Hepatitis B and C viral infections among STD clinic patients in India

While many studies from other countries have documented hepatitis B virus (HBV) and hepatitis C virus (HCV) infection rates in STD clinic patients, very few data are available from India. In the present report, we have analysed the rate of HBV and HCV infections in STD patients by using serological and molecular methods of diagnosis.

The study subjects were symptomatic STD patients (n = 143), who attended the STD clinic, Government General Hospital, Chennai, between September 1998 and August 2000, randomly included for a study on STDs after obtaining informed consent. Blood samples were evaluated for hepatitis B and HIV markers by ELISA kits; HBsAg, HBeAg/anti-HBe (Biorad laboratories, USA), anti-HCV (Murex Diagnostics, UK), anti-HIV 1 and 2 (Xyton Diagnostics, India). Anti-HIV positivity was confirmed by another ELISA kit (Sanofi Pasteur, France). Detection of HBV DNA and HCV RNA was performed by polymerase chain reaction (PCR)3 and RT-PCR methods.

The serological and molecular marker profile for HBV and HCV is shown in Table 1. HBsAg was positive in 37 (25.9%) patients, while HBV DNA was detected in 25 (67.6%) of them. HBV DNA was detected in 23 of 28 HBeAg positives and two of nine anti-HBe positive cases. The overall HBV positivity rate was 5.6%. Anti-HIV positivity was seen in 24 (16.8%) patients. Men had a significantly higher HBV positivity rate compared to women (27% (17/63) vs. 12% (9/70); p<0.05). HCV co-infection was observed in 5.6% of the HBV infected patients and in two (25%) of the HCV positive patients in whom HCV RNA alone was positive.

There was a low prevalence of injection drug use (7.7%), history of blood transfusion (5.6%), and homosexual contact (2.9%), and these risk factors showed no correlation with HBV and HCV positivity. Having multiple sexual partners was a risk factor significantly associated with HBV and HCV positivity in men. Men who had multiple sexual partners (n = 35) had 14.3% HBV positivity and 17.1% HBeAg positivity, while in those who did not report multiple sexual contact, 3.8% had HBeAg positivity and none had HCV positivity.

The results of the present study suggest that STD clinic patients may be considered as a targeted high risk group for routine screening for HBV and HCV to control the high infection rates. HIV co-infection in HBV/HCV infected patients is a matter of concern to evolve better clinical management strategies.

Our data emphasise the need for molecular diagnosis to prevent underdiagnosis of HCV infection in STD/HIV patients. The HBV positivity rate (26%) observed in the present series of STD patients is high compared to previous Indian reports.3 HBV infection in STD patients may be a much needed intervention to strengthen STD control programmes in India. Further large studies are required to assess the magnitude of HBV and HCV infections, role of sexual transmission, and associated risk factors in the STD population.

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References

Table 1: Serological and molecular markers for HBV and HCV in STD clinic patients in relation to sex

<table>
<thead>
<tr>
<th>Markers</th>
<th>Males (n=63)</th>
<th>Females (n=80)</th>
<th>Both (n=143)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBsAg No positive</td>
<td>10 (15.9)</td>
<td>27 (33.7)</td>
<td>37 (25.9)</td>
</tr>
<tr>
<td>HBeAg No positive</td>
<td>7 (11.1)</td>
<td>21 (26.3)</td>
<td>28 (19.3)</td>
</tr>
<tr>
<td>Anti-HBe No positive</td>
<td>3 (4.8)</td>
<td>6 (7.5)</td>
<td>9 (6.3)</td>
</tr>
<tr>
<td>HBV DNA No positive</td>
<td>6 (9.5)</td>
<td>19 (23.7)</td>
<td>25 (17.5)</td>
</tr>
<tr>
<td>Overall HBV positivity</td>
<td>10 (15.9)</td>
<td>27 (33.7)</td>
<td>37 (25.9)</td>
</tr>
<tr>
<td>HCV No positive</td>
<td>3 (4.8)</td>
<td>6 (7.5)</td>
<td>9 (6.3)</td>
</tr>
<tr>
<td>HCV RNA No positive</td>
<td>5 (7.9)</td>
<td>7 (8.8)</td>
<td>12 (8.4)</td>
</tr>
<tr>
<td>Overall HCV positivity</td>
<td>5 (7.9)</td>
<td>7 (8.8)</td>
<td>12 (8.4)</td>
</tr>
</tbody>
</table>


Female sex workers and fear of stigmatisation

Female sex workers are often forced to work underground and away from their local communities. Historical records show that female sex workers have been frequently singled out for social control and treated as a distinct section of the community. This social rejection of school children, has serious repercussions on the health provisions to them and on their willingness to seek medical care.

