

PostScript

BOOK REVIEW

Sexually Transmitted Infections and HIV

Edited by Dan Clutterbuck. Pp 209; £34.99 (softcover). London: Elsevier, 2004. 0-7234-3284-8.

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 comment 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 (less relevant as services reduce routine 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 website addresses for STI management (HIV related websites were listed clearly). I suspect a typographical error in the table recommending the duration of treatment with erythromycin 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.

The exposure risk table for blood borne viruses in relation to post-exposure prophylaxis for HIV is very helpful, although it would be worth understanding how it works before needing it in the acute situation.

“Oooh, this looks nice, nice pictures, is it ours?” was the response from our nurse specialist who spent some time flicking through it making appreciative noises.

It is a book that will definitely be used in our department.

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LETTERS

Acute bilateral parotitis caused by *Mycobacterium scrofulaceum*: immune reconstitution disease in a patient with AIDS

Immune reconstitution disease (IRD) among HIV infected patients is an adverse consequence of restoration of immune responses during the initial months of antiretroviral treatment (ART).¹ Previously, subclinical infections are “unmasked” or pre-existing opportunistic infections clinically deteriorate. Here we describe an unusual case in which a patient developed acute bilateral parotid enlargement as a result of IRD associated with *Mycobacterium scrofulaceum* infection.

A 66 year old West African man was investigated for dysphagia, weight loss, and fatigue. Oesophageal candidiasis and HIV-1 infection were diagnosed with a blood CD4 lymphocyte count of 6 cells $\times 10^6/l$ and a plasma viral load of 416 566 RNA copies/ml. Further investigations, including chest radiography, sputum examination, mycobacterial blood cultures, bone marrow examination and culture, and abdominal ultrasonography, were normal. Following treatment of oesophageal candidiasis, the patient started ART with zidovudine, lamivudine, and efavirenz.

Eight weeks later, the patient developed acute swelling posterior to the angles of the jaw bilaterally, causing discomfort on mouth opening. He did not have xerostomia or other local or systemic symptoms. On examination, firm smooth masses were found, more marked on the right than the left, arising from the behind the angles of the jaw and extending inferiorly into the neck (fig 1). The patient was afebrile and no lymphadenopathy was palpable elsewhere. Clinical examination was otherwise normal, including the oropharynx and seventh cranial nerve function.

Ultrasound examination confirmed that both parotid glands were diffusely enlarged and showed increased vascularity; intraparotid lymphadenopathy was not evident.

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 $\times 10^6/l$ 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/AIDS²; 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.¹ 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.^{3,4} Clinicians should also be aware that acute parotid enlargement may also be the result of IRD.

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Figure 1 Posterior view of the patient showing bilateral enlargement of the parotid glands (P) and unilateral enlargement of cervical lymph nodes on the right (LN).

Contributors

SDL wrote the manuscript; all authors were involved in the clinical care of the patient, data collection, and input to the final manuscript.

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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.^{1,2} If women are tested only for chlamydia and found to be negative, and tests for *Neisseria gonorrhoeae* are not performed, they are at risk of continuing infection with *N gonorrhoeae* as the infections

may occur together.³ Patients concerned that they may have a sexually transmitted infection may access care through their general practitioner (GP). When testing both symptomatic and asymptomatic patients for chlamydia, GPs do not always test for *N gonorrhoeae* (local laboratory data). Even if they did, problems with sample transport, storage, etc, may influence sensitivity of cultures.^{4,5}

To assess the effect of the introduction of nucleic acid amplification testing (NAAT) methods for *N gonorrhoeae* in a rural area with low gonorrhoea prevalence, all samples submitted for *Chlamydia trachomatis* NAAT in north Cumbria were also screened for *N gonorrhoeae* with the Roche Cobas Amplicor amplification and detection system, used according to the standard programme method. *N gonorrhoeae* was cultured and identified according to national HPA standard operating procedures.

From 471 genitourinary medicine (GUM) samples, 10/16 positive *N gonorrhoeae* NAATs were confirmed by culture; from 966 primary care samples 1/17 positive *N gonorrhoeae* NAATs was confirmed by culture. Confirmation was more likely in men. Six women with positive NAAT for *N gonorrhoeae* were treated by their GP before culture confirmation (none of their partners had evidence of infection) (table 1). One patient in GUM had clinical signs suggestive of *N gonorrhoeae* infection but negative cultures. Even if all cases where GPs had given treatment had gonorrhoea, the confirmed positive rate would only be 50%.

Of those with a positive *N gonorrhoeae* NAAT, only two confirmed cases were asymptomatic (both female and identified through GUM where culture for *N gonorrhoeae* is routine practice) (table 1). The concern of the authors that had prompted this research was that asymptomatic women with *N gonorrhoeae* who attended their GP for care 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 unconfirmed 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.⁶

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.⁷

The additional laboratory costs of the *N gonorrhoeae* NAAT testing materials for this number of samples was approximately £1500, 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.

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Table 1 Individuals tested for *Chlamydia trachomatis* by NAAT and for *Neisseria gonorrhoeae* by NAAT and culture methods

	Total tested for <i>C trachomatis</i> by NAAT	Specimens cultured for <i>N gonorrhoeae</i>	Positive for <i>C trachomatis</i>	Positive for <i>N gonorrhoeae</i> by NAAT	Those positive for <i>N gonorrhoeae</i> by NAAT confirmed by culture
GP	966 (903F, 63M)	388 (324F, 64M)	64 (6.6%)	17 (16F, 1M)	1 (M)
GUM	471 (221F, 250M)	493 (238F, 255M)*	63 (13.4%)	16 (7F†, 9M)	10 (2F, 8M)
Total	1437	881	127	33	11

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.