Face the Facts When Dealing With Genital Herpes

Patient education is critical, especially since many of those who test positive are asymptomatic.

BY DIANA MAHONEY
New England Bureau

BOSTON— "Genital herpes is a recurrent, lifelong viral disease. This is the one thing that patients and clinicians don't like to say, but there's no way around" it, Laura J. Mulcahy said at a conference on contraceptive technology sponsored by Contemporary Forums.

Other difficult truths about infection with herpes simplex virus (HSV) type 2? The overwhelming majority of people infected with the virus don't know that they have it, and people with asymptomatic or unrecognized disease shed the virus intermittently in the genital tract, said Ms. Mulcahy, a certified family nurse practitioner who is assistant medical director of the STD Center for Excellence at Montefiore Medical Center in New York.

"When we ask patients prior to screening for HSV-2 if they have a history of genital herpes … about 90% of those who ultimately test positive for HSV-2 antibodies reported having no history or symptoms of the infection," she said. This underrecognition can be attributed to the fact that the leading cause of HSV-2 infection is asymptomatic shedding of the virus.

"There is a misperception and some clinicians are still telling patients that the infection is spread only through [HSV-2] sores. This is absolutely not true. The virus can shed even when the skin looks normal, and that's when most infections occur," she said.

Patient education about asymptomatic disease is critical to an effective screening protocol. "When patients come in and have no symptoms, it means nothing to us," Ms. Mulcahy emphasized. Patients who come in for STD screening are told that, "from this day forward, the fact that you or your partner have no symptoms means nothing; the fact that you and your partner look fine means nothing; and the fact that you or your partner had a negative screen 6 months ago, if you've had partners in the interim, means nothing," she said.

Another factor contributing to the high rate of unrecognized disease is that many patients who have been screened for STDs believe they have been tested for genital herpes. "A complete STD screen does not include testing for herpes. Clinicians don't always tell this to patients, so many patients believe they are being tested for everything. If their STD screen is negative, they assume that means they don't have herpes," Ms. Mulcahy said.

For this reason, "clinicians who don't routinely screen for herpes [as part of an STD screening protocol] must inform patients that they are not being tested and chart that in the patient record so there is no confusion," she added.

If a patient asks to be screened for HSV-2, there are several points that should be addressed before testing, Ms. Mulcahy advised:

► The absence of symptoms does not predict a negative screen.

► In patients with lesions, a herpes culture has low sensitivity, especially as lesions heal. As such, a negative culture does not rule out HSV-2.

► In the event of a positive HSV-2 test in an asymptomatic person, it is not possible to determine how long the virus has been present, when or whether they will have outbreaks, or whether they will ever have a problem with herpes.

► In the event of a positive HSV-2 test, patients in some states have a legal obligation to inform current and future sexual partners of their infection status before genital to skin contact. "It is a misdemeanor in New York state, for example, to knowingly pass on or put someone else at risk for a sexually transmitted disease," Ms. Mulcahy said.

Counseling patients on these points before testing is imperative. "If you wait until after a positive screen, I can guarantee patients will no longer be listening. They need to know what to expect before they hear the word positive," she said.

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Among the tools used to screen for HSV-2, clinical examination and history are insensitive and nonspecific. "Symptoms are easily confused with other conditions or may present atypically, for example, as redness rather than sores," Ms. Mulcahy said. Viral culture is the most valid test available, despite the high rate of false negatives.

Polymerase chain reaction assays are another diagnostic option. They have increased sensitivity but are not approved by the Food and Drug Administration, nor are they available in all laboratories. Cellular detection methods, including Tzanck test and Pap smear, are not recommended for HSV detection because of their low sensitivity, she said.

Many type-specific serology tests, such as the older enzyme-lined immunoabsorbent assay tests, can result in false-positive results because of problems with cross reactivity. The newer type-specific HSV glycoprotein G1 (HSV-1) and G2 (HSV-2) tests are more reliable, but their sensitivities vary, she said, noting that a positive test should be confirmed with another test to reduce the risk of false-positive diagnoses. The Western blot is the reference standard serology test, but it is not approved and is only available from one laboratory at the University of Washington, Seattle.

"Do not underestimate the impact of this diagnosis on your patients. They will require extensive, thoughtful counseling [because] the physical impact of genital herpes is nothing compared to the psychological one," Ms. Mulcahy said.

