STIs often come in twos and threes HIV, syphilis and chlamydial co-infections.

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A 30 yr old homosexual male attended the department of genitourinary medicine on the advice of a friend. He gave a 3-month history of about 20 kg(3 stone) weight loss, dizziness, "malaise", night sweats and what he described as an "anal fissure", with pain and blood on opening his bowels. He also complained of a dry scaly rash on his hands and feet. He had stopped working. He had been diagnosed HIV positive by his GP four weeks earlier. In general he felt "awful" and was obviously concerned he may have advanced HIV disease. He had had two casual male sexual contacts, with whom he had unprotected receptive anal intercourse. Both were from the North East. The contacts occurred 8 and 9 months prior to presentation.

He had no significant past medical history and was on no medications. He gave a history of Hepatitis B vaccination and a negative HIV test 10 years ago. There had been no foreign sexual contact, he had no tattoos or piercings, was a non-smoker and drank very little alcohol.

On examination he was unwell, gaunt with generalised rubbery lymphadenopathy. There was an erythematous scaly demarcated rash on the palms and a thick scaly rash over the soles (figures 1&2).

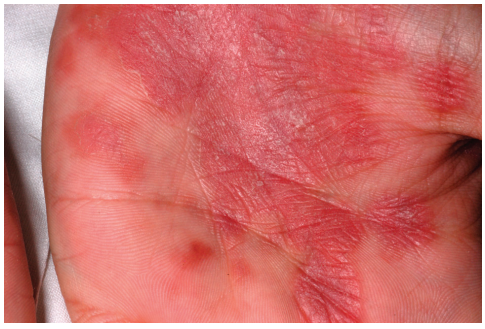

Figure 1.

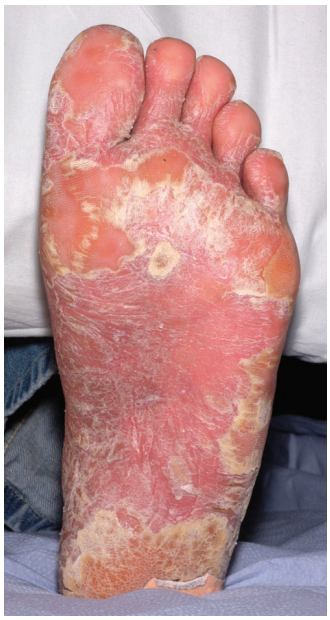

Figure 2.

The scrotum was erythematous and scaly. Perianal examination revealed excoriation, bleeding and either warts or skin tags. There was nothing to suggest perianal herpes. He had no penile discharge.

A presumptive diagnosis was made of advanced HIV disease with or without other infection. His skin was treated with emollient and antifungal cream pending results and an appointment made for review the following week when results would be available.

On review he was given his results and reassured, that with a normal CD4 count, at present he did not have advanced HIV. He did however have evidence of rectal chlamydial infection and early syphilis. In view of the rectal symptoms a further swab was taken for lymphogranuloma venereum (LGV). He was treated with three weeks of doxycycline 100mg twice a day (for Chlamydia) and weekly injections of benzathine benzyl penicillin 2.4

megaunits for 3 weeks (for syphilis). At each weekly review for his penicillin injections his symptoms and signs were improving such that by four weeks his skin was normal and he had no perianal/rectal signs or symptoms. His dizziness/malaise had all resolved and he had returned to work. Biochemical function had normalised. His syphilis serology responded with a four fold fall in his VDRL and his IgM test becoming negative. Follow up HIV viral load and CD4 count indicate stable disease. Contact tracing has so far been unsuccessful.

Discussion

Sexually transmitted infections are commonly multiple and the presence of one should prompt screening for others. Although this patient presented with symptoms suggestive of immune suppression related to his HIV infection, all his symptoms resolved with effective treatment of his syphilis and chlamydial infections.

Between 1998 and 2006 the number of syphilis cases seen at departments of genitourinary medicine has increased 20 fold[1]. Syphilis used to be known as "the great pretender" and its manifestations are many and varied. Classical primary syphilis will present with a painless chancre (ulcer) at the site of sexual contact – either genital or extra genital. As the lesion is often painless and may be in a hidden site it may be missed or not examined unless looked for specifically (oral, anal, vaginal). Without treatment the chancre will resolve. Secondary syphilis generally presents with one of a variety of skin rashes, most commonly papulosquamous, which often affects the palms and soles. Although serology may be initially negative in the primary stage, all tests will be strongly positive in secondary syphilis. Other common manifestations of early syphilis include malaise and lymphadenopathy with abnormal liver function tests. Patients may be seen with dermatological, neurological or ophthalmological complications of early syphilis when early syphilis may not be considered in the differential diagnosis.

Genital chlamydial infection in females is a common cause of infertility, pelvic infection and chronic pelvic pain. In younger males it is a frequent cause of epididymitis. Chlamydia can cause proctitis in both sexes, but more commonly in homosexual males. Chlamydia is also implicated in Reiter's syndrome - urethritis, conjunctivitis, arthritis and the skin manifestations of keratoderma blennorrhagica and mucosal ulceration. In the United Kingdom the majority of genital chlamydial infections are caused by serovars D to K. Lymphgranuloma venereum (LGV) is caused by chlamydial serovars L1 – L3. In the past this has generally been considered to be a tropical ulcerative sexually transmitted infection. The initial genital ulcer is small but infection causes inguinal lymphadenopathy and/or acute haemorrhagic proctitis (anorectal syndrome). Untreated infection can lead to scarring, swelling or deformity in the anogenital area (inguinal bubo, genital elephantiasis, lymphoedema, rectal stricture, perianal abscesses, perineal and rectovaginal fistulas). Until 2004 LGV was rare in the United Kingdom. Cases were initially reported in 2003 from various European centres and an enhanced surveillance system for LGV was set up in Great Britain in 2004. Between 2004 and 2006, 444 cases were confirmed and 418 had epidemiological data[2]. The majority were in men who have sex with men (MSM), white and in the 35-44 or 45- 54 age groups. The majority of cases were reported from London, Brighton then the North West. Isolated cases have been reported from the rest of the UK. There is a strong association with HIV infection. (80% co infection) Cases peaked in the third quarter of 2005 and numbers have fallen since then. Although not present in our patient it is important the diagnosis was considered. Without making the diagnosis it is possible patients may undergo investigations

for inflammatory or other bowel pathology and anecdotal reports suggest patients have been listed for colectomy which has only been avoided once an appropriate test and treatment has been undertaken. A subsequent patient has been seen recently at our other clinic where the diagnosis of LGV proctitis has been confirmed.

The patient remains very well and under regular review to ensure there is no relapse in his syphilis serology and for follow up of his HIV infection.

References

1 Health protection agency statistics on Syphilis http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/Stats/STIs/syphilis/statistics.htm#f1

2 Health protection agency statistics on LGV http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/Stats/STIs/lgv/statistics.htm