A case of a false positive result on a home HIV test kit obtained on the internet

There are two major reasons to diagnose asymptomatic HIV infection: to facilitate timely initiation of antiretroviral therapy, and to reduce the chance of onward transmission. A negative test offers an opportunity for preventive health promotion. All these aspects of testing require follow up by suitably trained personnel. We describe a case illustrating the hazards of self testing for HIV.

A 31 year old British heterosexual man attended the genitourinary medicine clinic requesting an HIV test. His last sexual contact was 3 weeks earlier with a female partner of 3 months. He had recently learnt that he had had a previous male partner who had had African sexual partners and therefore may be at higher risk of having HIV infection. He obtained a home HIV test kit (‘‘Discreet’’ HIV Home Test Kit, Seville Marketing Ltd) from a Canadian based internet site and this result was positive. On further inquiry he gave a history of sore throat and swollen cervical lymph nodes 2 months previously, although these symptoms had largely resolved. He had never tested for HIV before and had no other significant risk factors.

We requested an HIV test on the patient; the result was negative. We repeated the test after 3 months and again it was negative, confirming that the patient was not infected at the time he performed the home HIV test. The current HIV screening test used by our centre uses both HIV antibody and p24 antigen detection and is known to detect HIV infection 3–12 weeks after infection. Given that he was now symptom free with no further investigations were ordered. He became symptom free and HIV infection 3–12 weeks after infection.

Case 1

A 39 year old homosexual man presented to the accident and emergency department with fever, ulcerative gingivitis, and maculopapular rash, claiming to have been diagnosed as HIV positive 4 years previously. He reported safe sex with 30 casual male partners in the previous 2 years at this hospital and numerous negative HIV tests at other hospitals. The patients claimed to have chronic HIV infection 3–12 weeks after infection.

Inaccurate results: after 15 minutes, 59.3% of the kits gave inaccurate results. Moreover, the kits showed both inaccurate HIV positive results and inaccurate HIV negative results.1

This case is important because the use of the internet to obtain HIV test kits is likely to increase. One study in California found fairly high levels of interest in instant home HIV tests2 and it is not difficult to locate kits for HIV testing and other diagnostic services on the internet. A home HIV test kit using oral fluid has been licensed in the United States and a home blood collection and telemedicine system is also available,3 but these are not available legally in the United Kingdom or Europe. All healthcare professionals involved in counselling and testing patients for HIV should be aware that self taken HIV tests may be inaccurate and confirmatory testing in an appropriate laboratory should be performed before making a diagnosis of HIV infection.

Although access problems to sexual health services have rightly engendered innovative approaches to diagnosis and management, there should be a note of caution on using new HIV technologies of rapid testing in non-healthcare settings and legalisation of home and over the counter HIV testing kits.4 It is imperative that clinical governance issues are addressed. Medical consequences are important, but of greater significance is the distress to individuals and their partners who are wrongly diagnosed or inappropriately reassured through the use of poorly performing kits.

Contributors

LJ saw the patient before and after testing and wrote the case report; AR suggested the case be reported and reviewed/redrafted the manuscript.

Acknowledgements

Jane Sudlow counselled the patient and commented on the case. Julian Tang provided advice on HIV testing and confirmation.

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Ethics: A signed statement of consent to publish was obtained from the patient.

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There are no conflicts of interest.

References


Primary HIV infection masquerading as Munchausen's syndrome

Since 1986 there have been several case reports describing factitious HIV infection.1 We have seen two acute presentations where the patients claimed to have chronic HIV infection, were found to be HIV antibody negative but on closer evaluation were found to be seroconverting with primary HIV infection (PHI). We believe that the patients were motivated by the psychological need to assume the sick role, fulfilling the principal feature of a factitious disorder, rather than malingering.

Case 1

A 40 year old homosexual man presented to HIV services with an acute diarrheal illness, claiming to have been diagnosed as HIV positive at another hospital 2 years previously. A third generation HIV test, Abbott AXSYM HIV 1/2 gO (antibody only), was negative. He returned 1 month later, still denying any sexual risk, and requested a repeat HIV test, which was again antibody negative but reactive with the fourth generation assay, Abbott HIV Ag/Ab Combo (antibody and p24 antigen combined).

Case 2

A 39 year old homosexual man presented to the accident and emergency department with fever, ulcerative gingivitis, and maculopapular rash, claiming to have been diagnosed HIV positive 4 years previously. He reported safe sex with 30 casual male partners in the previous 3 months and stated that his regular male partner was HIV negative. He was found to have had four negative HIV tests in the previous 2 years at this hospital and numerous negative HIV tests at other hospitals. The third generation HIV test was negative. The following day, however, a fourth generation test was reactive.

