



## INSIDE

- *Lymphogranuloma venereum* outbreak in gay men
- Hamster-bite fever?
- Have tents, will travel in San Francisco

Volume 15, No. 3  
March 2005

*Travel Medicine Advisor*® is published monthly by Thomson American Health Consultants, 3525 Piedmont Rd. NE, Six Piedmont Center, Suite 400, Atlanta, GA 30305. Periodicals postage paid at Atlanta, GA. POSTMASTER: Send address changes to *Travel Medicine Advisor*®, P.O. Box 740059, Atlanta, GA 30374.

#### Customer Service:

1-800-688-2421. Copyright © 2005. All rights reserved. No part of this newsletter may be reproduced in any form or incorporated into any information-retrieval system without the written permission of the copyright owner. This is an educational publication designed to present scientific information and opinion to health care professionals to stimulate thought and further investigation. It does not provide specific advice regarding medical diagnosis, treatment, or drug dosages for any individual case. It is not intended for use by the layman.

#### Subscription Information:

*Travel Medicine Advisor*® Update is a bimonthly supplement to *Travel Medicine Advisor*® looseleaf service. Price: \$429 (includes *Travel Medicine Advisor* looseleaf reference manual plus one-year subscription to *Travel Medicine Advisor*® Update.) To subscribe, call 1-800-688-2421.

## Anthrax Vaccination Policy Dropped After Court Ruling

### *Court rules against forced military vaccinations*

By Gary Evans

THE DEPARTMENT OF DEFENSE (DOD) HAS HALTED MANDATORY ANTHRAX vaccinations of military personnel after a ruling by the US District Court for the District of Columbia. The injunction cited a congressional “prohibition on forced inoculations with investigational drugs” in issuing a permanent injunction.

Until the FDA certifies that the vaccine is safe and effective, the DoD “may no longer subject military personnel to involuntary anthrax vaccinations absent informed consent,” the court ruled. Six plaintiffs, known as John and Jane Doe No. 1 through No. 6, brought the action to challenge the lawfulness of the government’s anthrax vaccination program.

They’re all military personnel and civilian contract employees of the DoD who have submitted or have been instructed to submit to anthrax vaccinations without their consent. The ruling also cited an expert panel on finding that “no meaningful assessment of the [the vaccine’s] value against inhalation anthrax is possible.”

Moreover, interested parties who originally were invited to comment on the vaccine in 1985 “could not have anticipated that the FDA would permit the vaccine to be used for inhalation anthrax as a result of exposure through a biological attack,” the court found. “Now for the first time, 18 years later, the FDA’s Final Rule and Order asserts the FDA ‘does not agree with the panel report,’ and believes that ‘the vaccine is indicated for active immunization against [anthrax], independent of the route of exposure,’ and that the vaccine will ‘protect humans against . . . inhalation anthrax.’”

The court ruled that the FDA position was a significant post-comment expansion of the scope of the original inquiry and it deprived the public of a meaningful opportunity to submit comments and participate in the administrative process mandated by law.

In a press release, the DoD pointed out that the ruling does not question the safety and effectiveness of the anthrax vaccine.

“The injunction centered on FDA procedural issues, stating that additional public comment should have been sought before the FDA issued

its final rule in December of 2003,” the DoD stated. “DoD remains convinced that the anthrax immunization program complies with all the legal requirements and that the anthrax vaccine is safe and effective.” ■

## Lymphogranuloma venereum Outbreak in Gay Men

ABSTRACT & COMMENTARY

**Synopsis:** Health-care providers should be vigilant for LGV, especially among MSM exposed to persons from Europe, and be prepared to diagnose the disease and provide appropriate treatment to patients and their exposed sex partners.

**Source:** Van de Larr, et al. *Lymphogranuloma venereum* Among Men Who Have Sex With Men—Netherlands, 2003-2004. *MMWR*. 2004;53(42):985-988.

VAN DE LAAR AND COLLEAGUES REPORT AN OUTBREAK of *Lymphogranuloma venereum* (LGV) among

92 gay men in the Netherlands over a 17-month period (the Netherlands typically has fewer than 5 cases per year). Only 1 patient had symptoms typically associated with LGV (inguinal lymphadenopathy and painless genital ulcer). All other patients had predominant gastrointestinal symptoms including bloody proctitis with purulent or mucous anal discharge and constipation.

Laboratory diagnosis in these well-studied cases included PCR amplification from rectal swab specimens, followed by restriction endonuclease analysis of the outer membrane protein A gene to determine genotype. Confirmed cases were defined as clinical symptoms (or contact with a case), positive PCR for *C. trachomatis*, and L1, L2, or L3 genotype confirmed by PCR. Probable cases met the first 2 criteria and had a positive serologic test for *C. trachomatis*. Possible cases met only the first criterion and had a positive serologic test.

