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Data Reveal High Sexual Risk Among Asian MSMs

More intervention work is needed

INVESTIGATORS HAVE FOUND A DISTURBING TREND OF INCREASED LEVELS OF sexual risk behavior among a small, little-studied group: Asian/Pacific Islander (API) men who have sex with men (MSM).

Sexual risk behavior among this group has increased at a faster rate than with white MSM. This includes increases in unprotected anal intercourse with multiple partners, which rose from 12% in 1999 to 20% in 2002, compared with an increase from 19% to 20% in white MSM.[1]

At first glance, these findings may not be particularly alarming because the API MSM population has a very low rate of HIV infection, says Willie McFarland, MD, PhD, director of HIV/AIDS Statistics and Epidemiology at the San Francisco Department of Public Health.

But public health officials are concerned because this could be a sign that the window of opportunity is closing and HIV may soon begin to have a greater impact on this community, McFarland says.

"Now if sexually transmitted diseases (STDs) and risk behavior are equal to whites; who had experienced larger HIV transmission, then you could assume that HIV transmission will increase," McFarland says.

The key question is whether health officials will see a larger integration of the Asian community into the mainstream community, which would result in more sexual mixing, and a higher HIV prevalence pool might extend into the lower HIV prevalence pool, McFarland says.

At present, the HIV prevalence rate among API MSM is about 2.6%, and the incidence rate is 1.8%, says Kyung-Hee Choi, PhD, associate professor at the University of California, San Francisco.

"So that's almost two out of 100 young Asian/Pacific Islander MSM are getting infected," Choi says. "Now, the incidence rate may go up, and that's a concern."

One factor that may have prevented the HIV incidence rate from rising in the API community thus far is that it appears that when an API man has sex with a man who is white, Latino, or African-American, he is less likely to engage in risk behavior, Choi notes. "What's happening within the API MSM community is that when a sexual partner is API they are more likely to engage in risk behavior. Since HIV prevalence within the API community is low and they don't use condoms with other APIs, then HIV won't spread."

The unknown factor is whether this pattern of ethnic serosorting will continue, Choi explains.

Also, the HIV testing rate is relatively low among API MSM, so they may assume an API partner is HIV negative when that's not always the case, Choi says.

"There should be a continuing effort to stress that people need to be tested for themselves, but also to find out the status of their partners," Choi adds. While there may not be many HIV prevention programs specifically designed for the API community, there is one in San Francisco that is culturally savvy. The Asian and Pacific Islander Wellness Center has indi- vidual and group HIV interventions, as well as out- reach programs, says Maximilian Rocha, LCSW, director of health education at the center.

The center provides outreach services to sex clubs, bars, and to local businesses where APIs congregate, including restaurants and salons, he says. "Through outreach, we try to recruit for risk reduction counseling or some form of case management. We try to attract clients to come in for services by providing social groups and educational workshops."

Outreach workers also attend community events, street fairs, and health fairs to keep HIV services in the public eye for those who may be reluctant to take a brochure right then because of the stigma associated with HIV, Rocha notes. "We try to be integrated with our services and in collaboration with an internal HIV testing team."

One of the key priorities of the center's HIV prevention work is to be culturally competent and linguistically capable, he says.

There are Chinese, Thai, and Filipino-language educators, and, previously, there was a Vietnamese health educator, Rocha says. In all, the center has access to people who speak 20 different API languages, he adds.

An example of an intervention directed to one portion of the API community is the DOWNETime support group for Filipino men who do not identify as MSM, but who are on the down low — that is, they are having sex with men, Rocha explains.

While some support groups and social groups are sponsored by the center, there also are community groups that are held wherever people wish to congregate, including private homes, he says.

Although the program's anecdotal evidence suggests increased condom use after counseling and interventions, the outcomes have not yet been studied, and there's still work to be done, Rocha notes. "Resistance still is there. Men struggle with [using condoms] because it doesn't feel good, and sometimes, in our conversations with clients, we hear that

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this is not a top priority."

API men often are struggling with other issues, including housing, social needs, accessing peers, and having social relationships, Rocha adds.

In addition, the stigma of HIV and being gay poses a significant barrier to HIV prevention work.

For example, one health educator, who worked with the Vietnamese community, found that in Vietnam, the images associated with HIV are of women who are scantily dressed, who work as prostitutes, and who are on drugs and dying, he explains.

"So the stigma is that it's not me and only those kinds of people will get HIV," Rocha says. "So upon arriving here, they find that it's not true and that anybody can get HIV, and you may get it if you engage in these other risk activities." ■

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This article was published in the June 2004 issue of AIDS Alert.

Do All Human Bite Wounds Need Antibiotics?

ABSTRACT & COMMENTARY

Synopsis: *Changing the practice of routinely giving antibiotic prophylaxis to patients with these specific types of human bite wounds.*

Source: Broder J, et al. Low risk of infection in selected human bites treated without antibiotics. *Am J Emerg Med* 2004;22:10-13.

Most emergency medicine textbooks agree that human bite wounds, as well as dog and cat bite wounds, require antibiotic prophylaxis in addition to usual wound care practices. This study from the University of Maryland challenges this belief, and attempts to define a group of human bites at low risk of infection that do not require any antibiotic prophylaxis.

This prospective, double-blind, placebo-controlled study randomized patients with certain superficial human bite wounds to antibiotic or placebo treatment in an attempt to determine whether these wounds had similar rates of infection. Patients were eligible for enrollment if the bite wound was superficial (i.e., penetrating only the epidermis) and did not involve hands, feet, or skin overlying joints or cartilaginous structures.

