Hematospermia Due to Schistosome Infection in Travelers

Sir—Schwartz et al. [1] highlight hematospermia as a presenting symptom of schistosomiasis and comment that this presentation seems to be rare among travelers with schistosomiasis, although it is perhaps more common than is generally perceived. Indeed, several reports other than the 2 mentioned in their article have documented this presentation in returning travelers [2–4]. It is important to note that hematospermia is only one alteration in semen quality associated with male genital schistosomiasis. Other changes include yellow (rather than red or brownish) discoloration and reduction in viscosity to a “watery” consistency [2, 5, 6], and these symptoms may be more common than is hematospermia.

Subjective change in semen quality was a relatively common presentation among a series of returned travelers with schistosomiasis in New Zealand, being present in 7 of 13 males [2, 5]. All 7 had swum in Lake Malawi in southern Africa during the preceding 12 months, were infected with Schistosoma haematobium, and responded to treatment with praziquantel. Three also described testicular ache or testicular swelling. This is an unusual presentation in males with suspected schistosomiasis. Three also described testicular ache or testicular swelling. This is an unusual presentation in males with suspected schistosomiasis. 

Interestingly, all 7 presented to a sexual health clinic with changes in their ejaculate as their principal symptom. This is an unusual presenting symptom, even in sexual health clinics, and should prompt a high suspicion of schistosomiasis for anyone who has visited an area of endemicity. Furthermore, this symptom is likely to be reported more frequently if specifically sought in males with suspected schistosomiasis. 

References

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Hepatitis C Viremia Persistently Suppressed by HAART

Sir—We read with great interest the review by Cooper et al. [1] on the effect of highly active antiretroviral therapy (HAART) on hepatitis C virus (HCV) RNA in human immunodeficiency virus (HIV) and HCV co-infection. The authors found that the initiation of HIV treatment might cause an initial increase of HCV RNA levels (accompanied or not by elevated transaminase levels) followed by a decrease to levels lower than those before treatment. This response might be due to the so-called “immunorestoration syndrome.” Our data agree with those of Puoti et al. [2], but we would like to report a singular case of complete and persistent suppression of HCV RNA levels and normalization of serum transaminase levels in a patient coinfected with HIV and HCV who was receiving HAART.

In May 2000, a 39-year-old homosexual man was admitted to our department with a persistent fever (temperature, >38°C), weight loss of >15% of initial weight, vomiting, diarrhea, and myalgias. We found that the patient was seropositive (which was unknown before hospitalization) and diagnosed AIDS-related wasting syndrome (category C3, according to the classification of the Center for Disease Control and Prevention [Atlanta, GA] [3]). We also detected HCV antibodies in serum samples. At the time of diagnosis, laboratory values were as follows: CD4 T cell count, 140 cells/mm³; HIV RNA in plasma (as detected with the Amplicor HIV Monitor Test [Roche Diagnostic System]), 750,000 copies/mL; amino alanine transferase (ALT), 89 U/L; aspartate alanine transferase (AST), 120 U/L; γ-glutamyl transpeptidase, 172 IU; HCV RNA in plasma (as determined by Amplicor HIV Monitor Test), 714,000 copies/mL. The HCV genotype was 1b. Liver ultrasonography revealed medium-grade steatosis. The patient did not consent to undergo liver biopsy.

We started HAART therapy with zidovudine (600 mg daily), efavirenz (600 mg daily), and lamivudine (300 mg daily). The treatment was well tolerated by the patient, who showed a strict adherence to therapy.

The patient’s CD4 T cell count showed a progressive increase (245 cells/mm³ in