In some countries, including Iran, presence of prostitution and sexually transmitted infections (STIs) is systematically denied, being considered a taboo by the government and the majority of the society. There is no official record of the prevalence of prostitution in Iran. Sex workers in Iran are suffering from unavailability of medical services and knowledge about STIs. Social stigmatisation stops these resource deprived women from seeking proper medical care and treatment.

In a follow up study in 2002 in Kermanshah, Iran on 100 men with gonorrhea most of whom had met a female sex worker before the infection, Zargoshi reported an average 84% failure rate of standard therapies. This was much higher than the 12–25% resistance rate in the study by Zirak-Zadah et al in 1977 of sex workers of Shahre-Now (a brothel in Tehran before 1979). Their infection and resistance rate were similar to their American counterparts of that era.4 In those days sex workers had health coverage, something totally ignored these days. Fear of stigmatisation and prosecution, and high rate of self treatment seem to be responsible for the high rate of resistance to standard therapies.

The increasing rate of STIs and HIV/AIDS is alarming! Young girls and boys are among the high risk populations.1 The ministry of education has taken some steps forward and is now working hard on preventive education against STIs with special focus on HIV/AIDS, though there is no definite program for the out of school children. According to the ministry of health, injecting drug use (62.78%) and sexual contact (7.27%) are the two main routes of transmission of HIV/AIDS in Iran, and 26.12% of the cases are grouped under “unspecified under transmission” according to the report.5 Lack of any reliable records of the underground sex industry makes the data shaky.

Though in Iran commercial sex is not so widespread as in many other countries, sex workers should be considered as patients and efforts should be made to provide appropriate health coverage and preventive education on
STIs and HIV/AIDS with no prejudice. Adhering to unfounded propaganda and denial of the social realities propagates the social ill with catastrophic public health consequences.

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References

Clinically resistant trichomoniases

We read with interest the recent review on trichomoniases and would like to share our experience of a patient with clinically resistant infection, in whom various therapies were tried until we achieved a successful response.

A 39 year old Irish female factory worker presented in April 2001, complaining of a copious malodorous vaginal discharge associated with vulval soreness following unprotected sexual intercourse with a casual male partner 4 months previously. On examination the vulva and groin were erythematous and there was a profuse frothy yellow vaginal discharge with a pH >4.5. Microscopy revealed Trichomonas vaginalis and she was treated with a 5 day course of oral metronidazole 400 mg twice daily as per the UK national guidelines.1 Screening for chlamydia and gonorrhoea was negative.

Over the next 10 months, she re-attended a further 19 times with persistent symptoms and on each occasion denied any sexual contact or non-compliance with treatment. After her third visit, a management strategy was implemented on the basis of a literature review with a named clinician. In total, she received two courses of oral metronidazole (one preceded by oral amoxicillin),3 three courses of metronidazole suppositories (used as pessaries), a single dose of tinidazole, and a course of acetarsol and nonoxynol-9 pessaries. However, despite the planned treatments microscopy was repeatedly positive. She even had her intrauterine device removed in case this contributed to the problem.

Finally, in February 2002, she was treated with oral metronidazole 400 mg three times daily and metronidazole pessaries 1 g daily for 2 weeks following the recommendations of another consultant colleague in the region. Her symptoms had resolved and microscopy was negative when reviewed 3 weeks later. She did not experience side effects secondary to the high dose metronidazole and continued 1 g pessaries once every 2 weeks for 2 months as maintenance therapy. The frequency was then reduced to every 4 weeks for 2 months and, reassuringly, microscopy remained negative. Treatment was then stopped and she has not re-attended subsequently.

Management of patients with treatment failure is challenging as sensitivity testing is currently unavailable. A key factor in this woman was her frustration with multiple therapies, which resulted in erratic attendance. Acetarsol and nonoxynol-9 pessaries have been used with varying results but in our patient both were unsuccessful.2 In persistent infection it is important to ascertain a patient’s compliance with therapy and any possibility of re-infection, both of which were excluded. The use of extended courses of treatment has also been suggested in the management of other viral infections such as condylomatisis and bacterial vaginoses.2,3 Certainly, in our patient this approach was required.

The distressing symptoms associated with clinically resistant trichomoniases cannot be underestimated, thus sharing anecdotal management experience is essential. Devising a treatment schedule and providing a named clinician to ensure continuity of care is required. The distressing symptoms associated with clinically resistant trichomoniases cannot be underestimated, thus sharing anecdotal management experience is essential. Devising a treatment schedule and providing a named clinician to ensure continuity of care is required. The distressing symptoms associated with clinically resistant trichomoniases cannot be underestimated, thus sharing anecdotal management experience is essential. Devising a treatment schedule and providing a named clinician to ensure continuity of care is required. The distressing symptoms associated with clinically resistant trichomoniases cannot be underestimated, thus sharing anecdotal management experience is essential. Devising a treatment schedule and providing a named clinician to ensure continuity of care is required. The distressing symptoms associated with clinically resistant trichomoniases cannot be underestimated, thus sharing anecdotal management experience is essential. Devising a treatment schedule and providing a named clinician to ensure continuity of care is required. The distressing symptoms associated with clinically resistant trichomoniases cannot be underestimated, thus sharing anecdotal management experience is essential. Devising a treatment schedule and providing a named clinician to ensure continuity of care is required. The distressing symptoms associated with clinically resistant trichomoniases cannot be underestimated, thus sharing anecdotal management experience is essential. Devising a treatment schedule and providing a named clinician to ensure continuity of care is required. The distressing symptoms associated with clinically resistant trichomoniases cannot be underestimated, thus sharing anecdotal management experience is essential. Devising a treatment schedule and providing a named clinician to ensure continuity of care is required.

