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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, indurated ulcer over the dorsal aspect of the prepuce (fig 1). Dark ground microscopy (DGI) was positive for Treponema pallidum and VDRL titre was 1:64. Following penicillin therapy, it healed with perforation of the prepuce.

Case 2
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.

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 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.

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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. Consequent 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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References

Superior mesenteric artery syndrome in an HIV positive patient

A 27 year old HIV positive man with a CD4+ lymphocyte count of 26 cells x10^9/l presented with a 2 week history of progressive left sided weakness, vomiting, and weight loss. A computed tomograph (CT) brain scan demonstrated ring lesions bilaterally in the basal ganglia. Toxoplasma serology was positive at a titre of 1:526 and treatment for cerebral toxoplasmosis commenced. His weakness responded to therapy but vomiting continued despite antiemetics. An ultrasound scan demonstrated an enlarged, dilated stomach, dilated first and second parts of the duodenum, and an obstruction at the level of the third. Barium studies confirmed these findings but also demonstrated prominent peristalsis in the second part of the duodenum and an abrupt cessation of flow to barium in the middle of the third (fig 1). Some flow of barium into the jejenum was noted when the patient was turned prone. An abdominal CT scan demonstrated a reduction in the angle between the superior mesenteric artery and the aorta (fig 2). A diagnosis of superior mesenteric artery (SMA) syndrome was considered. Two litres of bile were aspirated per nasogastric tube daily and he continued to lose weight. His body mass index (BMI) fell to

Figure 1 Image from barium meal series. The proximal duodenum is dilated. There is an abrupt calibre change (arrow) in the third part where the superior mesenteric artery crosses. Distinct peristalsis was seen in this region during the study.

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Figure 1 Perforation of prepuce.
or nasogastric decompression is often difficult because of severe gastric dilatation. Duodenal jejunojunosotomy or gastrojejunojunosotomy are the surgical procedures of choice when medical therapy fails.\(^1\) Our patient did not experience immediate symptomatic relief through surgery but did achieve rapid weight gain via jejunal feeding. We report the first case of SMA syndrome in a patient with AIDS. The spread of HIV worldwide and its association with severe wasting makes this an important differential diagnosis for the clinician.

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Was the Papanicolaou smear responsible for the decline of Trichomonas vaginalis?

There has been a dramatic decline in the prevalence of trichomoniasis in Australia over the past 30 years. In 1979, 17.8% of women attending a Sydney STI clinic had *Trichomonas vaginalis* infection.\(^1\) By 1998 less than 1% of non-Indigenous women presenting to family planning and STI clinics in another part of the duodenum. *Clin Radiol* 1982;33:75–81.


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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 a “pessimistic” scenario, an epidemic in Russia of between 6–11% by 2010, and a “pessimistic” scenario, should they be examined.

1. Mavrov and Bondarenko
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2. The first indication that perhaps the data

3. As Mavrov and Bondarenko

4. HIV trends in

5. 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, in the past system of HIV surveillance. Rather than the 8.6% prevalence reported by Mavrov and Bondarenko among IDUs, central regional studies have shown prevalence of between 18% and 64% (table 1).

6. Behavioural factors also argue against the likelihood of a stable epidemic in Ukraine. In a study of female sex workers (FSWs) in two cities in 1998 and 1999, while HIV prevalence for “all populations” declined, every subpopulation increased, except for a decline from 0.07% to 0.064% among blood donors. Prevalence among pregnant women, who reflect the likely future of the epidemic, increased by 33%.

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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 often associated with significant morbidity and psychological distress, particularly for patients with extensive warts. Extensive genital warts with evidence of keratinisation are often refractory to podophyllin, podophyllotoxin, and cryotherapy, etc., and are best dealt with surgically or by topical 5-fluorouracil cream. Scissor excision has been mentioned in the treatment of sessile lesions over the shaft of penis, labia majora, and perianal warts.1 However, circumcision for extensive prepuceal warts finds no place in the list of treatments for genital warts in men. In addition to the psychological morbidities, larger and more numerous warts can cause discomfort, and particularly involving prepuce can cause phimosis, secondary infection, and marital disharmony and considerable anxiety in the sexual partner. Globally, approximately 25% of the world’s population is circumcised for religious, cultural, medical, or parental choice reasons. However, controversies surround its benefits and protective effects against STDs.2 For genital warts, one study has reported a significant association with the lack of circumcision.3

Substantive evidence supports the premise that circumcision protects males from HIV infection, penile carcinoma, urinary tract infections, and ulcerative STDs.4 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 prepuceal 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.1 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

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 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. This 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 and you will be well invested. For a specialist in the field it has limited value, except to recommend to trainees or newcomers.

If the editor decides to bring out another edition, he should somehow do the near impossible for multiauthored texts, and ensure they are all up to date. Oh, and also invest in a professional indexing service. Then, there really will be a precious jewel.

Barry S Peters

NOTICES

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, national 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, Eszterenstraat 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).
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Updated information and services can be found at:
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