### ■ COMMENT BY DEAN WINSLOW, MD, FACP

Since this *MMWR* report was issued at the end of October 2004, an alarming number of cases of LGV have been reported from cities in the United States, also predominantly in gay men. On Decem-

**Editor:** Frank J. Bia, MD, MPH, Professor of Medicine and Laboratory Medicine; Co-Director, Tropical Medicine and International Travelers' Clinic, Yale University School of Medicine. **Associate Editors:** Michele Barry, MD, FACP, Professor of Medicine; Co-Director, Tropical Medicine and International Travelers' Clinic, Yale University School of Medicine. Lin H. Chen, MD, Assistant Clinical Professor, Harvard Medical School Director, Travel Resource Center, Mt. Auburn Hospital, Cambridge, Mass. Philip R. Fischer, MD, DTM&H, Professor of Pediatrics, Department of Pediatric & Adolescent Medicine, Mayo Clinic, Rochester, MN. Mary-Louise Scully, MD, Sansum-Santa Barbara Medical Foundation Clinic, Santa Barbara, Calif. Kathleen J. Hynes, RN, BS, Group Health Cooperative of Puget Sound, Seattle. Elaine C. Jong, MD, Past President, American Committee on Clinical Tropical Medicine and Traveler's Health, American Society of Tropical Medicine and Hygiene; Co-Director, Travel Medicine Service, University of Washington Medical Center, Seattle. Jay S. Keystone, MD, MSc (CTM), FRCPC, Professor of Medicine; Former Director, Tropical Disease Unit, The Toronto Hospital, University of Toronto; President, International Society of Travel Medicine. Phyllis E. Kozarsky, MD, Professor of Medicine and Infectious Diseases; Director, International Travelers Clinic, Emory University School of Medicine, Atlanta. Maria D. Mileno, MD, Director, Travel Medicine, The Miriam Hospital, Associate Professor of Medicine, Brown University, Providence, RI. **Vice President/Group Publisher:** Brenda Mooney. **Editorial Group Head:** Lee Landenberger. **Managing Editor:** Robert Kimball. **Associate Managing Editor:** Leslie Hamlin. **Marketing Product Manager:** Schandale Kornegay.

Subscription prices: 1 year: \$429; single issue: \$143; 1-9 additional copies: \$319; 10-20 additional copies: \$239.

The editor and associate editors of *Travel Medicine Advisor Update* are members of the American Society of Tropical Medicine and Hygiene and/or the International Society of Travel Medicine. Statements and opinions expressed in *Travel Medicine Advisor Update* are those of the author(s) and/or editor(s) and do not necessarily reflect the official position of the organizations with which the authors are affiliated.

**ACCREDITATION:** Thomson American Health Consultants (AHC) designates this continuing medical education (CME) activity for up to 18 hours of Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Thomson American Health Consultants is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME for physicians. This CME activity was planned and produced in accordance with the ACCME Essentials. This CME activity is intended for the travel medicine specialist. It is in effect for 36 months from the date of the publication.

**THOMSON**  
AMERICAN HEALTH  
CONSULTANTS

*Travel Medicine Advisor* is published monthly by Thomson American Health Consultants, 3525 Piedmont Rd. NE, Six Piedmont Center, Suite 400, Atlanta, GA 30305.

**POSTMASTER:** Send address changes to *Travel Medicine Advisor*, P.O. Box 740059, Atlanta, GA 30374.

**Customer Service:** 1-800-688-2421.

Copyright © 2005. All rights reserved. No part of this newsletter may be reproduced in any form or incorporated into any information-retrieval system without the written permission of the copyright owner. This is an educational publication designed to present scientific information and opinion to health care professionals to stimulate thought and further investigation. It does not provide specific advice regarding medical diagnosis, treatment, or drug dosages for any individual case. It is not intended for use by the layman.

**Subscription Information:** *Travel Medicine Advisor* is a monthly supplement to *Travel Medicine Advisor* looseleaf service. Price: \$429 (includes *Travel Medicine Advisor* looseleaf reference manual plus one-year subscription to *Travel Medicine Advisor Update*.) To subscribe, call 1-800-688-2421.