A second case involved a 41 year old man who presented to the clinic because his long term partner had had an episodic rash affecting the natal cleft for the past 3 years. She had been seen by her GP and had also been referred to a local dermatology department. According to the patient the episodic rash had remained undiagnosed despite a skin biopsy having been performed by the dermatologist. He had taken a picture of the rash during an episode with his video mobile phone. This revealed the characteristic vesicles of herpes simplex infection. He himself had a distant history of genital herpes infection that had no recent recurrences. He was advised to encourage his partner to attend the clinic for further management (along with his mobile phone).

These two consultations illustrate how video mobile phones have been used in our clinic to facilitate and aid diagnosis. Dentists often send photographs via email of suspicious oral lesions to oral medicine specialists. Dermatologists are performing telemedicine consultations with GPs for the diagnosis and subsequent investigation of skin complaints.7 The use of mobile phones within GUM services is increasing, with some clinics testing results to patients.8 However, as far as we are aware this is the first time that patients have utilised similar technology to facilitate the diagnosis of genital lesions.

Who knows, maybe in the future, patients will phone up and use their video phones to do distant consultations with GUM Physicians. And the complaint: “It has always gone by the time a patient gets to see a doctor” will be a thing of the past.

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A video mobile phone and herpes simplex

The use of mobile phones in today’s society is pervasive, and for genitourinary medicine (GUM) attendees mobile phones as a common form of communication have been documented.9 However, as far as we are aware, the use of a mobile phone as a diagnostic aid has not been reported. A 35 year old black Caribbean man presented to our clinic and gave a history of having developed a collection of “small lumps” on his prepuce, 1 week previously. However, he had been unable to attend at that time. He reported that the lumps had improved and had crust over. He reported no systemic symptoms. On examination there were crusted lesions consistent with healing genital herpes and no palpable lymphadenopathy. Fortunately, the patient had taken a video clip using his mobile phone when the lesions had first appeared (he had taken both a still a video of his penis). The images were very clear and there was no doubt that this man had had an outbreak of genital herpes. As a result of the images from his video mobile phone we were able to make a confident diagnosis of genital herpes and then have an appropriate discussion with increased certainty.

Conflict of interest: none.

References
Non-disclosure of previously known HIV seropositivity in patients “newly” diagnosed with HIV infection

We read with interest the letter from Natarajan et al regarding extensive unexpected antiretroviral resistance in an African immigrant patient. The failure of HIV positive patients to disclose their status to healthcare workers has previously been documented with adverse clinical outcomes. 1

Case reports

In this case series, we present five individuals who had previously been diagnosed with HIV, who then re-presented for HIV antibody testing and subsequent treatment without disclosing their HIV positive status. All cases were of African origin and diagnosed between October 2002 and February 2003.

Case 1

We were alerted to the possibility of a previously known HIV diagnosis in this woman as her mean corpuscular volume (MCV) was suggestive of the lipodystrophy syndrome. As her mean corpuscular volume (MCV) was <100 cells ×10^6/L.

Case 2

This patient revealed her previous diagnosis and antiretroviral treatment history after a period of discussion regarding treatment initiation. She realised that she may have antiretroviral resistance from previous sub-optimal drug treatment.

Case 3

This patient revealed her known HIV diagnosis after a prolonged period of discussion. A decision to observe her immunological status was made in view of her apparently "low" viral load and a reasonable CD4 count. She had not expected this decision and eventually ran out of drugs. She then revealed her previous history as she was becoming symptomatic and therefore keen to recommence therapy and. Her nadir CD4 count was <100 cells ×10^6/L.

Case 4

Clinic staff at this centre recognised her from her previous attendances. In addition, her self-reported demographics and signature from her previous attendance and most recent attendance matched completely. This patient subsequently transferred her care to a different HIV treatment centre where she subsequently revealed she had taken AZT while in Uganda but still insisted that she had never formally been tested.

Case 5

This patient was diagnosed in the antenatal clinic and was on antiretroviral therapy. She did not disclose this to us and alleged that she was given the medication by her husband for malaria.

