Case reports

Patient data were collected from a STD clinic in a tertiary care hospital in south India from 2008 to 2010. All the patients were routinely screened for syphilis and HIV infection. Smears from the ulcers were taken and stained with Gram stain and/or Giemsa stain. Biopsy from the ulcer edge was taken whenever indicated. Following causes for non-sexually transmitted genital ulcers were recorded: Behçet’s disease was seen in two male patients. Infectious ulcers; One pregnant woman presented with multiple painful genital ulcers caused by Klebsiella spp. An HIV infected man on antiretroviral therapy presented with ecthyma gangrenosum of scrotum with unilateral lymphadenopathy caused by Pseudomonas sp. Chancroid-like ulcers; a monogamous, HIV-negative office worker and an HIV positive widow, sexually inactive since 5 years, presented with multiple, small shallow genital ulcers with excruciating pain simulating herpes genitalis. The ulcers did not respond to adequate therapy with acyclovir and organism could not be demonstrated on gram stain or bacterial culture. In both the cases, the ulcers healed completely with azithromycin. Fictitious ulcer; seen over the shaft of penis in an unmarried man. Genital aphtha due to chikungunya fever; during an epidemic of chikungunya fever in the region, 25 patients with acute disease presented with multiple aphthous ulcers involving scrotum, penoscrotal junction and adjacent crural region. Skin biopsy from the ulcers reveals lymphocytic vasculitis.

Conclusion

Causes of genital ulcers in patients referred to STD clinic may be varied. Atypical cases must be examined with care to identify the cause. Counselling plays an important role in the management of patients with non-sexually transmitted genital ulcer.

Clinical sciences poster session 2: herpes simplex virus

P3-S2.01 NON SEXUALLY TRANSMITTED GENITAL ULCERS; PATIENTS REFERRED TO A STD CLINIC


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Introduction

Non-sexually transmitted genital ulcers are a cause of significant morbidity among sexually active young men and women. Establishing the underlying cause of the genital ulcer and differentiation from sexually transmitted infections may be challenging for the treating physician.

P3-S2.02 VARIATIONS IN TESTING AND TREATMENT RECEIVED BY INFANTS WITH POSSIBLE NEONATAL HERPES

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Background

Data are scarce on clinical care of infants with possible neonatal herpes simplex virus (HSV) infection, a rare and serious condition that should be treated with systemic acyclovir for 14–21 days. We reviewed HSV testing and treatment in a large cohort of US infants in order to assess clinical care received.

Methods

We investigated >270,000 infants born from 1997 to 2002 at three managed care organizations participating in the US Vaccine Safety Datalink. Medical records were abstracted if an infant had a discharge ICD-9 code compatible with HSV infection, a positive laboratory test for HSV, or neonatal death. Abstracted data included symptoms, testing, and treatment. Two physicians reviewed likely HSV infections. We identified confirmed cases (compatible symptoms and positive laboratory test), probable cases (compatible symptoms only), and others (with an alternate diagnosis). Descriptive frequencies were calculated.

Results

We abstracted records from 770 infants, identifying 35 cases (24 confirmed and 11 probable) and 753 others. HSV infection manifested as skin, eye, and mucosal (SEM) disease in 20 cases, central nervous system (CNS) disease in 6 cases, and disseminated disease in seven cases. Among 55 cases, all 55 (100%) had symptoms compatible with HSV infection; these included vesicular lesions in 20 (57%) and seizure in 7 (20%). Overall, 55 (100%) were ever tested for HSV. At least 34 (97%) received some acyclovir; median time to treatment, available for 32 cases, was 3 days (range 0–35 days). Only 8 (23%) received systemic acyclovir for the recommended