LETTERS

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 20 year old unmarried male patient with genital mollusca contagiosa, and genital warts. Repeated unprotected exposure to commercial sex workers, presented with a painless, indurated ulcer 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. DGI from the ulcer was negative 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.

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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PostScript
12 and total parental nutrition was introduced for 6 weeks after which an exploratory laparotomy was performed. An anterior gastrotomostomy was made and a jejunal feeding tube inserted into the collapsed proximal small bowel. The patient recovered postoperatively and continued to vomit after meals. After 4 weeks his BMI increased to 15, vomiting stopped, and he demanded food. At the time of writing he is well, independent, and on antiretroviral therapy.

Superior mesenteric artery syndrome is a controversial diagnosis synonymous with vascular compression of the duodenum, arteriomesenteric duodenal compression syndrome, the cast syndrome, chronic duodenal ileus, and Wilkie’s syndrome. First described by Rokitansky in 1842, frequency of reports previously been reported in AIDS. It has not been thoroughly ascribed to a syndrome so much as a collection of isolated cases. It is rare because of sudden, severe weight loss resulting in a reduction of mesenteric and retroperitoneal fat. Preempting 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 first and second parts of the duodenum and an abrupt, linear hold up of flow to barium in the third with abnormal peristalsis and even reverse peristalsis frequently observed. Relief of the obstruction can in some instances be achieved by placing the patient prone during the intervention. CT studies can demonstrate reduction in the aortomesenteric mesenteric artery angle and serve as a non-invasive diagnostic tool. Reversal of weight loss is key to resolution, by surgical means if necessary. Nutritional support should be attempted first. Endoscopic or nasogastric decompression is often difficult because of severe gastric dilatation. Duodenal jejunostomy or gastrotomostomy are the surgical procedures of choice when medical therapy fails. 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 trichomonalis in Australia over the past 30 years. In 1979, 17.8% of women attending a Sydney STI clinic had Trichomonas vaginalis infection. By 1998 less than 1% of non-Indigenous women presenting to family planning and STI clinics in another jurisdiction were diagnosed with the condition and most Australian urban pathology laboratories do not diagnose a case from one year to the next. Similar observations have been reported elsewhere: the rate of detection of trichomonalis 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 trichomonalis 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 decline 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 trichomonalis remains hyperendemic (prevalence of approximately 25%).

(Of course these observations could be confounded 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 trichomonalis with the rate of cervical cancer screening in selected populations and through clinic based case-control studies. (The virtual absence of trichomonalis in urban Australia means that this work must be performed in other populations.) If the prevalence of T vaginalis is related to Pap screening or a similar approach to chlamydia control—that is, routinely linking nucleic acid amplification testing for C trachomatis with the Pap smear, could also be considered.

Conflict of interest: None.

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

A recent article published in Sexually Transmitted Infections presented 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

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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 socioeconomic 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 economic 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? Or does Ukraine in fact represent an ongoing epidemic inadequately described by official statistics?

The first indication that perhaps the data presented by Mavrov and Bondarenko reflects 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 0.064% 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. Kobyschka 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).

Behavioral factors also argue against the likelihood of a stable epidemic in Ukraine. In a study of female sex workers (FSWs) in Odessa conducted in 1997 and 1999, the percentage of FSWs reporting always using condoms declined (from 49% to 40% in 1999). A 1999 national reproductive health survey found that 27% of women reported condom use at the time of first sexual experience. While the recent attempt 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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Raising awareness of UK GUM clinic activities

In their recent letter on the sexual health issues which face performers in the adult entertainment industry, Gabrielson and Barston highlight the current lack of coherent sexual health infrastructure for this population in the United Kingdom. The work of AIM, the Association of Independent Magazines, in collaboration with the AIM Health Care Foundation in the United States, is a valuable model which identifies the unique sexual health requirements of adult industry workers. By providing specialist care for the performers, AIM provides advice and information to a group whose specific needs have been globally poorly addressed. Evidence of this is provided by the large number of performers who choose to access AIM Health Care for their HIV tests in the United States.