Comment

Patients may fail to disclose their HIV diagnosis for a variety of reasons. These include fear of discrimination, fear that disclosure may jeopardise their asylum application and also concerns as to how they may be treated. In most cases the reasons are complex and involve many different factors.

Non-disclosure can result in numerous adverse outcomes for the individual.

Possible consequences for the patients include inappropriate clinical decisions owing to failure to recognise pre-existing antiretroviral drug resistance and toxicities, failure to recognise and address relevant social problems, the risk of inappropriate treatment when diagnosed antenatally, and the increased risk of mother to child transmission.

The number of programmes providing antiretroviral therapy in resource poor settings is increasing. Resistance to antiretroviral drugs in sub-Saharan Africa has been documented in several countries. 2

Clinical clues to previous HIV diagnoses and antiretroviral drug exposure include haematological (raised MCV) and biochemical (raised lipids). Patients may also have morphological changes such as lipodystrophy and pigmentation. In addition, patients with an inappropriately low viral load and low CD4 count may have previously thought to have a non-B clade viral subtype. This supposition may not always be accurate. Clinicians meeting such patients should look for other signs of antiretroviral drug exposure.

Therapeutic drug monitoring (TDM) and genotypic resistance testing may also be useful in selected cases. All five of these cases have undergone genotypic resistance testing, three of whom showed extensive multiple drug resistance.

In all cases, disclosure occurred after multiple clinic attendances. It is highly probable that other cases of non-disclosure have occurred within this service. Clinicians should consider the possibility of HIV status non-disclosure and previous exposure to antiretrovirals when seeing “newly diagnosed” patients with HIV.

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Table 1 Details of cases with HIV*

<table>
<thead>
<tr>
<th></th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Case 5</th>
</tr>
</thead>
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<tr>
<td><strong>Sex</strong></td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>46</td>
<td>32</td>
<td>37</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td><strong>Place of original HIV diagnosis</strong></td>
<td>Congo</td>
<td>Kenya</td>
<td>Uganda</td>
<td>Uganda</td>
<td></td>
</tr>
<tr>
<td><strong>Time from original HIV diagnosis to presentation for HIV testing</strong></td>
<td>14 years</td>
<td>6 years</td>
<td>5 months</td>
<td>15 months</td>
<td>15 months</td>
</tr>
<tr>
<td><strong>Route of HIV acquisition</strong></td>
<td>Heterosexual sex</td>
<td>Heterosexual sex</td>
<td>Heterosexual sex</td>
<td>Heterosexual sex</td>
<td>Heterosexual sex</td>
</tr>
<tr>
<td><strong>CD4 count at first presentation &lt;10^6/μL</strong></td>
<td>354 (32%)</td>
<td>130 (7%)</td>
<td>238 (25%)</td>
<td>242</td>
<td>294 (20%)</td>
</tr>
<tr>
<td><strong>Viral load at first presentation &lt;10^6/μL</strong></td>
<td>90 607</td>
<td>78.3</td>
<td>50</td>
<td>101.9</td>
<td>96.9</td>
</tr>
<tr>
<td><strong>MCV at initial presentation &lt;10^6/μL</strong></td>
<td>118</td>
<td>3TC 3TC</td>
<td>3TC 3TC</td>
<td>3TC 3TC</td>
<td>3TC 3TC</td>
</tr>
<tr>
<td>Exposure to antiretroviral therapy</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>Number of consultations before disclosure</strong></td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td><strong>Time to disclosure</strong></td>
<td>8 weeks</td>
<td>8 weeks</td>
<td>6 weeks</td>
<td>16 months</td>
<td>4 months</td>
</tr>
<tr>
<td><strong>Reason for non-disclosure</strong></td>
<td>Believed that treatment would be denied</td>
<td>Concerned about disclosure to current partner</td>
<td>Concerned about impact of knowledge of diagnosis on asylum application</td>
<td>Unknown</td>
<td>Thought she was being treated for malaria by husband</td>
</tr>
</tbody>
</table>

*See case reports.
A 37 year old man was admitted with a 4 day history of headaches, fevers, and vomiting with a 2 week background of dysuria. On presentation with a seroconversion illness 3 years previously he received combination antiretroviral therapy (ARV) for 9 months. Four months before the current admission ARV was re-introduced for symptomatic HIV infection. The most recent CD4 count was 250 cells x 10^3/l and HIV viral load was 107 000 copies/ml. Hepatitis C infection had recently been diagnosed and the patient was receiving weekly interferon alfa. His symptoms began the day after the fifth injection. On examination he was pyrexial, temperature 39°C, had meningism and abdominal tenderness in both right upper quadrant and left iliac fossa. Investigations showed C reactive protein (CRP) 265 (normal = 0–4) IU/l, neutrophils 11 x 10^9/l, and normal urea and creatinine. Cranial computed tomography (CT) and cerebrospinal fluid analysis were normal. Urinalysis showed protein+ and blood+, urine culture was negative. Blood cultures grew Escherichia coli, which was treated with cefuroxime. Abdominal CT scan showed multiple low attenuation solid lesions with peripheral enhancement in both kidneys (fig 1A). The patient’s symptoms rapidly settled. He completed a 4 week course of oral cephaloxyl. As E coli was cultured from blood and a repeat scan after completion of treatment was normal (fig 1B) the renal CT appearances were ascribed to lobar nephronia.

