Need for Provision of Voluntary HIV Counselling and Testing (VCT) to Injecting Drug Users (IDUs)

Sir,

Injecting drug users (IDUs) are one of the most vulnerable groups for HIV AIDS. It accounts directly for an estimated 10% of all reported AIDS cases. Needle sharing is the major source for transmitting HIV virus among IDUS and unsafe sexual practices make the IDUs more vulnerable to spread the disease. Wives and children of the IDUs are at the risk of developing HIV AIDS. Despite the rapid spread of HIV infection among IDUs in Pakistan, little is known about their drug injecting and sexual behaviours. HIV moves into the community at large through sexual contact and through perinatal transmission. Moreover, evidence of HIV epidemics in non-injecting drug users (non-IDUs) has also been found in recent years.2

Pakistan’s HIV epidemic is fully established and expanding among the IDUs.3 Pakistan had an estimated 98,000 people living with HIV by the end of 2009, including children, adult males and females and high HIV prevalence of 27.2% among the IDUs. There is a 15% HIV prevalence among spouses and female partners of male IDUs in Punjab.4 Furthermore, transmission of HIV from people with injecting drugs to their wives is enhanced by the fact that around 80% of the former engage in unprotected sex.5 A national study conducted in 2011 among 26,500 women in antenatal clinics found the prevalence of HIV to be 0.04%.6

Volunteer Counselling and Testing (VCT) is a key component of both HIV prevention and care programmes. VCT is the process by which the patient undergoes counselling to enable him/her to make an informed choice about being tested for the human immunodeficiency virus (HIV). This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential. During VCT counselling sessions, the clinician inquires the patient’s HIV knowledge and attitude, drug use practices, sexual activities and a history of STDs and risky behaviours for transmitting the disease.

In Pakistan, there are some organizations providing the VCT services, but their scope is limited. Government and private institutions, those working with IDUs or providing the drug addiction treatment, awareness and rehabilitation services, should add the component of VCT in their regular treatment program.

VCT counselling has long-term effects, it will not only reduce the progression of the HIV in society and particularly in IDUs families, but also reducing the economic burden on the government, as it is known that antiretroviral drugs are quite costly.

REFERENCES


Aarskog-Scott Syndrome

Sir,

Aarskog-Scott syndrome is a congenital disorder characterized by unusual facies, short stature, abnormalities of hands and feet and genital anomalies. The credit for describing this syndrome is given to Dagflinn Aarskog and Charles Scott in early 1970.1,2 Based on its clinical presentation, this syndrome can be better termed as facial-digital-genital syndrome or faciogenital dysplasia. It is an X-linked genetic disorder with mutation of Xp11.2, characterized by multiple system involvement which is manifested as several facial, dental, ocular, neurological, musculoskeletal and urogenital abnormalities like short stature, mild to moderate mental retardation, maxillary hypoplasia, hypodontia, hypertelorism, brachydactyly and shawl scrotum.
A 13 years old boy (Figure 1A) presented to the dental department with a chief complaint of irregularly placed upper front teeth, along with cleft lip and palate. He had undergone surgical correction for the same at 7 months, 12 years and 13 years of age. He was the second child of non-consanguineous, healthy parents. Pregnancy was uncomplicated. Parents were in their 3rd decade of life at the time of child birth. Delivery was full term and normal, birth weight was 3200 g. All the milestones of childhood were delayed. His elder male sibling, having similar problems, died on the 2nd day of birth; two younger siblings were normal (Pedigree chart 1). On physical examination, he was found to be dwarf with a height of 107 cm and weight of 18 kg. Intelligent quotient level of the patient was found to be average. No abnormalities were detected on examination of cardiovascular system. He had dolicocephalic head with straight profile, hypertelorism, shallow orbit, blepharoptosis, antimongoloid slanting palpebral fissure, defective eyesight of left eye, low set ears, midfacial deficiency with sunken nasal bridge, depressed molar region, underdeveloped maxilla (Figure 1B). Examination of hands and feet showed mild inter-digital webbing, brachydactyly, clinodactyly, fusion of proximal and middle phalanges (Figure 1C). He had short neck, mild webbing of sides of neck. Examination of genitals revealed shawl scrotum, undescended testicles and micropenis (Figure 1D). On intraoral examination, there was surgical defect seen on hard palate, surgical scar on soft palate, abnormal attachment of lingual frenum with bifid tongue, delayed eruption of the teeth (Figure 1E). Panoramic radiography revealed impacted 21, retained deciduous molars, congenitally missing lateral incisors and 45 (Figure 1F); lateral cephalogram showed maxillary deficiency (Figure 1G). No abnormal findings were seen on hand wrist radiograph. Ultrasound abdomen and spine radiograph were normal. Based on the above mentioned clinical features and investigations, the case was diagnosed as Aarskog-Scott syndrome.

The classical presentation of this condition reported in the literature include general features such as short stature, delayed adolescent growth spurt, mild to moderate mental retardation, hyperactivity and attention deficit, usually good social performance; facial features like widow’s peak hairline, hypertelorism, downward slanting of palpebral fissures, ptosis, abnormal helices, low-set ears, short nose with broad flat nasal bridge and anteverted nares, long-philtrum, crease below lower lip, maxillary hypoplasia. Intraoral features include high arched palate, delayed eruption of teeth, hypodontia. Cleft lip and palate have been described in few affected males. Limb anomalies reported are brachydactyly, clinodactyly, syndactyly, single palmar creases, hyper-extensible joints, short feet and toes, gap between first and second toes. Genital anomalies are seen as pathognomonic and include shawl scrotum, bilateral cryptorchidism and inguinal hernia. Other features including mild webbing of neck, pectus excavatum, everted umbilicus. Radiographic findings like spina bifida and odontoid hyperplasia are also reported in some cases. In 1999 Santos reported 3 cases with hypertelorism, short nose, short stature, shawl scrotum, long-philtrum and brachydactyly.

The differential diagnoses of Aarskog syndrome include Noonan syndrome, Leopard syndrome and Robinow syndrome. The Noonan syndrome is frequently associated with cardiovascular abnormalities, pulmonary stenosis in some of them, which are not there in the Aarskog syndrome. The Aarskog syndrome is further characterized by a typical cranio-facial appearance and a constant genital anomaly with scrotal folds surrounding the base of the penis. Leopard syndrome is a rare multisystem disorder characterized by Lentigines, ECG abnormalities, pulmonic stenosis. Gingival hyperplasia and vertebral fusion are the main features of Robinow syndrome, which are not associated with Aarskog syndrome.

The management includes a multidisciplinary approach with involvement of various specialties. There is no known cure for Aarskog syndrome. In some cases, orthodontic treatment may help in managing certain
facial and dental abnormalities. Aarskog-Scott syndrome is a rare condition often associated with cleft-lip and palate, the most common congenital anomaly affecting the craniofacial region. So while examining a patient with cleft lip and palate various concomitant disorders have to be considered, including Aarskog-Scott syndrome.

REFERENCES

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