Comment

The ability to diagnose PHI has always required a high index of suspicion and a keenly taken history, and if missed the next opportunity for testing may not be until years later when the patient presents in ill health, with symptomatic HIV or even AIDS.2 Clearly, the missed diagnosis of PHI may have a deleterious effect on the individual’s prognosis, but there may also be significant public health consequences, as early infection is a core factor in the propagation of an epidemic.2 Because of high viral burden and decrease in risk taking sexual behaviour. Indeed, early detection of PHI probably represents the
single most important method of slowing the spread of HIV within populations, with mathematical modelling indicating that eliminating high infectivity in early infection has more effect than at any other disease stage. Thus, the diagnosis of PHI at high-risk individuals has considerable advantages in both individual and public health terms. These two cases demonstrate how easy it can be to disregard such patients as having factitious HIV infection and are a gentle reminder that a negative antibody test does not necessarily exclude PHI. Healthcare providers must continue to be alert to the less common clinical manifestations of PHI, be aware of the particular assays used in their own laboratory, and because no combination of symptoms is 100% sensitive or specific, diagnostic procedure must be broad and inclusive.

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References

Chlamydia trachomatis PCR positivity and inflammatory changes on cervical cytology

The presence of genital infection does not increase the likelihood of an inadequate Papanicolaou (Pap) test. Conversely, testing for Chlamydia trachomatis at the time of routine cytological screening presents an opportunity to detect asymptomatic genital tract infection. The PreservCyt fixative fluid (Cytology Corporation, Boxborough. MA, USA) used for the ThinPrep Pap test (Cytology Corporation) can be used for detection by the polymerase chain reaction (PCR) of C. trachomatis. This presents an opportunity to study the correlation between the chlamydia result and the Pap test finding.

We retrospectively reviewed all routine requests for chlamydia PCR in ThinPrep samples sent to our laboratory over a year. Data were collected on the woman's age, chlamydia PCR result, result of genital tract cultures if performed on the same date, and Pap test result. Data on the Pap test result included presence or absence of an epithelial cell abnormality either high grade (HGEA) or low grade (LGEA), whether the Pap was inflammatory and the presence or absence of the co-infecting pathogens. Cervical PCRs collected in PreservCyt transport medium were processed for C. trachomatis using the automated Cobas Amplicor (Roche Diagnostic Systems) and the method by Bian et al. Over the study period, 733 samples were received, of which 23 (3.1%) had C trachomatis DNA detected by PCR. Comparison of the women with chlamydia infection/index with those without chlamydia infection is shown in table 1. There was no statistical difference in the presence of high or low grade epithelial abnormalities, recognition of other pathogens, or age of the women; however, 26% of women with chlamydia had an inflammatory Pap test compared to 9% of women without chlamydia (p<0.01).

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References
1 What Medicine. CAM on the up as more people look for an alternative (www.whatmedicine.co.uk/articlesCompMed.htm).
The association of inflammation on Pap testing and chlamydial infection has been previously examined with variable methodologies and findings. We utilised the same sample (ThinPrep) for determining both the presence of inflammatory changes on Pap test and chlamydial infection and found a positive association between the two despite a low prevalence population. Our study confirms the feasibility of performing chlamydia PCR from liquid based cytology samples in a routine diagnostic setting. Testing for chlamydia should be considered in women with inflammatory Pap tests for which there is no other explanation.

### Table 1

<table>
<thead>
<tr>
<th></th>
<th>Positive C trachomatis</th>
<th>Negative C trachomatis</th>
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</thead>
<tbody>
<tr>
<td>PCR</td>
<td>24 (range 19–40)</td>
<td>28 (range 15–68)</td>
</tr>
<tr>
<td>p Value</td>
<td>0.182</td>
<td>0.012</td>
</tr>
<tr>
<td>LGEA/HGEA</td>
<td>5 (22%)</td>
<td>106 (15%)</td>
</tr>
<tr>
<td>Other pathogens</td>
<td>1 (17%)</td>
<td>12 (18%)</td>
</tr>
<tr>
<td>Inflammation on Pap test</td>
<td>6 (26%)</td>
<td>65 (94%)</td>
</tr>
<tr>
<td>LGEA, low grade epithelial abnormalities; HGEA, high grade epithelial abnormalities.</td>
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</tbody>
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The mean duration of diagnosing cardiovascular syphilis from the time of acquiring syphilis was 40 months (27 and 53) in the HIV seropositive group and 102 months (46 and 120) in the HIV seronegative group. The mean age of the HIV seropositive individuals who had cardiovascular syphilis was 40 months (27 and 53) in the HIV seropositive group and 102 months (46 and 120) in the HIV seronegative group. The mean age of the HIV seropositive individuals who had cardiovascular syphilis was 40 months (27 and 53) in the HIV seropositive group and 102 months (46 and 120) in the HIV seronegative group.

