If you have a burning desire to respond to a paper published in Sex Transm Infect, why not make use of our “eLetters” option?

Log on to the STI website (www.stijournal.com), find the paper that interests you, click on [Abstract] or [Full text] and send your electronic response by clicking on “eLetters submit a response”.

As before, the editors will decided whether to publish the eLetter in a future print issue.

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 1–2 weeks of treatment 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 painless, indurated ulcer over the dorsal aspect of the left labia majora, along with same sided inguinal lymphadenopathy of 1 week’s duration. Dark ground microscopy (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 2

A 20 year old unmarried male patient with high risk behaviour presented with a painless indurated ulcer on the dorsal aspect of the prepuce and unilateral inguinal lymphadenopathy. DGI was positive for T pallidum and VDRL titre was 1:32. 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).

Case 3

A 20 year old unmarried male patient with high risk behaviour presented with a painless, indurated ulcer over the dorsal aspect of the prepuce, multiple genital mollusca contagiosa, and genital warts.

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.8

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.

A C Inamadar, A Palit
Department of Dermatology, Venereology and Leprology, BLDCA’S Shri BM Patil Medical College, Hospital and Research Centre, Bijapur, Karnataka, India

Correspondence to: Dr Anu C Inamadar;
Aparun1@rediffmail.com

References


Accepted for publication 10 October 2002

Superior mesenteric artery syndrome in an HIV positive patient

A 27 year old HIV positive man with a CD4+ lymphocyte count of 26 cells x10^3/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

Figure 1 Perforation of prepucce.

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 prepucce.

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 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

Figure 1 Image from barium meal series. The proximal duodenum is dilated. There is an abrupt calibre change (arrow) in the third part where the superior mesenteric artery crosses. Distinct peristalsis was seen in this region during the study.
or nasogastric decompression is often difficult because of severe gastric dilatation. Duodenjejunalostomy or gastrojejunostomy 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.

R Stümple, A R Wright, J Walsh
St Mary’s Hospital, Praed Street, London W2 1NY, UK

Correspondence to: Dr Richard Stümple, Department of Anaesthetics, Northwick Park Hospital, Watford Road, Harrow, Middlesex HA1 3UJ, UK; rstemple@doctors.net.uk

Figure 2 Multislice CT with intravenous contrast medium: sagittal reconstruction through mid-abdomen. The angle between the superior mesenteric artery and the aorta is reduced causing compression of the duodenum [arrow]. Note grossly distended stomach anteriorly.

12 and total parenteral nutrition was introduced for 6 weeks after which an exploratory laparotomy was performed. An anterior gastrojejunostomy was made and a jejunal feeding tube inserted into the collapsed proximal small bowel. The patient recovered postoperatively and was discharged to a ward after 6 weeks. 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 Rokitskian in 1842, frequency of reports have recently declined and its existence debated.1 The syndrome has been ascribed to a reduction in the angle between the aorta and the superior mesenteric artery, scissoring the duodenum in its third part causing obstruction. This is often because of sudden, severe weight loss resulting in a reduction of mesenteric and retroperitoneal fat. Precipitating 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.2 It has not previously been reported in AIDS.

Characteristic symptoms, typically intermitting in nature, comprise bloating, nausea, and intractable biliary 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 investigation.3 CT studies can demonstrate reduction in the aortomesenteric mesenteric artery angle and intractable bilious vomiting relieved by adopting the prone or knee to chest position. In the absence of any health promotional activities relating to trichomoniasis and in a study in Brazil found similar results (a peak of 17.3% in 1978, falling to 3.4% in 1998).4 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 another part of the duodenum. Clin Radiol 1982;33:75–81. 2 Hines JR, Gore RM, Ballanyne GH. Superior mesenteric artery syndrome. Diagnostic criteria and surgical approaches. Am J Surg 1984;148:630–2. 3 Lundell L, Thulin A, Wilkie’s syndrome—a rarity? Br J Surg 1980;67:604–8. 4 Konen E, Amati M, Aipler S, et al. Angiography of superior mesenteric artery syndrome. Am J Roentgenol 1998;171:1279–81. Accepted for publication 16 December 2002

References

Was the Papanicolaou smear responsible for the decline of Trichomonas vaginalis?


Conflict of interest: None.

F J Bowden
Australian National University and Canberra Sexual Health Centre, PO Box 11, Woden ACT, Australia 2605, frank.bowden@act.gov.au

References

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
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, political 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 might need to reflect 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 acknowledged use 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. Kobyshev and colleagues 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).

Behavioural 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 increased (from 49% to 40%) between 1997 and 1999. A national survey of FSWs in Ukraine in 1999 found that 27% of women reported condom use at the time of first sexual experience.1 Recent data presented by Bondarenko et al. indicate 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.

J J Amon
Department of Preventive Medicine and Biometrics, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, MD 20814, USA; joe.j.amon@yahoo.com

References

Accepted for publication 16 December 2002

Raising awareness of UK GUM clinic activities

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.1

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.2 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 skilled performers have any form of regular STI screening either in their public or private lives.3 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 commended 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 whatever they, like their American counterparts, will choose to rely on private clinics to provide them with care and information.

D Cawley, R Wandnani
The Sandford Initiative, Glasgow, UK
Correspondence to: Declan.Cawley@gacomen.scot.nhs.uk

Partner notification in primary care

In the past decade chlamydia tests have become more widely available in primary care, and many female patients are now diagnosed and treated in this setting.3 The lack of skills and resources for partner notification in primary care is now a matter of public health concern.4 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 Nottingham 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 responders, 86% considered testing for genital Chlamydia trachomatis infection in women to be a GP role, while 60.7% considered that partner notification was also 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.

All 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%), explanation, supporting relationships and counselling (17.3% 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
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 arise from the defective 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 intraluminal 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, filliform, 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, trichloracetic 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 other disease. Considering the extensive involvement 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. However, circumcision for extensive prepuital 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 male population are circumcised for religious, cultural, medical, or parental choice reasons. However, controversies surround its benefits and protective effects against STDs. For genital warts, one study has reported a significant association with the lack of circumcision.

Substantive evidence supports the premise that circumcision protects males from HIV infection, human papillomavirus, and other genitourinary tract infections, and ulcerative STDs. 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 preputial warts, circumcision should be tried.

S Dogra, B Kumar
Department of Dermatology, Venerology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh, India

Correspondence to: Professor Bhushan Kumar, Department of Dermatology Venerology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh 160 012, India; kumarbhushan@hotmail.com

References
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.

So 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 an introduction to the field of immunotherapy which is both accessible and enjoyable. Read it within the next couple of years before it begins to date further and it will be time well invested. For a specialist in the field it has limited value, except to recommend to trainees or newcomers.

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 this 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. 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.

So 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 an introduction to the field of immunotherapy which is both accessible and enjoyable. Read it within the next couple of years before it begins to date further and it will be time well invested. For a specialist in the field it has limited value, except to recommend to trainees or newcomers.

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

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!

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: esccentraloffice@contraception-esc.com; website: www.contraception-esc.com).