Lymphogranuloma Venereum May Be Poised to Make a Comeback

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — Lymphogranuloma venereum, once common among gay men but rare in the United States for the last decade, may be poised to make a comeback, Gail Bolan, M.D., said at a meeting on HIV management sponsored by the University of California, San Francisco.

The Centers for Disease Control and Prevention recently reported on an outbreak of lymphogranuloma venereum (LGV) among men who have sex with men in the Netherlands (MMWR 2004;53:985-8).

There has been one confirmed U.S. case of the opportunistic infection out of Emory University (Atlanta), and the New York City Department of Health and Mental Hygiene reported two others in February.

Another possible case from San Francisco has not yet been confirmed, said Dr. Bolan, chief of the sexually transmitted disease control branch of the California Department of Health Services, in Berkeley.

LGV is common in Africa, Southeast Asia, Central and South America, and the Caribbean but has been rare in developed countries in recent years. The outbreak in the Netherlands included 92 confirmed cases during an 18-month period in 2003 and 2004, compared with an average of 5 cases annually during previous years.

Chlamydia trachomatis is the causative organism in LGV, but the serotypes involved are not the ones responsible for garden-variety chlamydia infections.

The classic presentation includes inguinal adenopathy (buboes). These start as painless papules, nodules, or ulcers that resolve spontaneously. In the outbreak in the Netherlands, however, only one of the patients had a genital bubo. Most had GI symptoms including mucopurulent anal discharge and bloody proctitis. Other symptoms of this infection, which is sometimes mistaken for Crohn's disease, include bleeding, tenesmus, fever, and constitutional symptoms. Anoscopy shows diffuse friability and discrete ulcerations. The destructive granulomatous process can cause complications such as scarring, genital elephantiasis, fistulas, rectal strictures, and perianal abscesses.

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The CDC's study of the Netherlands outbreak identified several risk factors, including unprotected receptive anal intercourse or fisting, casual-sex gatherings, and other concurrent STDs. Of the patients whose HIV status was known, 77% were HIV-positive.

A positive chlamydia test from the mucosal site or a bubo aspirate is necessary to confirm the diagnosis. For rectal lesions, it's better to get a swab under control by anoscopy than to take a blind rectal swab, Dr. Bolan said. But the available serologic tests are poorly standardized, she added. It's better, when possible, to confirm the specific LGV serotype by polymerase chain reaction sequencing or tissue culture and monoclonal antibodies.

The CDC's treatment guidelines recommend oral doxycycline, 100 mg b.i.d., for 21 days. Oral erythromycin, 500 mg four times daily for 21 days, is an alternative. Some experts also recommend oral azithromycin, 1 g weekly for 3 weeks, but this regimen has never been formally evaluated.

Partners of affected patients (within the 30 days prior to the onset of symptoms) need evaluation. If these individuals are asymptomatic, they should be treated with doxycycline, 100 mg b.i.d., for 7 days, or with a single dose of 1 g of azithromycin. ■

Oseltamivir Reduces Rates of Pneumonia, Antibiotic Use

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — The benefits of oseltamivir aren't limited to treating and preventing influenza, Beth L. Nordstrom, Ph.D., reported in a poster presentation at the annual Interscience Conference on Antimicrobial Agents and Chemotherapy.

Oseltamivir (Tamiflu) is indicated for the treatment of influenza in patients aged 1 year and older who have been symptomatic for no more than 2 days, and for prophylaxis of influenza in persons aged 13 years and older.

New data suggest that the drug also reduces the risk of pneumonia in all age groups, and the rates of antibiotic use and hospitalization in the oldest and youngest patients, said Dr. Nordstrom, of Ingenix Epidemiology, Auburndale, Mass.

In a retrospective cohort study sponsored by Hoffmann-La Roche, claims data from a large U.S. insurer containing a diagnosis of influenza from Dec. 1, 1999, through March 31, 2002, were analyzed.

Patients of all ages who had received oseltamivir were at significantly lower risk for pneumonia, particularly the oldest and youngest age groups. Among children aged 1-12 years, the proportion with a diagnosis of pneumonia was 0.7% among the 586 for whom oseltamivir was dispensed on the day of influenza diagnosis, compared with 2.5% of the 17,886 who did not receive oseltamivir, a 66% risk reduction.

In patients aged 13-59, pneumonia was diagnosed in 1.3% of the 10,649 who received the drug, compared with 2.1% of the 41,007 who did not—a reduction of 19%. In adults aged 60 and older, the difference was 1.7% of 463 with oseltamivir versus 8.8% of 3,298 without, a 59% drop.

