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Characteristics of elderly Chinese male with sexually transmitted infections: a preliminary survey

Speaker: Dr. N.M. Luk
Medical and Health Officer, Social Hygiene Service

Sexually transmitted infections (STI) is an important public health issue in Hong Kong. It is more common among the young and sexually active population but there is no preclusion from the elderly. Recent studies showed that STI are not uncommon among the elderly and the percentage of elderly patients attending male STI clinic increased from 4.87 to 7.47 between 2000 and 2003. As the proportion of elderly population is growing in Hong Kong, STI in the elderly will certainly become a growing concern in public health.

A retrospective study of STI among Hong Kong Chinese elderly (65 or older) male patients attending the Yaumatei Social Hygiene Clinic was carried out in 2003. Three hundred and seventy-two patients were included for analysis. Seventy-four percent of patients did not use condom during casual sex, 57% had casual sex in Hong Kong, and 58% had one or more casual sexual contact per year. Non-gonococcal urethritis, genital wart, gonorrhoea, late latent syphilis and genital herpes were the commonest STI diagnosed. Statistical analysis using odds ratio revealed that casual sex in the past 3 months, older age (more than 75), higher frequency of casual sex were the risk factors for STI in the elderly. The study also found that only 25% of patients had sex with regular partner within one month of presentation and many of them had stopped having sex with their regular partners for years. The speaker pointed out that unsatisfactory sexual relationship between Chinese male patients and their regular sex partner might be an important predisposing factor to their practice of casual sex.

Learning points:
Sexually transmitted disease is not uncommon among elderly in Hong Kong. Unsatisfactory sexual relationship with regular sex partner may be an important predisposing factor to casual sex in the Chinese elderly males. Further studies looking into this aspect may be warranted.

Bearings of HIV infection on other sexually transmitted infections

Speaker: Dr. W.K. Tang
Medical and Health Officer, Social Hygiene Service

Sexually transmitted infections (STIs) usually occur in people with high risk sexual behaviours. For generations, multiple STIs occurred in individual patients. However, not until HIV emerged, did these infections interact so significantly with each other.

Emergence of HIV epidemic has dramatically altered the field of STIs. Although most STIs present and progress as usual irrespective of the HIV status, it is well documented that HIV infection can alter the presentation, progression and/or treatments

of other STIs. In this lecture, the speaker tries to highlight this important aspect.

Genital herpes in HIV-infected patients can be more severe, presents at atypical sites, and lasts longer than normal population. When treatment is required, for example in the first episode of the disease, a higher dose of antiviral is usually needed. Suppressive therapy in frequent relapsers (>6 recurrences per year) is beneficial not only for symptomatic improvement but also in the reduction of shedding of both viruses and thereby their transmission.

For most people with HIV and syphilis co-infections, serologic tests are accurate and reliable for diagnosis and follow-up of the response to treatment. Thus these tests can be interpreted as those in immunocompetent patients. However, as a consequence of the immunologic abnormalities seen in HIV infection, diagnosis of syphilis through standard serologic testing may be challenging. Either false-positive or false-negative Venereal Disease Research Laboratory (VDRL) tests, because of polyclonal B cell activation after HIV infection, may occur. There may be a delay in VDRL response after treatment. The anti-fluorescent Treponema antibody (anti-FTA) test may be negative due to immunodeficiency. Theoretically, syphilis enzyme immunoassay (EIA), which is recently introduced into the Social Hygiene Service, may help circumvent this problem. However, more data is needed to assess its role in the diagnosis of syphilis in the HIV infected group.

HIV infected patients also appear to progress more rapidly through the clinical stages of syphilis and they often have an atypical clinical presentation. Patients may have a refractory course after treatment. No treatment regimens for syphilis have been demonstrated to be more effective in preventing neurosyphilis in HIV-infected patients than the current one recommended for non-HIV infected patients. Careful follow-up after therapy is essential. The management of syphilis in HIV-infected host is a complex issue in which further study is clearly necessary.

Relatively few studies have evaluated chancroid, granuloma inguinale, and lymphogranuloma venereum in HIV-positive patients. The clinical presentation, diagnoses and treatments of these diseases appear to have only minor or no significant differences from those in HIV-negative patients. HIV-infected patients who have chancroid should be monitored closely because this group of patients are more likely to experience treatment failure and to have ulcers that heal more slowly. Also combination treatment may be needed for HIV-positive patients with granuloma inguinale.

Genital human papilloma virus infections occur more commonly in HIV-infected patients when compared with age-matched healthy controls. The lesions tend to be more diffuse, dysplastic and subclinical. Higher rate of malignant transformation is also reported. Successful treatment of condylomas thus appears easier when a person's underlying HIV infection is better controlled.

Molluscum contagiosum in HIV-positive patients typically affects the face and neck. Generalised involvement must be differentiated from disseminated fungal infections. There is no evidence that lesions resolve spontaneously unless the underlying immunity is improved.

Scabies in HIV patients can be more contagious and fulminant. Young patients with HIV risk factors in whom papular or crusted scabies develops without an apparent underlying cause should be suspected of having HIV infection. Multiple treatments and sometimes, systemic agents are needed to achieve a cure.

Learning points:

HIV infection can have profound effects on other STIs. A high index of suspicion of an underlying HIV infection is needed when one sees patients with STIs which have atypical manifestations.