### Statement of Financial Disclosure

In order to reveal any potential bias in this publication, and in accordance with Accreditation Council for Continuing Medical Education guidelines, we disclose that Dr. Bia is a consultant for GlaxoSmithKline and Bristol Myers Squibb. Dr. Barry is a consultant with the Ford Foundation. She and Dr. Bia receive funds from Johnson & Johnson for academic programs. Dr. Hill reports a speaker's bureau relationship with Chiron and Merck. Dr. Jong is a consultant with Berna-Vaccines, is on the speaker's bureau of Aventis and GlaxoSmithKline, and is involved in research with Merck. Dr. Keystone is a consultant for Merck, on the speaker's bureau of GlaxoSmithKline and is involved in research with Roche. Dr. Mileno is a consultant with GlaxoSmithKline and is involved in research with Merck. Dr. Chen, Dr. Fischer, Dr. Scully, and Ms. Hynes report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

Thomson American Health Consultants accepts pharmaceutical sponsorship of some programs but only in the form of unrestricted educational grants that must meet all ACCME and ANCC requirements.

ber 22, San Francisco Department of Public Health reported 9 cases of LGV during the month of November (the first cases of LGV in San Francisco since 2001).<sup>1</sup>

Additional cases have recently been reported from France, Sweden, Atlanta, and Houston.<sup>2</sup> Any possible epidemiological link between these cases is unknown at this time.

LGV is caused by the L1, L2, or L3 strain of *C. trachomatis* (serovars A, B, Ba, and C produce trachoma and strains D-K cause the more commonly encountered oculo-genital syndromes).<sup>3</sup> The organism generally gains entrance to the body across epithelial cells of genital or anorectal mucosa or abrasions in the skin, and is almost always sexually transmitted, but transmission by fomites, nonsexual contact, and laboratory exposure has been rarely reported. A generally painless ulcer at the site of inoculation is often observed early in the course of the disease, followed by painful regional lymphadenitis and often prominent constitutional symptoms. In heterosexual men, tender, generally unilateral lymphadenopathy is often observed and can be noted both above and below the inguinal ligament, resulting in a groove sign (the differential diagnosis includes secondary syphilis, cat scratch disease, and other causes of lymphadenitis). Suppuration may occur. In homosexual men who practice receptive anal intercourse (and occasionally in women after heterosexual exposure due to lymphatic spread from the cervix or posterior vaginal wall), prominent perirectal and pelvic lymphnode involvement is seen. Later in the course of the illness (often years after initial infection), rectal stricture or elephantiasis of the genitalia may occur. Hyperplasia of intestinal and perilymphatic tissue often results in proctocolitis. Later, perirectal abscess, other pelvic abscesses, rectovaginal, and anal fistulas may be seen. In these late stages, it may be difficult to detect *C. trachomatis*.

Various nucleic acid amplification tests for *C. trachomatis* LGV-associated strains have been studied in the investigational setting. Commercially available complement fixation (CF) and microimmunofluorescence (MIF) tests for *C. trachomatis* antibodies are relatively sensitive and specific for diagnosis of LGV. If acute phase sera are drawn early in the course of infection, a 4-fold rise in titer is observed. However, if serologic testing is not performed until the third week of illness, a stable positive titer of  $\geq 1:64$  (CF) or 1:128 (MIF) is considered diagnostic (titers this high are rarely seen with infection, due to the more common oculo-genital strains).

Whereas uncomplicated *C. trachomatis* infections with oculo-genital syndromes can be successfully treated with either a 7-day course of doxycycline or a single dose of azithromycin, successful treatment of LGV requires a 3-week course of treatment, with the preferred agent being

doxycycline 100 mg BID. While effective in treating the systemic symptoms and proctocolitis associated with LGV, the lymphadenopathy may be slow to respond, and there may be little beneficial effect of treatment on the late complications described above. ■

## References

1. San Francisco Monthly STD Report (Data for November 2004); report prepared December 22, 2004.
2. Gullion J, et al. HAN Advisory, Texas Department of State Health Services, December 23, 2004.
3. Stamm WE, et al. *Chlamydia trachomatis* (Trachoma, Perinatal Infections, *Lymphogranuloma Venereum*, and Other Genital Infections).
4. Mandell, et al. Principles and Practice of Infectious Diseases. Elsevier. 2005;2239-2255.

---

*Dr. Winslow, MD is Chief of Division of AIDS Medicine at Santa Clara Valley Medical Center and Clinical Professor at Stanford University School of Medicine.*

---

## Hamster-Bite Fever?

### ABSTRACT & COMMENTARY

---

**Synopsis:** *A child developed tularemia after being bitten by a pet hamster.*

**Source:** CDC. Brief Report: Tularemia Associated With a Hamster Bite—Colorado, 2004. *MMWR*. 2005;53:1202-1203.

A COLORADO FAMILY PURCHASED 6 HAMSTERS FROM A pet store, all of whom died within a week from a diarrheal illness. One, however, managed to bite a 3-year-old child on the index finger before dying. One week later, the child developed fever and painful left axillary lymphadenopathy, as well as sloughing of skin at the site of the bite. The child was given amoxicillin/clavulanic acid without success, and 7 weeks after the onset of illness, the left axillary lymph node was excised. *Francisella tularensis* was recovered from the tissue, and the patient was found to have a convalescent titer to this organism of 1:4096. He was successfully treated with ciprofloxacin.