The CT appearance of lobar nephronia is of either a single, or more uncommonly, multiple lesions in either one or both kidneys. The appearances are of either inflammatory (hypo-dense wedge-shaped) areas, or mass-like lesions.1,2 A radiological differential diagnosis for single lesions includes intrarenal abscess, renal carcinoma, and simple cyst. For multiple lesions, it includes microabscesses, lymphoma, hamartomata, and metastases.

The clinical severity lies between that of pyelonephritis and renal abscess and it is important to differentiate lobar nephronia from these pathologies as management differs both in duration of antibiotics and the need for drainage of renal abscess. Histologically, the conditions differ. By contrast with the tissue necrosis and liquefaction seen in an abscess, in lobar nephronia there is localised hyperaemia, interstitial oedema, and leucocyte infiltration. These features are less severe and are diffuse in acute pyelonephritis. E coli is the most common causative organism. Other pathogens include Proteus mirabilis, Staphylococcus aureus, Klebsiella spp, Pseudomonas aeroginosa, and enterococci. Antibiotics are given for up to 6 weeks and relapse may occur.

The majority of reports of lobar nephronia in the general population are in children, probably reflecting the higher incidence of urinary tract infections in children. Although lobar nephronia has been described previously in adult HIV infected patients,3 our patient had an unusual presentation with meningism. Response to antibiotics was good and it is unclear to what extent immunosuppression due to HIV or hepatitis C infection, or interferon alfa may have contributed to the development of lobar nephronia. This case describes an uncommon presentation of renal infection in HIV infected adults and highlights the need to exclude differential diagnoses, especially lymphoma and metastases.

Molluscum contagiosum presenting as penile horn in an HIV positive patient

Dermatologists have the advantage of visualising the skin lesions and making the diagnosis. In immunocompetent patients most of the skin conditions have the characteristic clinical presentation and hence the diagnosis is made clinically by good visual impression. But the human immunodeficiency virus (HIV) has taken away this advantage. Owing to its profound effect on the immune system, the natural course and clinical features of most of the dermatological diseases have been altered. In this report we describe the unusual presentation of molluscum contagiosum as penile horn, in an HIV positive patient.

Case report

A 34 year old man presented with asymptomatic rapidly enlarging papular lesions on the penis and scrotum present for the past 6 months. He also had a significant weight loss and loss of appetite for the past month. On examination he was emaciated and had yellowish greasy scaling on the scalp, eyebrows, nasolabial folds, and chest. Examination of the lymphoreticular system did not reveal any abnormality. Genital examination revealed three well defined flesh coloured papules, two on the mucosal aspect of prepuce skin (one each at the 10 o’clock and 2 o’clock positions) and the other one on scrotal skin near the root of the penis (fig 1). The size varied from 3 mm to 7 mm. All the lesions were non-tender and had keratotic projection in the centre, the height of which was more than its diameter. The scrotal lesion was fleshy and had a verrucous surface, and on pressing the lesion cheesy material could be expressed. Routine haemogram, liver, and renal function tests were within normal limits. Stool examination showed occasional Cryptosporidium. ELISA for HIV was positive. The CD4 count was just

References


Figures

Figure 1 (A) CT scan of the abdomen showing multiple low attenuation solid lesions (arrows) with enhancing rims in both kidneys. There is associated splenomegaly, but no intra-abdominal lymphadenopathy and no ascites. (B) CT scan on completion of treatment. The appearance of the kidneys is normal.

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Approximately 640,000 children were newly infected with HIV in sub-Saharan Africa during 2003. Without any contraceptive use, this number would be 813,000 children. Thus, current contraceptive use is already averting approximately 22% HIV positive births annually. However, given the relatively low contraceptive prevalence in sub-Saharan Africa, increasing contraceptive use has great potential for additional impact in averting HIV positive births. The proportion of unintended births is 25% in sub-Saharan Africa; and assuming that 25% of HIV positive births are also unintended, the potential for contraception to avert even more HIV infections is profound—an addition of over 160,000 HIV positive births averred annually.

As resources are rapidly shifting to focus on providing antiretroviral therapy for HIV infected people, the negative consequences associated with unintended childbearing are likely to worsen for women if funding for contraception does not keep pace with increasing demand. Across all developing countries, current family planning spending levels are estimated to prevent 187 million unintended pregnancies. In turn, more than 100 million induced abortions are prevented annually and 60 million unplanned births are avoided. We already know that contraceptive use has numerous health benefits for women and families; our calculations suggest that contraceptive use to prevent unintended pregnancies can also have a significant effect on reducing infant HIV infections. We urge funders to refocus on family planning, not only to prevent unintended pregnancies but also HIV infections.

