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 penicillin 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
population in spite of the rather small and hetero-
genous material examined we find that the trends are parallel to those seen elsewhere indicating the global nature of the current herpes pandemic. The fact that most other STDs especially the bacterial ones are treated at the primary level by virtue of the large number of currently available antibiotics, all easily available over the counter, herpes is likely to remain a major public health problem. Geographic and socio-economic influences as stated by Guinan et al do not seem to play such a role in our population. Asympto-
matic infection plays a major role in maintaining viral circulation in society, while the sexual activity, age at first intercourse and type of contraceptives used may influence the risk of acquisition. These factors have to be borne in mind when developing an effective control programme. At present there is no such programme on a national scale for herpes but judging from the trends projected, it may very soon become a necessity.

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2 Adler MW. Epidemiology of STDs in the west. Sem Dermatol
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 Screening for Chlamydia trachomatis in a
Turkish population

In the last few years Chlamydia trachomatis has been
recognised as one of the most important sexually
transmitted pathogens. Genital infections due to this
organism present a major world-wide public health
problem.

We evaluated 93 out of 100 endocervical specimens
obtained from nonpregnant women in their first visit
to the gynaecology out-patient clinic in the Ege
University Hospital, irrespective of their reason for
attendance. The patient group consisted of both
symptomatic and asymptomatic patients. The
patients were grouped according to their ages, sub-
jective symptoms and cervical lesions. Specimens
were tested by a commercially available direct
immunofluorescence test kit (Chlamyset, Orion
Diagnostica, Finland). Specimens were considered
positive if ten or more fluorescing elementary bodies
were seen. The overall positivity rate was 34.4% (32/
93). The results are shown in the table.

| Table  The rates of genital chlamydial infection in different
patient groups |
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<td>Groups</td>
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<td>Age (years)</td>
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<td>30-40</td>
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<td>Symptoms and signs</td>
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<td>Group II†</td>
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<td>Group III‡</td>
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<td>Total</td>
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*Patients with only subjective symptoms.
†Patients with subjective symptoms plus cervical lesions.
‡Asymptomatic patients.

Tissue culture is considered as the "gold stand-
ard" in the diagnosis of chlamydial infections. Since
tissue culture techniques are not practical for
most clinical laboratories, non-culture antigen
detection tests have become available and widely used.
Direct fluorescent antibody (DFA) is one of these
tests and its advantages over tissue culture are that it
does not require a transport system, can detect both
dead and live organisms, makes it possible to assess
the specimen adequacy, is less expensive, and the
results are available days earlier. The sensitivity
and specificity of the DFA test are in the range of 50-
96%, and 94-96% respectively. Therefore, it is
recommended as an alternative to the tissue culture in
high risk populations.

In this study we used the DFA test for screening,
since our laboratory facilities were very limited for
tissue culture.

The overall infection rate was 34.4% in our study.
Similar percentages have been reported in previous
studies using similar techniques. Our highest
positivity rate was found in the 30-40 age group
(39.6%). Although chlamydial infections are known
as the most prevalent venereal disease in adolescents
and young women at child bearing age, this is not
true for the Turkish female population, because
sexual activity usually begins with marriage and the
marriage age has risen (> 25) in the past few years,
especially in the cities. Although genital chlamydial
infections are reported to be associated with clinical
signs and symptoms, they may also show an asympto-
matic course. In some studies, the positivity rates
in symptomatic women were found to be significantly
higher than the control groups. In contrast, there
have also been studies in which no significant dif-
fERENCE between symptomatic and asymptomatic
women has been found. In our study, there was no
statistically significant difference between the
positivity rates of the three patient groups shown in
the table. Although the number of patients in the