In the United Kingdom this would also seem to be the case, as the few adult performers who have any form of STI screening also prefer to use the facilities of private clinics. The role of GUM clinics stretches beyond an examining role in the diagnosis of genital Chlamydia trachomatis infection in women to be a GP role, while 60.7% considered that partner notification is not a role of the GP. 90.5% of respondents thought that one or more patients had had a positive test at the practice in the preceding year. Among GPs who had recently been involved in managing chlamydia, 82.5% always or sometimes managed the patient wholly within primary care; 70.1% said they “always” or “sometimes” managed partners. However, responsibility for ensuring this happened was generally devolved to the patient, since 73.8% “always,” and 22.5% “sometimes” dealt with partner notification by telling the patient to get the partner treated.

GPs appeared to be well aware of the importance of contact tracing. Respondents were asked to state difficulties in managing chlamydia in free text form. Of 200 GPs stating one or more difficulties, 76.5% mentioned partner notification. Other problems commonly cited were follow up or compliance (21.5%), explanation, supporting relationships and counselling (17.5% of respondents), perceived inadequacies of tests, mainly poor sensitivity and invasiveness (12.5%), and the diagnosis of coexisting infections (10.5%).

The majority of GPs (69.9%) would treat with an appropriate antibiotic of equal or greater dose and duration than that currently recommended by the Central Audit Group for

Table 1 Prevalence of HIV among injecting drug users, 2000

<table>
<thead>
<tr>
<th>Site</th>
<th>HIV prevalence (%)</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poltava</td>
<td>41.7</td>
<td>259</td>
</tr>
<tr>
<td>Donetsk</td>
<td>39.7</td>
<td>252</td>
</tr>
<tr>
<td>Kryvyi Rig</td>
<td>28.1</td>
<td>249</td>
</tr>
<tr>
<td>Odessa</td>
<td>64.0</td>
<td>293</td>
</tr>
<tr>
<td>Simferopol</td>
<td>27.2</td>
<td>261</td>
</tr>
<tr>
<td>Khariv</td>
<td>17.8</td>
<td>170</td>
</tr>
</tbody>
</table>

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 likely to be caused by the human papillomavirus in the keratinocytes, effective immune response in individuals with persistence and recurrence of warts, and the lack of specific antiviral therapy. Various treatments tried in the management of genital warts are topical podophyllin, podophyllotoxin, cryotherapy, electrosurgery, chemical cautery, carbon dioxide laser, 5-fluorouracil cream, topical imiquimod cream, and intralesional interferon. We wish to highlight the role of circumcision in extensive genital warts involving prepuce, which were refractory to the conventional treatment. A 50-year-old patient presented to us with genital warts for duration of 4 years. On examination, lesions were in the form of sessile, filiform, and papular keratotic verrucous lesions present involving both outer and undersurface of almost whole of the prepuce (Fig 1). These lesions were treated by us and in the past by various doctors with topical podophyllin, trichloroacetic acid cautery, electrosurgery, etc, for periods ranging from weeks to months with only minimal response, with the lesions coming back. The patient had some difficulty in retraction of the prepuce and was psychologically disturbed. The patient otherwise was healthy with no evidence of any other disease. Considering the extensive in-solvent of prepuce and refractory nature to various treatments, circumcision was performed. Histopathological examination of the excised tissue showed changes consistent with warts without any cellular atypia. Surgical wound healed well in a week with no complications.

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 prepuval 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 men are 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.1

Substantive evidence supports the premise that circumcision protects males from HIV infection, penile carcinoma, sexually transmitted 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 prepuval 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 without any 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
Australasian Sexual Health Conference: Tango down South—2003!

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


7th European Society of Contraception Seminar


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).
Treatment of *Candida glabrata* using topical amphotericin B and flucytosine

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