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"SUSPECTED CASES OF ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN KAGERA REGION"

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SUMMARY

24 patients who were admitted and treated at Kagera regional hospital from September 1984 to January 1985 with clinical features strongly suggestive of acquired immunodeficiency syndrome (AIDS) are presented. One patient who was treated, but died in hospital in May 1984 with features strongly suggestive of AIDS, has also been included making a total of 25 patients.

There were 10 males and 15 females patients with ages ranging from 22 to 45 years, average age being 30.5 years.

The commonest symptoms were diarrhoea, present in 19 patients, and fever which was present in 17 patients. Among the females, 11 out of 15 had amenorrhoea of varying duration. The commonest signs were severe weight loss present in 18 patients, itching skin rash present in 13 patients and genital ulceration present in 12 patients. The only opportunistic infection was oral moniliasis present in 19 patients.

10 patients died while on treatment in hospital after staying there for an average of 27.5 days.

The purpose of this report is to arise interest and create an awareness of the possibility of an AIDS outbreak in the Kagera region and at the same time appealing for assistance in acquiring diagnostic facilities and expertise in order to confirm our supsicions.

INTRODUCTION

An alarming increase in the incidence of genital ulcerative disease at Kagera regional hospital was noted since the beginning of last year, 1984. It was also noted that some of the patients with genital ulceration presented other associated symptoms and signs that cannot be accounted for by venereal diseases. The mortality rate in this group of patients is high. A good number of patients discharged from the hospital after unseccessfull treatment on genital ulceration seem to have died in their villages.

This has been a matter of considerable public concern, prompting us to look into the possibility of an AIDS outbreak in this region. Enquiries made to doctors working in other hospitals in the region revealed that patients with an AIDS like syndrome were not uncommon in their practice. At present, there have been reports of AIDS in Zaire and Rwanda, one of which is a border country of Kagera region, and this has justified our concern.

In all the presented patients, the risk factors for AIDS are clearly missing. Heterosexual contacts may be the major mean of transmission of the agent causing AIDS as it has been suspected to be in other African countries (1, 2, 3).

People Health education on this added danger of sexual promiscuity may help to minimize the spreading of this disease.

Patients and methods

24 patients presented in this report were selected from the admitted patients in Kagera regional hospital during the period between September 1984 and January 1985. Only patients with 4 or more of the clinical features suggestive of AIDS were included. The clinical features of AIDS that were considered are the following:

1. chronic fever for more than 2 months.
2. severe weight loss
3. chronic diarrohea of unknown cause
4. generalised lymphadenopathy
5. oral candidiasis
6. extensive anogenital ulceration
7. mucocutaneous herpes simplex virus infection
8. bilateral pneumonia not responding to antibiotic or tuberculostatic treatment.

Clinical presentation

This series is made of 25 patients; 10 males and 15 females. They were all young patients whose age ranged from 22 to 45 years, with average age of 30.5 years.

Table 1: CLINICAL FEATURES

SYMPTOM/SIGN	NUMBER OF PATIENTS
Diarrhoea	19
Oral moniliasis	19
Weight loss	18
Chronic fevers	17
Itching skin rash	13
Genital ulceration	12
Amenorrhoea in females	11
Chest tightness	8
Generalized lymphadenopathy	8

Diarrhoea was the commonest symptom present in 19 patients. In 4 of the patients the diarrhoea, which was initially watery, at a certain point became bloody, while in the rest it was watery throughout.

In all patients no cause of the diarrhoea could be found and the diarrhoea was of long duration in all, average duration being 3 months. All the patients who have died so far had this symptom.

Oral candida albicans infection was a feature in 19 patients. 10 of these patients had retrosternal pain on swallowing, a feature which could signify oesophageal candidiasis but this could not be ascertained because no oesophagascopy was performed.

18 patients were found to be severely cachaectic on examination and 3 of these were empirically put under anti-tuberculous treatment without any change in the general condition of the patients.

Itching maculopapular rash was a common feature present in 13 patients. In 4 of these the rash was associated with purpura, spots on the trunk and extremities while 4 other patients had multiple skin abscesses as well.

Severe genital ulceration was a feature in 12 of the patients. The ulcers were often multiple, involving the prepuce glans penis and penile shaft in the males and the clitoris and labia in females. In all patients the inguinal region and, the perineum were affected. In four of the patients the ulcerations were characterised by a sorrounding vesicular rash resembling clinically Herpes simplex virus infection.

