A Man with a Rash and “Pink Eye”

STD Case Studies from the Denver Metro Health Clinic
Case

• 45 year-old HIV+ gay male, presented to the STD clinic as a contact to gonorrhea
• Generalized rash since 6 weeks
• Discontinued HIV medication 5 weeks prior
• CD4 count dropped from >1,000 to 460/mm3
• Rash did not resolve
• “Pink Eye” since 1 week, predominantly right-sided
  — Pain
  — Blurry vision
Sexual and STI History

- Committed relationship with HIV+ partner
- Occasional oral/anal sex with incidental partners, mostly protected
  - Last contact: 2 weeks ago
- History of primary syphilis 4 years ago
  - Treated with 2.4 MU LAB at this clinic
  - Last RPR: NR (12 months ago)
Note: “ciliary flush” around the edge of the cornea
In evaluating this patient, what is the **LEAST** useful?

A. Neurologic examination
B. Quantitative non-treponemal test (RPR/VDRL)
C. Treponemal test (TPPA, FTA-ABS)
D. Lumbar puncture Refer to ophthalmologist
E. Refer to ophthalmologist
Results

- RPR: reactive at 1:256
- TPPA: positive
- LP: VDRL 1:1; 70 WBC
- Ophthalmic examination: anterior uveitis
What is the likely diagnosis?

A. Primary syphilis
B. Secondary syphilis
C. Tertiary syphilis
D. Neurosyphilis
E. A and D
F. B and D
How should this patient be treated?

A. Per CDC guidelines for secondary syphilis: single dose of 2.4 million units of benzathine penicillin i.m.

B. Per CDC guidelines for syphilis with uveitis and HIV infection: 2.4 million units of benzathine penicillin i.m. once a week for 3 weeks

C. Per CDC guidelines for neurosyphilis: aqueous crystalline penicillin G 18-24 million units per day for 10-14 days.
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Two Men with Extensive Genital Ulcer Disease

Recent Cases at the Denver Metro Health Clinic
Case 1

- 47-y.o. Caucasian MSM complaining of painful lesion penis since 2 weeks
- Sexual history: 1 male partner in past 3 months; oral sex (both insertive and receptive) and insertive anal sex only
- No history of STIs
- No history of (injection) drug use
- Last HIV test >2 years ago (negative)
Case 1

- Inspection:
  - 2.5 cm round, superficial ulceration on shaft penis
  - No lymphadenopathy
What is your first thought?

A. Primary syphilis
B. Chancroid
C. Genital herpes
D. Lymphogranuloma venereum
What Test Would be the Least Useful?

A. Herpes culture
B. HIV rapid test
C. Syphilis darkfield
D. RPR
E. All should be done
Case 1

- Lab (stat):
  - Dark field: negative (x 4)
  - RPR: non-reactive
  - HIV (rapid test): reactive
Now what do you think?

A. Primary syphilis
B. Chancroid
C. Genital herpes
D. Lymphogranuloma venereum
E. Something else
Case 1

• Differential Diagnosis:
  – Primary syphilis (atypical presentation)
  – Genital herpes

• Management:
  – Doxycycline 100 mg bid (pt penicillin allergic)
  – Acyclovir 400 mg tid
  – Referred to HIV care
Case 1

• Follow-up at 1 week:
  – Lesion slightly improved
  – However, pt feels sick, short of breath and running a fever
  – RR 86/56
  – Temp: 103 °F
  – Pulse-ox 83%

• Lab results from previous visit
  – Herpes culture: positive for HSV-2
  – HIV confirmed by Western Blot
  – CD4 count: 12 / uL
  – Viral load: 32,900 copies /mL
  – FTA: negative
Case 1

• Diagnoses:
  – HIV infection (advanced)
  – Pneumocystis carinii (jiroveci) pneumonia
  – Extensive genital herpes

• Management
  – Admitted to hospital
    • PCP confirmed and treated
    • High-dose acyclovir for genital lesion
  – Follow-up in HIV care
    • PCP resolved
    • Penile lesion resolved
    • Started OI prophylaxis and anti-retroviral therapy
Case 2

- 24 y.o. Hispanic male complaining of penile lesions since 1 month
- Pt denies high risk sexual behaviors, sex with men, or injection drug use
- No history of STI
- Last HIV test: 4 months ago – negative (according to pt.)
Case 2

• Inspection
  – Large, partly confluent, superficial erosions inside foreskin, corona and extending onto glans penis ~ very painful to the touch
  – Tender, bilateral inguinal lymphadenopathy

• Lab (stat):
  – Dark field: negative (x4)
  – RPR: non-reactive
  – HIV (rapid): reactive
Case 2

• Diagnosis: Extensive genital herpes in (advanced) HIV infection

• Management
  – Acyclovir 800 mg tid
  – Additional labs (herpes culture; viral load; CD4 count)
  – Referred to HIV care

• Follow-up Labs:
  – HSV culture: positive for HSV-2
  – HIV confirmed positive by Western Blot
  – CD4 count: 64 / uL
  – HIV Viral load: 48,000 / mL
Conclusion

• Despite efforts to promote early detection and treatment of HIV infection, HIV-infected patients continue to present with advanced stages of HIV infection.

• Such patients may initially be seen at STI clinics with extensive HSV-related genital lesions.
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