### ■ COMMENT BY STAN DERESINSKI, MD, FACP

*Francisella tularensis* is a small, aerobic, catalase-positive, pleomorphic, Gram-negative coccobacillus. It is infrequently detected in Gram stains of clinical material. In addition, its growth in culture requires the presence of a sulfhydryl source and, as a consequence, it will not be

recovered on most routinely used solid media in the absence of supplementation. As a consequence, its isolation requires a high index of clinical suspicion, which is important to communicate to the clinical microbiology laboratory. This communication is also of importance because the organism presents a significant biohazard in the laboratory. Infection may be confirmed with serological studies.

While *F. tularensis* infects a large spectrum of both vertebrates and invertebrates, rabbits and rodents are most important. Transmission to humans occurs most frequently as the result of contact with contaminated animal products or insect bite, although it may also occur via aerosol, contact with contaminated environment or, as in the case summarized here, via animal bites. In experimental systems, as few as 10 organisms are capable of causing disease.

Although overlap of the syndromes is not uncommon, 6 clinical forms of tularemia are typically described: ulceroglandular, glandular, oculoglandular, pharyngeal, typhoidal, and pneumonic. The child whose illness is summarized here would be classified as having the glandular form. The axilla is the most frequent site of adenopathy in rabbit-associated human tularemia, while the inguinal lymph nodes are most frequently involved in tick-associated disease—presumably reflecting the lymphatic drainage of the sites of inoculation.

Texts still recommend streptomycin as the treatment of choice for patients with tularemia, with gentamicin as an alternative. Doxycycline therapy has apparently been associated with failures. The organism is susceptible in vitro to fluoroquinolones, and ciprofloxacin therapy was successful in the case reviewed here. ■

---

*Dr. Deresinski, MD, FACP, is Clinical Professor of Medicine at Stanford University and Associate Chief of Infectious Diseases at Santa Clara Valley Medical Center.*

---

## Have Tents, Will Travel in San Francisco

### Testing facility travels to clients

By Melinda Young

CONTINUUM OF SAN FRANCISCO HAS A GOAL OF finding people who are unaware that they are HIV-positive through its grant from the Advancing HIV Prevention Initiative of the Centers for Disease Control and Prevention (CDC).

“We estimate there are 1200 people, just in our neigh-

borhood, who are HIV-positive and don’t know it,” says Cicily Emerson, MSW, director of prevention services for Continuum.

### A Real Outreach Effort

“The Tenderloin area has a high rate of homelessness, lots of residential hotels, and a lot of street activity, including sex work, heavy drug dealing, and panhandling, and it’s basically a busy area with a lot of street activities,” she says. “So the idea was to reach out and try to engage the ones who were positive and get them into HIV care and reduce their risk.”

To meet this goal, Continuum has invested in 2 inflatable tents measuring about 20 feet in diameter. One of the tents contains a lobby, and the other has individual counseling rooms.

The tents are stored and transported to testing sites each day in a mobile van, and Continuum has permits to set up the tents in parks, Emerson explains.

“The tents are eye-catching, and we try to do at least 18 [rapid HIV] tests in 1 day,” she notes. “The counseling session can be short or long, depending on the client’s risk factors.”

Also, the Continuum staff working in the tents include a lab manager because California requires professionals to handle phlebotomy, Emerson says.

The lobby tent is for setting up appointments, and contains a television that plays movies while people wait.

There also are ventilation and cooling systems inside the tents, which are powered by electricity generators, she adds.

The mobile testing sites provide clients with harm-reduction kits that include condoms, lubrication, and safe injection kits with a tourniquet and bleach, as well as with snacks and beverages, Emerson notes. Those tested also are given a gift incentive valued at \$10, she adds.

Clients can make an appointment to be tested at the tent via a toll-free number or by walking in on one of the regular days the tent is in their neighborhood, Emerson says. “The tents are set up, weather permitting, but most of the time, it’s fairly temperate here. The temperature doesn’t fluctuate too much,” she explains.

The reason Continuum uses the tents instead of relying on the mobile van is because the tents create a warmer and more private environment, Emerson says. “The idea is to have something that’s more versatile than a van,” she adds. “And, maybe it will reduce the stigma a little because when there’s a mobile health van, a lot of people know what it is, and everyone knows what a person is doing there.” ■