Among the female patients amenorrhoea was a commonly found feature. 11 out 15 females presented amenorrhoea. One of these patients aborted a fetus of 28 weeks of gestation before she died 2 days later, while one patient still on treatment is now 22 weeks pregnant. The rest of the patients were not found to be pregnant. The average duration of amenorrhoea in the non pregnant pa-

tients was found to be 8.3 months.

8 patients complained of chest tightness and dyspnea but no coughing. Two of the patients were found, after x - rays, to have bilateral infiltrative pulmonary lesions while in all the patients tuberculosis was easily ruled out since the patients were not coughing at all.

Generalized lymphadenopathy was noted in 8 patients. In all patients cervical, axillary and inguinal lymphonodes were enlarged in one female patient the lymphonodes were coalesced and tender in the inguinal region and, in her, they brought to the swelling of the lower limb due to lymphostasis.

Table 2: DURATION OF SYMPTOMS

DURATION	NUMBER OF PATIENTS
Less than 1 month	6
more than 1 month less than 6 months	8
more than 6 months less than 1 year	8
more than 1 year	3
TOTAL	25

More than 50% of the patients came to the hospital within 6 mounths.

Table 3: OCCUPATION OF THE PATIENTS

OCCUPATION	NUMBER OF PATIENTS
Peasant	16
Police officer	1
Conductor	2
Prisoner	1
Teacher	1
Petty trade	1
Not mentioned	3
TOTAL	25

Most of the patients were peasants.

Table 4: MARITAL STATUS

MARITAL STATUS	NUMBER OF PATIENTS
Married	13
Single	7
Divorced	3
Not mentioned	2
TOTAL	25

50% of the patients were married. Only 30% of the females were married.

The known risk factors for AIDS, namely homosexuality, drug abuse and haemophilia were completely absent. None of the patients had any blood transfusions within 2 years from the onset of the disease. All the male patients admitted having had multiple sexual partners as a habit; among the females only the single or divorced ones (2/3 of the total) admitted having had multiple sexual partners as a habit.

10 out of 25 patients died while treated in hospital for an average of 27.5 days. The average duration of the disease for the patients who died was 178.5 days where the average duration of the disease for all the patients was 205.2 days.

DISCUSSION

25 patients with clinical features strongly suggestive of AIDS have been reported. It is still too early to say conclusively that there is AIDS in Kagera; but it must be agreed that the situation calls for careful investigations. The regional hospital is severely limited in laboratory investigations that need to be performed and so most of the opportunistic infections usually detected by culture of cerebrospinal fluid and blood have been missed.

We have reported a syndrome with a high mortality rate, which was not seen up to very recently. We are appealing for assistance in diagnostic facilities at least to rule out AIDS, because we feel that this is an important medical problem for Kagera region and quick action is quite justified.

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"THERAPY OF THE SEXUALLY TRANSMITTED DISEASES"

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The term "venereal diseases", currently used in the past, has in recent years fallen into disuse and was replaced by "sexually transmitted diseases" or STD.

This new term is justified since the spectrum of these diseases, once limited to the five traditional venereal diseases (gonorrhoea, syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale), is to-day remarkably extended as a result of deeper epidemiological understanding, clinical and pathogenetic awareness and accurate laboratory research to correlate che clinical picture with etiologic agents.

Three main consideration derive from the new conception:

1) Some of the newly recognized STD have become epidemic or hyperendemic throughout the world and may have an even greater impact on the health of the community, than the traditional venereal diseases.
2) The clinical manifestations within the sphere of STD are so different as to exceed the usual limits of venereology, involving other medical specialities like gynecology, gastroenterology, ophthalmology, etc.
3) The STD have a worldwide spread with a prevalence in the first decades of life (whether transmitted directly or indirectly), from the newborn to adolescents and young adults with evident socio-economic repercussions.

In the patient's management, a syndrome-oriented approach is at first spontaneous, since the patient arrives to clinical observation usually before an etiological diagnosis is established. In Tables 1 and 2 are listed the most common clinical syndromes, respectively in males and females, together with the leading sexually transmitted causal agents. As you can see, some of these syndromes are common to both sexes and not all have a genital localization.

However, once the clinical features of the syndrome are defined, our approach must change: it should be agent-oriented, that is based on the identification of the pathogenic microorganism. In fact, while no single drug can be expected to be active on all pathogens potentially involved in the etiology of this type of syndromes, the same drug may well be indicated for the treatment of different clinical syndromes sustained by the same microorganism.

The sexually transmitted pathogens are of different nature: bacterial, viral, protozoal, fungal, helmintic, ectoparasitic. Toghether with the diseases caused, they are listed in Tables 3, 4 and 5.