Sir,

To encourage male involvement in HIV/STI (human immunodeficiency virus/sexually transmitted infections) risk reduction, the RISHTA (Research and Intervention in Sexual Health Theory to Action) project was established at a population research institute in Mumbai. The project developed a Male Health Clinic (MHC) at a government urban health center (UHC) in a slum area in northeast Mumbai to provide clinic-based intervention. The clinic aimed at providing treatment and counseling services to patients with general complaints as well as complaints related to STI through medical officers who had been trained in the syndromic management of STI. In this study we assessed the performance of the MHC with respect to the syndromic management of STI. The case sheets of the patients attending the clinic were reviewed. The study sample comprised all patients attending the clinic from April 2004 to September 2005.

A total of 1587 patients attended the MHC during the study period; among them 5.8% (92/1587) were patients with STI. Fifty percent (46/92) of these patients presented with genital ulcer disease, 25% (23/92) with scrotal swelling, 15.2% (14/92) with urethral discharge, 5.4% (5/92) with inguinal bubo, and 4.4% (4/92) with warts; 11% (10/92) had multiple STDs. An earlier study has reported urethral discharge as the most frequent syndrome (43%) in male STD patients, followed by genital ulcer (24%) and genital warts (11%).[1]

The overall cure rate for STD was 51.1% (47/92). The highest cure rate of 71.4% (10/14) was seen in urethral discharge, followed by 60% (3/5) in inguinal bubo, 47.8% for both genital ulcer disease (22/46) and scrotal swelling (11/23), and 25% (1/4) for warts. In our study, we found that the STD treatment protocols were followed in 67.4% (62/92) of the patients; in contrast, a study from Chennai reported only 10% adherence to treatment protocols.[2] For individual diseases, the treatment protocol was followed in 100% (4/4) cases of warts, in 71.4% (10/14) cases of urethral discharge, in 69.6% (32/46) cases of genital ulcer disease, in 60% (3/5) cases of inguinal bubo, and in 56.5% (13/23) cases of scrotal swelling. It can be seen that protocols requiring multiple visits and involving detailed physical examination (such as for inguinal bubo and scrotal swelling) were followed in a lower proportion of patients.

The condom promotion rate in our study was 83.7% (77/92) among STD patients. The study in Chennai found lower rates of condom promotion (30%) among STD clinic attendees.[2]

The partner notification rate in our study was 20.7% (19/92). The study in Chennai reported higher rates of partner notification (27%) among STD clinic attendees.[2] Of the 19 partners notified in our study, 7 attended the clinic for examination and treatment, while 12 were provided treatment on the basis of symptoms reported by their partners.

The referral rate to Integrated Counseling and Testing Centre (ICTC) for STD patients was 38% (35/92).

To ensure that the treatment protocols are adhered to in all patients we recommend periodic training of medical officers in the syndromic management of STD. It is also proposed to establish a female health clinic (FHC) to ensure 100% partner notification and treatment.

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Sir,

Granuloma annulare (GA) is a benign, usually self-limiting, necrobiotic disorder of unknown aetiology. Clinical variants of GA are localized, generalized, subcutaneous and perforating type. Generalized GA is a rare variant that represents 8.5-15% of all cases of GA. Generalized GA presents clinically with skin-colored, erythematous or violaceous dermal papules and/or small annular plaques with elevated borders. Various associations have been reported with GA, which include diabetes mellitus, malignancies, thyroid diseases, hepatitis B and C virus infection, drugs and acquired immunodeficiency syndrome.

A 45-year-old male patient farmer by occupation presented with generalized, multiple, asymptomatic skin-colored papules, annular and arciform plaque involving neck, back [Figure 1], chest [Figure 2], shoulder, upper and lower extremities since past 1 year. Patient also had multiple grouped vesicular lesions over erythematous base involving right thoracic dermatome. Patient also had multiple grouped hypopigmented macules involving left thoracic dermatome indicating healed lesions of Herpes zoster. History of multiple unprotected sexual exposures was present. Histopathological examination of skin biopsy from the annular plaque with H and E stain revealed diffuse palisading granulomas in upper dermis [Figure 3], special staining with PAS (Periodic Acid Schiff) stain revealed diffuse palisading granulomas with mucin deposits in upper dermis. ELISA test for HIV was positive. Blood sugar levels were normal. Blood VDRL in serial dilution was negative. Patients CD4 count was 34 cells/mm$^3$.

GA was first described by Colcott Fox in 1895. It is a chronic cutaneous eruption that presents clinically as dermal papules, plaques or nodules due to various degenerative changes in dermis termed necrobiosis. It can be localized, perforating, generalized or subcutaneous. [1] Diabetes mellitus, iritis, sarcoidosis, autoimmune thyroiditis and various neoplasms have been found in association with GA. [2] GA with AIDS is being increasingly reported. [3] Generalized GA is the most common clinical pattern in HIV

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