Differential diagnosis of annular cutaneous lesions

Speaker: Dr. P.T. Chan
Medical and Health Officer, Social Hygiene Service

Annular cutaneous eruptions may be divided, according to their morphology, into erythema, pustules/bullae, keratotic or perforating papules. Annular erythema can be classified, according to the aetiology, into congenital, inflammatory, infective, neoplastic, endocrine, vascular or iatrogenic. As in all other disciplines in medicine, history, physical examination and investigations are essential in making the correct diagnosis.

The most common form of annular cutaneous lesion is tinea corporis and cruris. Most of the tinea infections in Hong Kong are caused by Trichophyton species. One exception is tinea capitis which is caused mostly by Microsporum species. The diagnosis of tinea infection can be confirmed by skin scraping for fungal smear and culture. Topical treatment is usually sufficient but oral therapy can be considered in patients who are intolerant to topical drugs, have extensive disease, have hyperkeratotic palm/sole lesions or are immunosuppressed. Leprosy manifests as a clinico-immunological spectrum, ranging from tuberculoid leprosy at one end to lepromatous leprosy at another. Annular cutaneous eruption with sensory loss and peripheral nerve thickening may be the presenting feature of tuberculoid or borderline leprosy. The diagnosis is confirmed by split skin smear and skin biopsy. Multidrug therapy is employed in treating leprosy to reduce the emergence of resistance strain. Syphilis is a sexually transmitted disease caused by Treponema pallidum. Cutaneous eruption is a common manifestation of secondary syphilis. It is characterised by red to copper-coloured maculopapules distributed symmetrically over the body with involvement of palms and soles. In tertiary syphilis, nodular syphilide manifests as coppery red nodules arranged in groups or in an arcuate or circinate pattern. The diagnosis of syphilis can be confirmed by serology or direct demonstration of spirochetes by dark ground examination. Unless otherwise contraindicated, penicillin injection is the most effective treatment for syphilis.

Subacute cutaneous lupus erythematosus (SCLE) can present as either papulosquamous or annular forms. Anti-Ro antibody is often present in SCLE patients. Skin biopsy for histology and direct immunofluorescence helps to confirm the diagnosis. The disease is usually treated by topical steroid and sun protection. For refractory cases, a wide variety of systemic agents including hydroxychloroquine may be used. Erythema marginatum usually spreads quickly but it disappears rapidly in hours to several days. It is important to recognise this entity as it is one of the major criteria for the diagnosis of rheumatic fever. Pityriasis rosea is a clinically distinctive disease characterised by the development of herald patch with collarette of scales and secondary eruption with multiple oval macules arranged in a Christmas tree distribution. It is speculated to be a dermatosis induced by an infective agent but so far no conclusion can be made on the responsible agent. Topical steroid, oral antihistamine, erythromycin and ultraviolet B have been reported to be useful in the management of pityriasis rosea. Lichen planus is an inflammatory dermatosis which has a number of variants. One of them is annular lichen planus. The annular variant is most often found in the penis and intertriginous area. Treatment includes topical/intralesional steroid and antihistamine.

Erythema multiforme is a self-limited, relapsing disease that is characterised clinically by target-shaped urticarial plaques and mucous membrane lesions. It is a disease entity mostly triggered by herpes simplex, as opposed to Stevens-Johnson syndrome and toxic epidermal necrolysis which are often drug-related. The disease can usually be diagnosed clinically when the typical target lesion, consisting of a central dusky disc surrounded by a ring of pale oedema and erythematous halo, is seen. Topical steroid,

analgesics and mouth wash are often employed in treating erythema multiforme. In cases with frequent relapses, suppressive acyclovir therapy may be considered. Granuloma annulare characteristically manifests as non-scaly, annular eruptions over distal extremities. Histologically, the disease is characterised by a triad of necrobiosis, mucin deposition and histiocytic infiltration. Its relationship with diabetes mellitus is controversial. For localised granuloma annulare lesions, topical/ intralesional steroid or cryotherapy can be employed. For generalised granuloma annulare, systemic retinoids, dapsone or photo-chemotherapy can be considered.

Erythema annulare centrifugum (EAC) is characterised clinically by annular lesions that migrate centrifugally and histologically by a lymphohistiocytic infiltrate that tightly aggregates around the blood vessels. Historically, it was divided into superficial and deep forms. But recently, there is dispute on whether these two forms belong to the same disease spectrum or are two separate diseases. Reported triggering factors for EAC are diverse but there have been doubt on whether their association is genuine. Topical steroid, calcipotriol and oral antihistamine have been reported to be useful in the management of EAC.

Mycosis fungoides (MF) is the most common type of cutaneous T-cell lymphoma. The disease starts off with erythematous and fine scaling lesions with a variable degree of poikiloderma. Central healing leads to arcuate or horse-shoe shaped configurations. The disease can progress to tumour or erythroderma phases over years to decades. Diagnosis of mycosis fungoides requires clinico-pathological correlation. Because of the tendency of neoplastic cells to reside in the skin, staging computerised tomography and bone marrow biopsy are only necessary in more advanced stages of disease. Skin directed therapy, such as topical steroids, chemotherapy or bexarotene can be used for early stage MF. In more advanced disease stages, photo-chemotherapy, radiation therapy or systemic chemotherapy may be used. Erythema gyratum repens (EGR) manifests as multiple annular erythematous scaling lesions that give rise to a wood grain pattern. As a paraneoplastic disease, one should investigate the possibility of underlying malignancy in managing patients with EGR. About 83% of cases of EGR are associated with underlying malignancy, the most common of which is carcinoma of bronchus.

Learning points:

The most common form of annular cutaneous eruptions is tinea infection. History, physical examination and investigations are essential in making the correct diagnosis.