Such counseling should include information about the natural history of disease, the ability to bear children, the transmission risk to sexual partners, and the variations in severity of primary vs. recurrent episodes. It also is important to dispel cancer myths, reiterate the fact that the virus can be transmitted in the absence of symptoms or lesions, remind patients of their obligation to inform current and future partners, and recommend counseling and testing for sexual partners, she said.

Risk-reduction strategies also should be discussed, including avoiding sexual contact when symptoms or lesions are present and using latex barrier protection and suppressive therapy. There are three oral antiviral drugs—acyclovir, valacyclovir, and famciclovir—approved for the treatment of genital herpes. Topical treatments, she stressed, "absolutely do not work and have no role in the treatment of genital herpes." ■

Syphilis Skyrockets; Diagnosis Delayed in HIV-Positive Men

BY NANCY WALSH
New York Bureau

BOSTON — The diagnosis of syphilis is often delayed in HIV-positive patients, as it is characterized by a wide range of symptoms that may not be recognized as infection with *Treponema pallidum,* according to Dr. Lawrence A. Siegel of the division of international medicine and infectious diseases, Cornell University, New York.

After declining to an all-time low in 2000, the rate of syphilis in the United States rose from 3 per 100,000 population in 2001 to 5.7 per 100,000 in 2006. Syphilis has increased particularly dramatically among men who have sex with men (MSM), who made up 4% of cases in 2000 but who represented 64% of cases in 2006, Dr. Siegel reported in a poster session at the 15th Conference on Retroviruses and Opportunistic Infections.

Nationwide, approximately 60% of cases of syphilis now are seen in HIV-positive, urban MSM, but in New York City, 97% of syphilis cases are in MSM. To more fully characterize this coinfected population in New York City, Dr. Siegel and his colleagues undertook a retrospective chart review of all HIV-positive MSM diagnosed with incident syphilis at the Cornell HIV clinic between January 2001 and December 2007.

A total of 118 cases of syphilis were identified. Stage at diagnosis was primary in 8 patients, secondary in 80, early latent in 17, and late latent in 13, Dr. Siegel reported. Three patients had neurosyphilis.

Median age of the patients was 38 years. A total of 33% were white, 30% were black, 34% were Hispanic, and the rest were classified as "other."

The HIV RNA level was less than 400 copies/mL in 56%, and median CD4 count was 399 cells/mm^3. Rapid plasma regain (RPR) titer at the time of syphilis diagnosis was 1:8 or lower in 17%, 1:16 to 1:32 in 36%, 1:64 to 1:128 in 37%, and higher than 1:256 in 10%. Clinical presentations were varied, and the diagnosis was delayed in nearly half of the patients overall. (See box.) A total of 96% of patients had a fourfold decrease in RPR titer at 1 year, but reinfections were common, being seen at a rate of 10% per year.

Delays in Syphilis Diagnosis Vary With Presenting Symptoms in HIV-Positive Patients

Symptom	Patients with delay in diagnosis	Median delay (days from symptom onset)
Mouth ulcers (n = 13)	69%	78
Sore throat (n = 25)	56%	44
Cervical lymphadenopathy (n = 23)	52%	56
Chancre (n = 13)	46%	73
Inguinal lymphadenopathy (n = 13)	46%	36
Subjective fever (n = 18)	39%	42
Generalized rash (n = 70)	23%	25
Rash on palms and soles (n = 44)	9%	7

Note: Based on data for 118 syphilis cases in HIV-positive patients.
Source: Dr. Siegel

A multivariate analysis showed that higher baseline RPR titer and diagnosis of latent syphilis were associated with a longer time until the RPR titer became negative, Dr. Siegel reported at the meeting, which was sponsored by the Foundation for Retrovirology and Human Health and the Centers for Disease Control and Prevention.

Different treatment regimens—one or three doses of 2.4 million U benzathine penicillin, or doxycycline 100 mg twice daily for 30 days—were not associated with a longer time until RPR negativity, the researchers found.

Cases of early syphilis in this population are often not identified, so a higher index of suspicion is needed among clinicians. More frequent serologic testing also is warranted, Dr. Siegel and his colleagues concluded. ■