Perforating chancre: any cause-effect relation with HIV infection?

Variation in clinical pictures of syphilis, when co-infected with HIV are well known. Normally, a classic Hunterian chancre heals within 1–2 weeks of treatment without scarring. Primary chancre, healing with perforation of the site, does not commonly occur. 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 sequel.

Case 1
A 21 year old woman presented with a 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 over 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 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.

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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 ×10⁹/l presented with a 2 week history of progressive left sided weakness, vomiting, and weight loss. A computed tomograph (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 confirmed. Two litres of bile were aspirated per nasogastric tube daily and he continued to lose weight. His body mass index (BMI) fell to

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Figure 1 Perforation of prepuce.

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 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. Duodenoejunojejunostomy or gastrojejunostomy are the surgical procedures of choice when medical therapy fails.1,2 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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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.3 By 1998 less than 1% of non-Indigenous women presenting to family planning and STI clinics in another jurisdiction were diagnosed with the condition4 and most Australian urban pathology laboratories do not diagnose a case from one year to the next. Similar observations have been reported elsewhere: the rate of detection of trichomoniasis in Papanicolaou (Pap) smears in Denmark fell from 4% in 1965 to <2% in 1997,5 and a study in Brazil found similar results (a peak of 17.3% in 1978, falling to 3.4% in 1998).6

In the absence of any health promotional activities relating to trichomoniasis and in a setting where the prevalence of another STI, Chlamydia trachomatis, has shown a fourfold increase in notifications in the past 10 years (Communicable Diseases Network Australia, National Notifiable Diseases Surveillance System, personal communication), what can explain the decline and fall of T vaginalis?7 I propose that the change in prevalence is an unintended consequence of the introduction of coordinated Pap smear screening programmes in the 1970s and 1980s. As the Pap screening programmes gained momentum in the urban areas, a positive finding on the Pap smear, which has a sensitivity for the diagnosis of T vaginalis of around 50–60%, would have been conveyed to the referring medical practitioner who would treat the woman with metronidazole or tinidazole. In addition, the increasing use of these antibiotics for the treatment of other conditions, in particular bacterial vaginosis, may have further reduced the prevalence during the same period. As there are no cytological changes that are diagnostic of C. trachomatis, Pap screening would be expected to have no effect on chlamydia prevalence.

In Australian urban populations the proportion of women undergoing Pap screening in the 20–40 year age group is approximately 70%. On the other hand, in some remote Aboriginal populations the introduction of coordinated screening has lagged behind urban areas1 and trichomoniasis remains hyper endemic (prevalence of approximately 25%).8

(Of course these observations could be confounded by a number of factors: Pap screening rates correlate with socioeconomic status and the rate of partner change could be different between these groups. However, it has been shown that access to services is more important than differences in the rate of partner change when comparing STI rates in Indigenous and non-Indigenous populations in Australia.9)

The Pap smear hypothesis could be tested by correlating the prevalence of trichomoniasis with the rate of cervical cancer screening in selected populations and through clinical 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 vaginalis is related to Pap screening, a sliming approach to chlamydia control—that is, routinely linking nucleic acid amplification testing for C trachomatis 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 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, social and economic and sexual 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’s national reproductive health survey found that 27% of women reported condom use at the time of first sexual experience.

In their recent letter on the sexual health infrastructure for this population in the United Kingdom. AIM provides an authenticating agency for HIV certification, the role of GUM clinics stretches beyond an authenticating agency for HIV certification, 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. Kobysheva 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 condoms increased from 48% to 40% to 99% national reproductive health survey found that 27% of women reported condom use at the time of first sexual experience.

In the recent attempt to model the future course of the HIV/AIDS epidemic in Ukraine, developed 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.

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References

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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 Bar- ton 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. 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.

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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. The lack of skills and resources for partner notification in primary care is now a matter of public health concern. We undertook a postal survey 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 respondents, 86% considered testing for genital Chlamydia trachomatis infection in women to be a GP role, while 60.7% considered that partner notification was 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.

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

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Sex Transm Infect: first published as 10.1136/sti.79.3.265-a on 1 June 2003. Downloaded from http://sti.bmj.com/ on July 30, 2023 by guest. Protected by copyright.
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 patients are often depressed and have a poor quality of life, with significant psychological morbidity. Of the total genital warts, approximately 25% of the patients have no response to the conventional treatment. However, circumcision can be an effective procedure to treat these problems. In the management of genital warts, circumcision was performed after the conventional treatment failed. The patient was referred to the dermatologist, and circumcision was performed. The patient had complete resolution of the warts after circumcision.

Circumcision can be an effective procedure to treat genital warts. However, it is important to note that circumcision is a surgical procedure and has its own risks and complications. It is important to inform the patient about the risks and benefits of circumcision before performing the procedure. In conclusion, circumcision is an effective procedure to treat genital warts, and it should be considered as an option for patients who have failed to respond to conventional treatments. 

References


Figure 1. Circumcised prepuce studded with extensive warts.
vagina for 28 nights. After this course of treatment she remained symptomatic and positive on culture for *C. glabrata*. Following the success with topical flucytosine and amphotericin B in the above article our pharmacist obtained this preparation. The patient was given amphotericin 100 mg plus flucytosine 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 flucytosine. 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.

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**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 criticisms 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 ContraceptionSeminar**

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, Essensstraat 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).