The impact of oseltamivir on antibiotic dispensing and hospitalization was also greater in the youngest and oldest age groups. Antibiotic use dropped with oseltamivir by 30% in the 1- to 12-year-olds, by 9% in the 13- to 59-year-olds, and by 14% in the 60-plus group. Hospitalizations were reduced by 71% with oseltamivir in the 1- to 12-year-olds, by 25% in the 13- to 59-year age group and 45% in the 60-plus patients, Dr. Nordstrom reported. ■

CLINICAL CAPSULES

Avian Flu

Two cases of Avian influenza in a family in Thailand appear to have resulted from person-to-person transmission of the disease. In most of the previous human cases, the individuals had well-documented contact with sick or dying poultry, Kumnuan Ungchusak, M.D., of the Thai Ministry of Public Health, Nonthaburi, Thailand, and colleagues reported.

The index patient became ill following exposure to dying household chickens, and her mother, who came from a distant city to care for her, developed pneumonia and died after providing 16-18 hours of unprotected nursing care. She had no known exposure to poultry. An aunt who helped care for the index patient also developed fever and then pneumonia in the days following the care (N. Engl. J. Med. 2005;352:333-40).

Autopsy tissue from the mother and nasopharyngeal and throat swabs from the aunt were positive for influenza A. Viral gene sequencing showed no change in key features of the virus; the sequences clustered closely with others from recent avian isolates in Thailand, they noted.

Bacterial Meningitis

Ciprofloxacin and ceftriaxone are better than rifampin for prevention of bacterial meningitis in patients at risk of developing the infection, a recent Cochrane Review suggests.

These drugs appear to be as effective as rifampin—the treatment that tends to be used for eradicating *Neisseria meningitidis* associated with bacterial meningitis—but they are associated with less risk of development of antibiotic resistance, said Abigail Fraser, M.D., of Rabin Medical Centre, Petah-Tikan, Israel, and her colleagues.

Furthermore, ciprofloxacin and ceftriaxone are each given in a single dose, whereas rifampin is given twice daily for 2 days. For this reason, selecting ciprofloxacin or ceftriaxone could improve compliance, the reviewers concluded (Cochrane Database Syst, Rev. 2005 [1]:CD004785.pub2. DOI:10.1002/14651858.CD004785.pub2).

Preventing IPD

A recent outbreak of invasive pneumococcal disease in Alaska led to an investigation that has underscored the preventability of the disease and the importance of vaccination.

Between January 2003 and March 2004, 14 cases of invasive pneumococcal disease were reported in a rural region of the state. The mean number of cases per year in the area is 2.8, according to the Centers for Disease Control and Prevention.

Serotype 12F, which is contained in the 23-valent pneumococcal polysaccharide vaccine, was the cause of disease in 9 of the 14 patients, and 6 of those 9 patients had a medical indication for vaccination (MMWR 2005;54:72-5).

The outbreak highlights the need for providing vaccination in both inpatient and outpatient settings at every opportunity. Because many people without a regular physician might seek care in an emergency department or urgent-care clinic, it is important for these types of facilities to also provide vaccination to those with a medical or age-related indication, the investigators said, noting that doing so could substantially reduce complications and deaths due to pneumococcal disease.

Barriers to vaccination should be identified, and standing orders programs should be implemented, they added.

MRSA Precautions

Single-room or cohort isolation of hospitalized patients with methicillin-resistant *Staphylococcus aureus* infection does not appear to reduce transmissions, a study suggests.

Admission and weekly screens were performed to determine the incidence of MRSA colonization during the prospective, 1-year study conducted in the intensive care units of two London teaching hospitals. For the middle 6 months of the study period, patients with MRSA were not isolated; during the first 3 months and last 3 months, MRSA-positive patients were isolated in single rooms or nursing cohorts. All 866 patients who needed ICU care for longer than 48 hours were included, Jorge A. Cepeda, M.D., of University College London Hospitals and his colleagues reported.

During the two periods of the study, patients had similar characteristics and MRSA acquisition rates. Use of standard precautions and hand-washing rates did not change between the two study periods. There was no evidence of increased MRSA transmission during the period when infected patients were not isolated, compared with the period when infected patients were moved to isolation rooms (hazard ratio 0.73), the investigators said (Lancet 2005;365:295-304).

Given these findings and the risks inherent in moving and/or isolating critically ill patients, isolation policies in intensive care units with endemic MRSA should be reevaluated, they concluded, adding that efforts to find more effective means of containing MRSA are needed.

—Sharon Worcester