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Competing interest: none declared.

References
However, the role of the sexual route in the transmission of hepatitis B, hepatitis C, and HIV seems to be significant. We conducted this study to survey the distribution of HCV infection as well as the associated risk factors in the female sex worker population in Tehran, Iran. We surveyed 149 sex workers, with the mean period of prostituting (p = 0.01 and p = 0.005, respectively). Out of 149 sex workers, with the mean period of prostituting 11.3 (SE 1.7) months; four cases (2.7%, 95% CI: 0.7 to 3.4) were HCV positive and one case (0.7%, 95% CI: 0 to 1.7) had HBsAg positive. There was no sexual contact related variable significantly associated with HCV seropositivity in the sex worker population (table 1). One of these four cases who were anti-HCV Ab positive had a history of non-IDU, and none of them had a history of IDU.

Although we have been unable to ascertain the source of the HCV positivity in these women with multiple sexual exposures, it seems that promiscuity is not an important factor for hepatitis C because of the low HCV prevalence rate in general population in Iran (0.12%); the low rate of promiscuity in Iran because of the religious (Islamic) and social culture, the low mean period of prostituting in our study sample, or the regular use of condoms in almost all of the study population. However, it may also be because of the low infectivity of HCV in heterosexual intercourse. Moreover, in our study, none of the HCV positive cases in the sex worker population study had a history of IDU while 4.4% of the studies failed to carefully exclude hepatitis C virus. Because of the low HCV acquisition from non-sexual sources. However, IDU is a much more significant risk factor for HCV infection than extramarital sexual contact in Iran. Therefore, screening for HCV infection is advocated in injecting drug users in order to prevent the spread of HCV.

### Table 1: Comparison of different factors between HCV positive and HCV negative cases of prostitute groups to determine risk factors associated with HCV infection

<table>
<thead>
<tr>
<th>Factor</th>
<th>HCV positive</th>
<th>HCV negative</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 4)</td>
<td>(n = 145)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate or elementary</td>
<td>19.5 (SE 1.5)</td>
<td>28.3 (0.7)</td>
<td>NS</td>
</tr>
<tr>
<td>Secondary</td>
<td>3 (75.0%)</td>
<td>90 (64.7%)</td>
<td>NS</td>
</tr>
<tr>
<td>Advanced</td>
<td>0</td>
<td>8 (5.8%)</td>
<td></td>
</tr>
<tr>
<td>Homosexuality (yes/no)</td>
<td>2 (50.0%)</td>
<td>61 (41.6%)</td>
<td>NS</td>
</tr>
<tr>
<td>HCV positivity (yes/no)</td>
<td>HCV negative</td>
<td>22/118 (15.7%)</td>
<td>NS</td>
</tr>
<tr>
<td>Average number of weekly partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One or less</td>
<td>2 (50.0%)</td>
<td>47 (35.1%)</td>
<td></td>
</tr>
<tr>
<td>Two to four</td>
<td>2 (50.0%)</td>
<td>73 (54.5%)</td>
<td></td>
</tr>
<tr>
<td>More than four</td>
<td>0</td>
<td>14 (10.4%)</td>
<td></td>
</tr>
<tr>
<td>Duration of prostituting (month)</td>
<td>10.7 (SE 4.8)</td>
<td>11.3 (SE 1.8)</td>
<td>NS</td>
</tr>
<tr>
<td>Regular use of condom (yes/no)</td>
<td>4/0 (100%)</td>
<td>120/23 (83.9%)</td>
<td>NS</td>
</tr>
</tbody>
</table>

Collecting the essence of man: semen collection for HIV transmission studies in sub-Saharan Africa

Efforts to understand male to female sexual transmission of HIV must include semen analysis. Estimating sexual infectiousness using blood HIV RNA concentrations as a surrogate marker may be biased. Semen is routinely collected in Europe and the United States for HIV research and has recently been collected in clinical trials in sub-Saharan Africa; however, there are no published data about issues associated with semen collection.

We conducted a study at the Central Hospital of Litolwwe, Malawi, from January 2000 to June 2001 to better understand the relation between trichomonas and HIV-1 viral load. Men attending STI and dermatology clinics consented and were enrolled. All men with Trichomonas vaginalis and a comparison group of HIV positive men attending the dermatology clinic without trichomonas or STI symptoms were asked to provide semen. Both male and female clinic staff asked men to donate semen at the baseline visit. If subjects agreed to provide semen they were given a wide mouthed specimen container, escorted to a designated toilet near the examination rooms, and asked to provide semen by masturbation. To determine independent predictors of collection, a multivariate logistic regression model was created utilising those factors associated (p <0.01) with semen collection on bivariate analyses. Eight randomly selected subjects who had been asked to donate semen were invited to participate in a focus group about semen collection.