### References


### Cardiovascular syphilis in HIV infection: a case-control study at the Institute of Sexually Transmitted Diseases, Chennai, India

It is known that HIV co-infection with syphilis may accelerate the onset of gummat and neurosyphilis and increase their severity. However, this has only been reported for cardiovascular syphilis in two previous cases.

This case-control study deals with a total of 14 HIV seropositive and 100 HIV 1 and 2 seronegative individuals with syphilis, who were seen in our clinic between June 2000 and May 2001. Of the 14 HIV seropositive individuals, 12 were reactive for VDRL (venereal disease reference laboratory) and TPHA (Treponema pallidum haemagglutination assay) and two had primary syphilis confirmed by dark field examination for T pallidum. Of the 100 HIV seronegative individuals, 85 had reactive VDRL and TPHA and 15 had primary syphilis confirmed by dark field examination. The prevalence of cardiovascular syphilis in the HIV seropositive and seronegative groups was 14.3% and 2%, respectively (OR 8.2; 95% CI 1.1 to 61.5).

Two HIV seropositive individuals with cardiovascular syphilis had aortic root dilatation while the two HIV seronegative individuals had aortic aneurysm. The HIV seropositive individuals were asymptomatic with regard to cardiac status but one HIV seronegative individual had chest pain and the other was asymmetric. None in the HIV seropositive group had aortic root dilatation (p<0.01). There was a theoretical possibility that aortic root dilatation could be a manifestation of HIV or opportunistic infections involving the heart. A parallel study done on cardiovascular involvement in HIV seropositive individuals from the same institute during the same time interval had revealed that none of the 61 non-syphilitic HIV seropositive individuals had aortic root dilatation, compared with 2 out of 14 with syphilis (p<0.01; paper in preparation).

The mean duration of diagnosing cardiovascular syphilis from the time of acquiring syphilis was 40 months (27 and 53) in the HIV seropositive group and 102 months (46 and 120) in the HIV seronegative group. The mean age of the HIV seropositive individuals who had cardiovascular syphilis was 31.5 years (29 and 34) and that of HIV seronegative individuals was 43.5 years (44 and 47).

The shorter duration for diagnosing cardiovascular syphilis in HIV seropositive group was 40 months (27 and 53) compared with 45 months (46 and 120) in the HIV seronegative group. The mean age of the HIV seropositive individuals who had cardiovascular syphilis was 31.5 years (29 and 34) and that of HIV seronegative individuals was 43.5 years (44 and 47).

The drugs were apparently prescribed by a doctor in Nigeria at the cost of about US$250 for six sachets and the pharmacist dispensing them had been asking why the girls were taking them. Apparently the sachets did not come with any leaflets or drug information inserts.

My patient and her friends appeared to be totally unaware of the fact that the combivir had been prescribed by a drug in Nigeria at the cost of about US$250 for six sachets and the pharmacist dispensing them had been asking why the girls were taking them. Apparently the sachets did not come with any leaflets or drug information inserts. My patient and her friends appeared to be totally unaware of the fact that the combivir was being prescribed by a drug in Nigeria at the cost of about US$250 for six sachets and the pharmacist dispensing them had been asking why the girls were taking them. Apparently the sachets did not come with any leaflets or drug information inserts.
NNRTIs was only confirmed after weeks of unsuccessful therapy by further resistance testing.

My patient has alerted all her friends in Nigeria as to the real nature of combivir and advised them to stop using it for breast enhancement. She has also told me that she believes the doctor in Nigeria who prescribed these drugs may have had this activity terminated.

Because no one I have spoken to has come across this particular misuse of antiretroviral therapy I felt it was worth highlighting to a wider audience in the hope that such practises may be addressed.

Acknowledgements
This patient has agreed to publish details of her case to help prevent recurrent misuse of this drug.

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CORRECTION

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The order of the authors of the paper by Götz et al on page 24 of the February 2005 issue (HM Götz et al. A prediction rule for selective screening of Chlamydia trachomatis infection. Sex Transm Infect 2005;81:24–30) were wrong. The order should have been as follows: HM Götz, JEAM van Bergen, IK Veldhuizen, J Broer, CJPA Hoebe, EW Steyerberg, AJJ Coenen, F de Groot, MJC Verhooren, DT van Schaik, and JH Richardus.
Cardiovascular syphilis in HIV infection: a case-control study at the Institute of Sexually Transmitted Diseases, Chennai, India

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