SEXUALLY TRANSMITTED INFECTIONS AND HIV


This pretty, shiny new book slid out of the packaging. I was rather surprised that a book entitled Sexually Transmitted infections and HIV was as small and neat. The preface explained all—a book “intended for those new to the management of sexually transmitted infections and HIV,” and, as such, it succeeds well in its aim.

The increasing demand on services providing for those concerned that they may have acquired a sexually transmitted infection and emphasis on “near-patient treatment” and “one stop shop” provision means that it is likely that patients will attend an increasing variety of clinical services in order to get access to care. This book will be a useful aid in clinics providing contraceptive advice, genitourinary nurse led clinics, and general practice. It is a good introduction to the subject. It is written so clearly that I have left it with patients who are seeking information.

The introduction to history taking includes discussion of reactions of the history taker, warning appropriately about the potential for voyeurism. I found no reference to the appropriate behaviour when attempting to examine a man with an erection, but I don’t know of any other book that discusses this either!

As with all books wishing to provide simple clear advice, some of the advice was over didactic for my taste, and I would have liked references quoted when the text said “there is evidence that.” Specific areas where I thought the book would benefit from additional content would include: differing opinions among genitourinary physicians about appropriate management and review of non-gonococcal urethritis; advice to “avoid sexual intercourse” until after follow up appointment (examination, and review in order to deal with increasing numbers of patients); reduction in use of centrifuges or potassium hydroxide because of local interpretation of health and safety guidelines; listing of websites addresses for STI management (HIV related websites were listed clearly). I suspect a typographical error in the table recommending the duration of treatment with ethrithromycin used in uncomplicated chlamydial infection, and I would disagree with “blind treatment” for candidiasis in those presumed at low risk of sexually transmitted infection, this is when genital herpes and its appropriate treatment window can be missed.

There are lots of useful figures and checklists but, because of this, sometimes they are presented in the middle of text relating to other conditions, box illustrations for Pneumocystis and Mycobacterium tuberculosis in HIV were in the middle of text relating to neurology.

However, several cervical lymph nodes were also unilaterally enlarged on the right (fig 1).

Blood investigations revealed no inflammatory response and normal serum concentrations of angiotensin converting enzyme, calcium and amylase and autoantibodies. A chest radiograph and abdominal ultrasound were normal. No pathogens were identified in sputum or in blood cultures for bacteria and mycobacteria. Immunoglobulin G to mumps virus was detectable in serum, indicating previous infection. A fine needle aspirate (FNA) of the right parotid was paucicellular, precluding a cytological diagnosis. The patient’s blood CD4 count had rapidly increased to 80 cells x10^6/l and the viral load was undetectable. A presumptive diagnosis of IRD was made, although any underlying infection was unknown.

Two weeks later, the right sided lymph nodes had enlarged further. M. scrofulaceum was cultured from the original FNA. Treatment with rifabutin and clarithromycin was started and ART was continued. The right sided lymph nodes became fluctuant and discharged pus, which contained acid fast bacilli but was culture negative. The parotitis and lymphadenitis subsequently resolved over several weeks.

M. scrofulaceum typically causes cervical lymphadenopathy in children and is a rare cause of disease in patients with HIV/AIDS. 2 Parotid disease has not previously been reported. Mycobacteria are the organisms most frequently reported to underlie IRD, which commonly presents with acute lymphadenitis or deterioration of pulmonary disease. 3 However, this is the first report of mycobacteria associated IRD presenting with parotid disease. The differential diagnosis of parotid disease in patients with HIV infection is broad, and includes infections, malignancies, benign lymphoepithelial cysts, diffuse infiltrative lymphocytosis syndrome and Sjögren’s syndrome. 4 Clinicians should also be aware that acute parotid enlargement may also be the result of IRD.

Acknowledgements

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Testing for *Neisseria gonorrhoeae* by nucleic acid amplification testing of chlamydia samples using Roche Cobas Amplicor in a rural area in the north of England does not find more gonorrhoea in primary care

Men with urethral gonorrhoea are usually symptomatic, women are less likely to have symptoms. If women are tested only for chlamydia, and found to be negative, and those positive for *N. gonorrhoeae* in men with urethritis due to *Chlamydia trachomatis* by NAAT amplification testing of nucleic acid with untreated *N. gonorrhoeae* might, if only tested for chlamydia, continue with untreated *N. gonorrhoeae* infection. Although the study protocol included patient information explaining that false positive test results were possible, considerable anxiety was provoked in both patients and their GPs when a possible diagnosis of gonorrhoea was made. Our predictions from local GUM prevalence of gonorrhoea and the estimated sensitivity and specificity of the testing method suggested that confirmed positive samples from men were unlikely, but predicted approximately five unconfirmed positive results from women (one from GUM, four from primary care). We had four unconfirmed positive results from women in GUM and 16 in primary care. Cross reactivity may occur with some non-pathogenic strains of *Neisseria* and *Lactobacillus* species and may explain the higher positivity rate in women.

Medical practitioners have differing responsibilities according to their area of work. GPs have a particular duty of care towards the individual. GUM physicians have a duty of care to the individual but also have public health responsibilities. Public health policies needed to protect the community may be in conflict with current bioethical principles regarding the care of individual patients.

The additional laboratory costs of the *N. gonorrhoeae* NAAT testing materials for this number of samples was approximately £150, without taking into account the costs of laboratory or clinician time. We think that screening for *N. gonorrhoeae* by NAAT with this method is neither cost effective nor appropriate in this low prevalence population.

### Table 1

<table>
<thead>
<tr>
<th>Total tested for C trachomatis by NAAT</th>
<th>Specimens cultured for <em>N gonorrhoeae</em></th>
<th>Positive for <em>C trachomatis</em></th>
<th>Positive for <em>N gonorrhoeae</em> by NAAT</th>
<th>Those positive for <em>N gonorrhoeae</em> by NAAT confirmed by culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP 966 (903F, 63M)</td>
<td>388 (324F, 64M)</td>
<td>66 (6.6%)</td>
<td>17 (1.6%, 1M)</td>
<td>1 (M)</td>
</tr>
<tr>
<td>GUM 471 (221F, 250M)</td>
<td>493 (238F, 235M)</td>
<td>63 (13.4%)</td>
<td>16 (7F, 9M)</td>
<td>10 (2F, 8M)</td>
</tr>
<tr>
<td>Total 1437</td>
<td>881</td>
<td>127</td>
<td>33</td>
<td>11</td>
</tr>
</tbody>
</table>

Female specimens (F), male specimens (M).

*Discrepancy in NAAT v culture numbers as some men could not provide urine specimens and some individuals had cultures taken from more than one site.

One female had received antibiotics in the week before sample being taken—excluded from further analysis.

All urinary samples from men and all cervical samples from women with requests for *Chlamydia* NAAT testing were also tested for *N. gonorrhoeae* by NAAT methods. The reasons that general practitioners do not send culture specimens from their patients are unknown.