Kaposi's Seen in HIV Patients on Antiretrovirals

BY TIMOTHY F. KIRN
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SAN FRANCISCO — Some HIV-infected patients who are well managed on highly active antiretroviral therapy are developing Kaposi's sarcoma, Dr. Toby A. Maurer said at a meeting on HIV management sponsored by the University of California, San Francisco.

In this trend, which has been identified in San Francisco by Dr. Maurer and her associates, patients often have CD4 counts of 300 and even 600 cells/mcL and low viral loads. Yet they have the telltale purple blotches of Kaposi's, said Dr. Maurer, chief of dermatology at San Francisco General Hospital.

"These patients are very perplexing to us clinically," she said, explaining that these are not flares of Kaposi's, which can sometimes happen at the start of highly active antiretroviral therapy (HAART). Rather, these are occurrences in patients who are fairly well maintained on the therapy.

The question is whether these patients have developed abnormal T-cell function over time on HAART, despite high CD4 cell counts, thus causing the loss of immunologic control of their Kaposi's sarcoma; or whether their systemic disease was not detected and treated.

"Clinically we are trying to decide what to do with these patients because antiretrovirals don't seem to do it," Dr. Maurer said. "And, [the patients] are not sick enough nor do they have evidence of systemic KS to warrant chemotherapy."

Although she said there is still no good, reliable method of detecting Kaposi's that has spread and is systemic, Dr. Maurer offered a suggestion to those checking Kaposi's lesions on the legs: Look for edema in the appendage because that is a sign of systemic disease. Systemic disease has a high mortality rate, about 25%, and those patients need more than just antiretroviral treatment.

Dermatologists who have seen this phenomenon of patients on HAART who have had a recurrence of Kaposi's sarcoma may contact Dr. Maurer at maurert@derm.ucsf.edu. ■

Gonorrheal Testing of Anus, Throat Urged

SAN FRANCISCO — As the incidence of gonorrhea continues to increase, physicians need to be doing more testing for the venereal disease in the anus and the throat, particularly in gay men, said Dr. Gail Bolan, chief of the sexually transmitted diseases control branch for California.

Gonorrhea incidence in the United States as a whole and in California specifically had been declining for 3 decades before starting to climb in about the year 2000, Dr. Bolan said at a meeting on HIV management sponsored by the University of California, San Francisco.

A recent study in San Francisco of men who have sex with men reported that if only urine and urethral screening were performed in those men, about 65% of gonorrhea cases would be missed, she noted.

The study found that 85% of the rectal infections were asymptomatic, indicating the possibility that these infections may be an important factor fueling the incidence increase (Clin. Infect. Dis. 2005;41:67-74).

In addition, the study also reported that 53% of chlamydial infections were at nonurethral sites.

Partly because of these concerns, the Centers for Disease Control and Prevention recently updated its sexually transmitted diseases guidelines to include what to ask when taking a sexual history to screen for disease.

The new guidelines suggest that the sexual history taking must include specific questions regarding what is known as the "5 P's": partners, pregnancy protection, protection from sexually transmitted diseases, practices, and past history of sexually transmitted diseases. "You need to do appropriate sexual history, identify sites of exposure, and then, depending on those sites, do appropriate testing," she said.

Dr. Bolan also said that fluoroquinolone-resistant gonorrhea continues to be a problem. The CDC guidelines recommend that fluoroquinolones not be used in men who have sex with men or in areas where fluoroquinolone resistance is high.

—Timothy F. Kirn