site: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

PAN-AMERICAN HEALTH ORGANIZATION, REGIONAL OFFICE OF THE WORLD HEALTH ORGANIZATION

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).

AUSTRALASIAN SEXUAL HEALTH CONFERENCE: TANGO DOWN SOUTH—2003!

4–7 June 2003, Christchurch Convention Centre, New Zealand

Further details: Dart Associates (tel: +02 9418 9396/97; email: dartconv@mpx.com.au; web site: http://www.acshp.org.au).

7TH EUROPEAN SOCIETY OF CONTRACEPTION SEMINAR

12–13 September 2003, Budapest, Hungary

The 7th ESC Seminar on contraceptive practice in Europe: differences in availability and accessibility, will be held in Budapest Hungary. The main themes are availability and accessibility of: (1) contraceptive methods, (2) emergency contraception, (3) testing and treatment of sexually transmitted infections, and (4) abortions.

Further details: ESC Central Office, Essenerstraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 0852; fax: +32 2 582 5515; email: esscentraloffice@contraception-esc.com; website: www.contraception-esc.com).
Partner notification in primary care

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