Exclusion criteria included immune-compromised status, age younger than 18 years, bites older than 24 hours, and allergy to penicillin or related compounds. No patients with puncture-type bite wounds were enrolled.

Patients meeting entry criteria were randomized into the placebo or antibiotic arm of the study. Wounds were debrided as necessary and irrigated with 500 cc of normal saline. Tetanus prophylaxis was given as necessary. No wounds required sutures. Patients then were discharged from the emergency department with a five-day course of either cephalexin plus penicillin or placebo, and were instructed to return at 48 and 96 hours to be checked for signs of infection. All wounds were rechecked by the same examiner (blinded to treatment group) to eliminate the possibility of inter-rater variation in the assessment of whether wound infection was present.

One hundred-twenty-seven (127) patients were enrolled. One patient in each group was lost to follow-up, leaving 125 patients completing the protocol. The two groups were similar with respect to age and weight.

None of the 63 patients in the antibiotic group developed wound infections (0%, 95% CI 0-4.6%), and one of 62 patients in the placebo group developed wound infection (1.6%, 95% CI 0-7.3%). The groups were similar in terms of medication compliance, andno patient developed an allergic reaction.

The authors conclude that this study supports changing the practice of routinely giving antibiotic prophylaxis to patients with these specific types of human bite wounds.

■ COMMENTARY BY JACOB W. UFBERG, MD

This study supports a more common-sense approach to human bite wounds: Very superficial wounds in low- risk body areas that are given meticulous wound care are unlikely to become infected. While the study is limited by small numbers, even the wide confidence intervals do not exceed wound infection rates commonly seen among the wounds we treat in the emergency department.

Jacob W. Ufberg is the editor of Emergency Medicine Alert. This article was published in the June 2004 issue.

Melioidosis in Australia

ABSTRACT & COMMENTARY

Synopsis: *Melioidosis is endemic in parts of Australia that may be visited by tourists.*

Source: Melioidosis—Australia (Northern Territory). ProMED-Mail Archives. March 22, 2004.

ALLEN CHENG REPORTED THAT, AS OF MARCH 20, 15 patients with melioidosis had been seen at the Royal Darwin Hospital during the 2003-2004 rainy season. The Royal Darwin is the referral center for the "Top End" region of the Northern Territory of Australia.

COMMENT BY STAN DERESINSKI, MD, FACP

Melioidosis, first described in homeless morphine addicts in Rangoon in 1932, is caused by the soil and water organism *Burkholderia pseudomallei*. It is endemic in tropical areas, particularly in Southeast Asia. Cases are also seen in Africa, India, the Middle East, the South Pacific, and northern Australia.[1] Isolated cases have occurred in tropical areas of the Western Hemisphere, as well as in Hawaii and Georgia. Infection is believed to be acquired by inhalation of contaminated dust, ingestion of water containing the organism, and by contact with contaminated soil. The latter is facilitated by the presence of abrasions or more severe breaks in epidermal continuity. Person-to-person transmission by contact with body fluids is described, including 2 cases of sexual transmission.

Melioidosis in Australia is not restricted to the Northern Territory, also being reported from Queensland in association with heavy rains. Between November 1, 2001, and October 31, 2002, 47 cases were identified in the Northern Territory and Queensland. While the average annual incidence per 100,000 population was 5.8 overall, it was 25.5 among indigenous Australians.[2] Eighty-seven percent of cases occurred during the wet season. The mortality rate was 21%. In an earlier series of 252 cases in northern Australia over 10 years, 46% of patients were bacteremic, and the overall mortality was 19%.[3]

The incubation period may be as short as 2 days and as long as years. This means that patients may present after many years in a nonendemic area. After the Vietnam war, this knowledge led to concern of a "ticking time bomb" of disease emerging in veterans well after the war. Fortunately, this event never materialized to any extent.

Infection may be inapparent. Clinical disease may result from an acute localized infection, such as a local cutaneous infection at the site of inoculation, which may, however, lead to bacteremia. Pulmonary infection may range from a relatively mild bronchitis to severe progressive pneumonia, and acute bloodstream infection may present as septic shock. Chronic infection may affect any body organ. One-third of affected Thai children present with acute uppurative parotitis.

B. pseudomallei grows readily on a number of media. It may be suspected when an oxidase-positive Gram-negative bacillus is found to be resistant to gentamicin and colistin but susceptible to amoxicillin/clavulanate—a quite unusual antibiotic susceptibility pattern.

Patients with comorbidities such as diabetes mellitus and chronic lung disease are at increased risk of infection. An adult with cystic fibrosis who had returned from vacation in northern Australia was recently seen by the Infectious Disease Service at Stanford with an exacerbation of pulmonary infection due to *B. pseudomallei*. The association with cystic fibrosis has previously been reported a number of times. The combination may be lethal.

A variety of antimicrobials have been used in the treatment of melioidosis. A randomized trial in Thailand involving 214 culture-confirmed cases found no difference in mortality between patients randomized to either ceftazidime or imipenem, although failure after 48 hours of therapy was observed more frequently in the cephalosporin recipients.[4] Meropenem is used at the Royal Darwin Hospital where, in fact, all patients admitted to their ICU with sepsis during the wet season receive this carbapenem as initial therapy until culture results exclude melioidosis. This same group has also reported that adjunctive therapy with G-CSF improved survival in a cohort analysis with comparison to a historical control.[5] ■

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Stan Deresinski is the editor of Infectious Disease Alert. This article was published in the June 2004 issue.