
LETTERS TO THE EDITOR

Syphilis and HIV infection

In 1990, of 29 patients presenting with syphilis, to the General Dermatological Department in Barcelona, 10 were also seropositive for HIV. Eight patients were men. Seven were black West African immigrants, and the remainder were white local residents. The main risk factor for HIV infection among the white patients was the use of parenteral heroin, whereas among the African patients it was sexual intercourse with local prostitutes. Early syphilis (primary or secondary stages) was present in four patients; the other six had latent or late syphilis. Follow up studies in two patients disclosed abnormalities, three patients had no clinical signs and the CSF examination was normal, and the other five were lost. One patient suffered from right hemiparesis and irritability. Physical examination revealed brown macular lesions in the palms and soles, but no fever or meningeal symptoms. CT disclosed small temporal infarcts in the left hemisphere. This patient had received 7.2 megaunits of benzathine-penicillin 18 months previously as a treatment for a secondary syphilis. The RPR titres, which had been negative after therapy, reached a value of 1/64, and the titre of TPHA was 1/80. CSF examination disclosed high protein levels, mononuclear pleocytosis, decreased glucose levels and positive VDRL. The patient was then treated with intravenous crystalline penicillin G, 4 megaunits every 4 h for 14 days. After this time the neurological symptoms had disappeared and the routine CSF examination was normal. The VDRL was negative 40 days later. The other patient had no clinical signs of neurological disease, but increased protein levels, increased mononuclear cells and decreased glucose levels in the CSF, together with an increased titre of RPR (1/64) and TPHA (1/2560) in the serum. The patient had been treated with 2.4 megaunits of benzathine-penicillin six months before in the course of primary syphilis. At that time he had been discovered to be seropositive for HIV. These observations further emphasise the high incidence of syphilis and concomitant HIV infection, as well as the failure of recommended doses of penicillin in the treatment of syphilis in patients additionally infected with HIV.¹⁻³ It is suggested, therefore, that higher and prolonged doses of peni-

cillin should be considered in the treatment of these patients.

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Rising incidence of genital herpes in an STD clinic in North India

In the light of the changing epidemiology of sexually transmitted diseases, we would like to share our experience, especially about genital herpes in the STD clinic situated in an urban town in India (population 600 000). While the bacterial STDs (syphilis, gonorrhoea, chancroid) continue to be a major public health problem in this region, genital herpes is now rapidly emerging as another. The recognition, in recent years, that genital ulcer disease especially genital herpes, may be a marker of underlying HIV infection¹ adds significance to this disease. In addition, unlike the bacterial STDs, this disease is difficult to treat and control. In the pre AIDS era in India, before 1986, an average of 15.5 cases/year were seen in our clinic. Subsequently, from 1986-90, an average of 34 cases/year were seen. We found that whereas in 1977, only 12 new cases of genital herpes were recorded in our clinic, this had risen to 44 new patients in 1990. These figures, though small, reflect almost a four fold rise in genital herpes in 13 years.

Similar trends have been reported from Western countries. In the UK, 7547 cases were seen in 1976 in STD clinics, which increased to 17 966 cases in 1987.²

The Center for Disease Control has estimated that on an average there are between 200 000 and 500 000 new cases of herpes each year in the USA. The same is true of the trend in South East Asia.³ In our