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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.\(^1\) Normally, a classic Hunterian chancre heals within 2 weeks without scarring.\(^2\) Primary chancre, healing with perforation of the site, does not commonly occur.\(^3\) 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 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 titre was 1:64. Following penicillin therapy, it healed with perforation of the prepuce.

Case 2

A 20 year old unmarried male patient with high risk behaviour presented with a painless indurated ulcer over the dorsal aspect of the prepuce and unilateral inguinal lymphadenopathy. DGI was positive for Treponema pallidum and VDRL titre was 1:64. Following treatment with penicillin, the ulcer healed slowly, leaving a perforation on the labia majora.

Case 3

A 23 year old unmarried man, with a history of repeated unprotected exposure to commercial sex workers, presented with a painless, indurated ulcer on the dorsal prepuce, multiple genital mollusca contagiosa, and genital warts.

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 had a history of genital ulceration and was treated for suspected lymphogranuloma venereum. Following treatment with penicillin, the ulcer healed at a slower pace leaving a large perforation on the prepuce (fig 1).

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.\(^7\) In an immunocompetent host with primary syphils, 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.\(^4\)

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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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.

Figure 1 Perforation of prepuce.

References


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Superior mesenteric artery syndrome in an HIV positive patient

A 27 year old HIV positive man with a CD4+ lymphocyte count of 26 cells x10⁹/l presented with a 2 week history of progressive left sided weakness, vomiting, and weight loss. A computed tomography (CT) brain scan demonstrated ring lesions bilaterally in the basal ganglia. Toxoplasma serology was positive at a titre of 1:256 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 jejunum 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...
or nasogastric decompression is often difficult because of severe gastric dilatation. Duodenojjunostomy or gastrojejunoanastomosis are the surgical procedures of choice when medical therapy fails.2 6 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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References

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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 selected populations and through clinic based-case-control studies. (The virtual absence of trichomoniasis in urban Australia means that this work must be performed in other populations). If the prevalence of T vagi-

nal is related to Pap screening, a simple approach to chlamydia control—that is, routinely linking nucleic acid amplification testing for Chlamydia with the Pap smear, could also be considered.

Conflict of interest: None.

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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 Infections1 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
epidemic in Russia of between 6–11% by 2010, and the potential for economic decline and geopolitical instability: HIV trends in Russia in terms of controlling the HIV 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’s re-study in 1999 may not reflect the current status of the epidemic 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. Kobyschà 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 condom declined from 49% to 40%. A 1999 national reproductive health survey found that 27% of women reported condom use at last intercourse, but 8.1% of women reported being infected with HIV. 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.

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 authenticating agency for HIV certification, which should not be allowed to become the primary reason for contact between performers and GUM staff. Stronger emphasis needs to be placed on re-education within the UK industry to highlight the need for regular STI screening, health education and promotion. Especially since performers have any form of regular STI screening either in their public or private lives. We believe that it may be helpful to raise awareness of services offered by modern GUM clinics in the United Kingdom, by training and targeted information for adult performers.

By taking control of sexual health the industry will not only have healthy performers but will also provide the viewing public with a safer sex message that is portrayed in an entertaining, safe and non-threatening manner. Therefore, bearing in mind the complexities facing performers, the adult entertainment industry should be commenced for working with core HIV/GUM services and piloting a study into the sexual health of adult performers. It will be of particular interest to see whether sexual health care can be provided for this group within the bounds of the NHS or whether they, like their American counterparts, will choose to rely on private clinics to provide them with care and information.

In the past decade, chlamydia tests have become increasingly available in primary care, and many female patients are now diagnosed and treated in this setting. The lack of skills and resources for partner notification in primary care is now a matter of public health concern. We undertook a study in three districts in order to explore their current practice and attitudes in relation to partner notification and treatment.

Partner notification in primary care

In their recent letter on the sexual health issues which face performers in the adult entertainment industry, Gabrielsen and Barton highlight the current lack of coherent sexual health infrastructure for this population in the United Kingdom. The work of 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.

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Accepted for publication 16 December 2002

Raising awareness of UK GUM clinic activities

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Partner notification in primary care

In the past decade, chlamydia tests have become increasingly available in primary care, and many female patients are now diagnosed and treated in this setting. The lack of skills and resources for partner notification in primary care is now a matter of public health concern. We undertook a study in three districts in order to explore their current practice and attitudes in relation to partner notification and treatment.

All GPs in the North East Health District (n=367), and GPs recruited for the Chlamydia Partnership Project in north London (n=65) (a randomised trial of health adviser led partner notification for primary care patients) were invited to complete a short questionnaire. The response rate was 56%.

Of the 242 respondents, 86% considered testing for 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 patients. 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 contact tracing. Other problems commonly cited were follow up or compliance (21.5%), inadequacies of tests, mainly poor sensitivity (10.5%), 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
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 refractory to available therapies. Many patients have had multiple treatments and are left with substantial anxiety in the sexual partner. The psychological and sexual discomforts for the patients and their partners with recurrent/persistent extensive preputial warts, circumcision should be tried.

Treatment of Candida glabrata using topical amphotericin B and flucytosine

We read with interest the article by White and colleagues on the treatment of Candida glabrata using topical amphotericin B and flucytosine because this infection can prove difficult to treat. We have since used this treatment on a 28-year-old woman with a 10-year history of recurrent candidiasis.

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 refered to continue with nystatin pessaries for another 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
vagina for 28 nights. After this course of treatment she remained asymptomatic and positive on culture for C. glabrata. Following the success with topical fluconazole and amphotericin B in the above article our pharmacist obtained this preparation. The patient was given amphotericin 100 mg plus fluconazole 1 g in Aquagel in a total 8 g dose, which was given by vaginal applicator nightly for 14 nights. She was reviewed 2 and 6 weeks after finishing treatment, her symptoms had greatly improved and cultures for yeast were negative on both occasions.

White's paper described the successful treatment of three patients with candidiasis using topical amphotericin B and fluconazole. Our patient makes up the fourth case of successful eradication of refractory vaginal C. glabrata using this combination which, like the other cases, was very well tolerated.

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 for 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. Which leads to my final criticism before summing up—the index is entirely inadequate and mitigates strongly against using this as a book of reference.

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 a good review of the major issues, and mitigates strongly against using this as a book of reference.

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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

BOOK REVIEW


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 the 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.

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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, regional 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!


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, 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).