In all, 212 men were asked to provide semen and 145 succeeded (table 1). The table shows the adjusted results controlling for factors associated with collection. Having a

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First case of spectinomycin resistant Neisseria gonorrhoeae Isolate in New Delhi, India

Spectinomycin is recommended as an alternative antimicrobial in CDC treatment guidelines of uncomplicated gonococcal infection. There are reports available on spectinomycin resistant Neisseria gonorrhoeae isolates from China, Philippines, and Sri Lanka but no resistance has been reported from India and other South East Asia Region countries such as Bangladesh, Thailand, and Indonesia. To our knowledge, this is the first report of spectinomycin resistant N gonorrhoeae from India.

A 21-year-old female patient with a history of vaginal discharge for the past month attended the gynaecology outpatient department of Saldarjung Hospital in August 2002. On speculum examination purulent cervical discharge was noticed. Investigations were carried out for Chlamydia trachomatis and Neisseria gonorrhoeae presence using standard techniques. Endocervical curettage was collected for Chlamydia trachomatis and Neisseria gonorrhoeae detection. Blood specimen was taken for VDRL, TPHA, HIV (after pretest counselling), and HBs Ag. All the tests proved negative, but on microscopy of the endocervical smear, Gram negative intracellular diplococci were observed. N gonorrhoeae was isolated on chocolate agar and saponin lysed blood agar with VCNT inhibitors. Standard methods were utilised for confirmation of the isolate. Antimicrobial susceptibility testing towards penicillin, tetracycline, ciprofloxacin, ceftriaxone, and spectinomycin was carried out by the Australian Gonococcal Surveillance Programme method based on the calibrated dichotomous sensitivity technique. The isolate was observed to be sensitive to penicillin, tetracycline, ciprofloxacin, and ceftriaxone but resistant to spectinomycin. Minimum inhibitory concentration by agar dilution technique was observed to be 128 μg/ml (cut-off value for spectinomycin resistance >128 μg/ml).

The patient was treated with ciprofloxacin 500 mg, single dose. Test of cure was performed after 2 weeks.

The regional STD Teaching, Training and Research Centre has been monitoring antimicrobial susceptibility of N gonorrhoeae for penicillin, tetracycline, ciprofloxacin, and ceftriaxone since 1995 and has been acting as the WHO regional reference laboratory for the Gonococcal Antimicrobial Susceptibility Programme (GASP) in South East Asia Region since 1999. Antimicrobial susceptibility testing for spectinomycin started in 2000 under GASP.

From 2000 to 2003 antimicrobial susceptibility testing has been carried out in 449 consecutive isolates of N gonorrhoeae. Out of 449 isolates, 413 were from male patients with acute gonococcal urethritis and 36 from females with cervicitis. All the isolates were...
found to be sensitive to spectinomycin except this isolate.

This centre is also collecting and analysing data from local point laboratories in India under GASP (Chennai, Delhi, Hyderabad, Kolkata) and 100% isolates were reported to be sensitive to spectinomycin in India.

Detection of a spectinomycin resistant isolate is a cause for concern as there are reports of resistance from other countries—as high as 11.1% from China. Spectinomycin is the best alternative for patients allergic to cephalosporins.

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High HIV risk profile among female commercial sex workers in Vinnitsa, Ukraine

In many countries significantly higher rates of HIV infection have been documented among sex workers compared to most other population groups. We have analysed HIV risk behaviour among the female commercial sex workers in Vinnitsa, Ukraine, because this issue is still unstudied in the country.

The study protocol was approved by the ethics committee of Vinnytsia Pirogov Medical University. Data collection was carried out in May to July, 2003 using a cross sectional design with a self reported questionnaire method and was linked to the programme “Network of mobile and information support for female sex workers” operated by the non-government organisation (NGO) “Stalist.” This programme provides informational support, medical service, and condoms for female sex workers in Vinnitsa region. Trained outreach workers of NGO “Stalist” performed recruitment of subjects on the major roads of the city. Oral informed consent in all cases was obtained.

Altogether, 58 sex workers were involved into the study. The age of the participating women ranged from 15 to 34 years, with a mean age of 23.1 years. Around 25 (44.8%) respondents provided financial support from others (parents, children, husband, etc). Even though nine (15.5%) women had said that they were married, only four (6.9%) were living with their husbands, and 46 (79.3%) did not have a husband or a regular sexual partner. In spite of the fact that 46 (79.3%) female sex workers believe that they are not at risk, our results show a high HIV risk profile in this group (table 1).

It is well known that use of injecting drugs is a powerful factor for HIV transmission, and our findings highlight considerable prevalence of injecting drug use among sex workers in Vinnitsa. High rates of sharing injecting paraphernalia were registered as well, which, in our opinion, is the consequence of being “injection dependent.” In Canada it was identified that needing help injecting was a strong risk factor for syringe sharing, and it is troubling that this risk factor has now been identified as a predictor of HIV seroconversion.

Our data showed that permanent use of condoms was low, in spite of the fact that most of the respondents accepted that having sex without condoms increases the risk of HIV. Being on the margin of society, the ability of commercial sex workers to negotiate safer working conditions is limited. Their financial position can make them vulnerable to customers willing to pay more

Table 1 HIV risk profile among female commercial sex workers (n = 58)

<table>
<thead>
<tr>
<th>Variable</th>
<th>No</th>
<th>%</th>
<th>95% CI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injecting drug use at least once</td>
<td>41</td>
<td>71</td>
<td>57.3 to 81.9</td>
</tr>
<tr>
<td>Regular injecting drug use</td>
<td>34</td>
<td>59</td>
<td>44.9 to 71.4</td>
</tr>
<tr>
<td>Injecting drug practice†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borrow used syringes</td>
<td>8</td>
<td>24</td>
<td>10.7 to 41.2</td>
</tr>
<tr>
<td>Lend used syringes</td>
<td>2</td>
<td>9</td>
<td>1.9 to 23.7</td>
</tr>
<tr>
<td>Require assistance injecting</td>
<td>13</td>
<td>38</td>
<td>22.2 to 56.4</td>
</tr>
<tr>
<td>Inject drugs in a group</td>
<td>11</td>
<td>32</td>
<td>17.4 to 50.5</td>
</tr>
<tr>
<td>Number of clients per average day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One or two</td>
<td>8</td>
<td>14</td>
<td>6.1 to 25.4</td>
</tr>
<tr>
<td>Three or four</td>
<td>21</td>
<td>36</td>
<td>24.0 to 49.9</td>
</tr>
<tr>
<td>Five and more</td>
<td>29</td>
<td>50</td>
<td>36.6 to 63.4</td>
</tr>
<tr>
<td>Condome use during the last sexual contact</td>
<td>38</td>
<td>66</td>
<td>51.9 to 77.5</td>
</tr>
<tr>
<td>Condome use during the last month</td>
<td>29</td>
<td>50</td>
<td>36.6 to 63.4</td>
</tr>
<tr>
<td>More than in the half of cases (=50%)</td>
<td>16</td>
<td>28</td>
<td>16.7 to 40.9</td>
</tr>
<tr>
<td>In the half of cases (50%)</td>
<td>8</td>
<td>14</td>
<td>6.1 to 25.4</td>
</tr>
<tr>
<td>Less than in the half of cases (&lt;50%)</td>
<td>5</td>
<td>9</td>
<td>2.9 to 19.0</td>
</tr>
<tr>
<td>Reasons for occasionally not using condoms during sex trade</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client refusal</td>
<td>32</td>
<td>55</td>
<td>41.5 to 68.3</td>
</tr>
<tr>
<td>Higher payment</td>
<td>23</td>
<td>40</td>
<td>27.0 to 53.4</td>
</tr>
<tr>
<td>Permanent client</td>
<td>24</td>
<td>41</td>
<td>28.6 to 55.1</td>
</tr>
<tr>
<td>Use of psychoactive substances before a sexual context during the last month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>12</td>
<td>21</td>
<td>11.2 to 33.4</td>
</tr>
<tr>
<td>More than in the half of cases (=50%)</td>
<td>16</td>
<td>28</td>
<td>16.7 to 40.9</td>
</tr>
<tr>
<td>In the half of cases (50%)</td>
<td>24</td>
<td>41</td>
<td>28.6 to 55.1</td>
</tr>
<tr>
<td>Less than in the half of cases (&lt;50%)</td>
<td>4</td>
<td>7</td>
<td>1.9 to 16.7</td>
</tr>
<tr>
<td>Never</td>
<td>2</td>
<td>3</td>
<td>0.4 to 11.9</td>
</tr>
</tbody>
</table>

*Confidential interval.
†Among regular injecting drug users.
money for unprotected sex and other high risk practices. In addition, if a sex worker is under the influence of drugs while working, her judgment is impaired and it is less likely that safer sex methods will be used.

Thus, results of our study emphasise that providing informational support, medical service and condoms cannot entirely solve the HIV preventive problem among female sex workers in Vinnitsa, Ukraine. Sex workers’ vulnerability and dependence on clients, injecting drug use, significant rates of sharing injecting paraphernalia, and use of psychoactive substances before sexual contacts contribute significantly to the high HIV risk profile of this group.

Contributors
PK designed the study, carried out statistical treatment and analysis of the data; VP supervised all procedures concerning data collection and editing, assisted in data analysis and drawing conclusions from the paper.

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