LEONARD H. CALABRESE, DO, EDITOR

The changing face of the AIDS epidemic

BONE MARROW ASPIRATION AND BIOPSY IN HIV INFECTION

Bone marrow biopsies offer little diagnostic or prognostic information about HIV-infected patients because bone marrow changes in these patients appear to be nonspecific. Nevertheless, aspiration, culture, and biopsy are indicated in certain conditions. HIV-infected patients with either non-Hodgkin's or Hodgkin's lymphoma often have bone marrow involvement, and a biopsy may be useful for staging the disease and ascertaining myeloid reserves before starting chemotherapy. Patients with isolated thrombocytopenia without anemia or leukopenia should undergo biopsy to ensure adequate megakaryocytes. Finally, fever and constitutional symptom evaluation in HIV-infected patients may prompt a bone marrow biopsy: in these patients, a biopsy can rule out lymphoma, underlying opportunistic infection, and lymphomatous involvement in Kaposi's sarcoma.

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HIV INFECTION IN WOMEN

Though women account for only 10% of the cases of human immunodeficiency virus (HIV) infection in the United States, they are contracting HIV at a faster rate than any other population. As the number of HIV-infected women grows, health care professionals will need to confront several issues. There is little information about the sex-specific medical and psychosocial problems affecting women with HIV infection. For instance, white homosexual men between 30 and 34 with Kaposi's sarcoma have the longest survival rates. But Kaposi's sarcoma rarely appears in women. In addition, the earliest opportunistic infection in HIV-infected women may be a gynecologic disease rather than *Pneumocystis carinii* pneumonia, making early diagnosis of HIV infection difficult. Compounding this problem is the fact that many clinical trials have excluded women, so that little is known about how the available treatments for HIV infection affect women.

Psychosocial issues of HIV infection are also different for women. The vast majority of HIV-infected women are poor, undereducated, and lack the resources needed to gain access to medical care, find shelter and food, and provide for dependent children. Many HIV-infected women may wrongly perceive that acquired immunodeficiency syndrome (AIDS) service organizations, traditionally run by homosexual men, have little to offer them. And finally, the risk associated with childbearing or the loss of childbearing potential may have a devastating impact on the mental health status of many HIV-infected women.

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SEPTIC ARTHRITIS AND HIV

Despite the profound state of immunosuppression seen in HIV-infected patients, sepsis involving joints has only been reported in a few circumstances. An intravenous drug user developed a case of *Sporothrix schenkii* infection in a metacarpophalangeal joint and a distal interphalangeal joint simultaneously, both result-

From the continuing medical education symposium, "Fourth Annual Update on AIDS." Symposium directors: Leonard H. Calabrese, DO, and Dennis Kelley, RN, Department of Rheumatic and Immunologic Diseases, The Cleveland Clinic Foundation.

ing in acute arthritis. In another case, an HIV-infected intravenous drug user developed an acute monoarticular arthritis from infection with *Cryptococcus neoformans*. At the Cleveland Clinic, a 35-year-old homosexual man with AIDS developed an acute monoarticular arthritis of the left knee caused by *Histoplasma capsulatum*. The synovial fluid from this joint also grew out HIV. Even though septic arthritis has not been commonly seen among HIV-infected patients, these observations indicate that an acute monoarticular arthritis in these individuals should be considered potentially septic.

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CURRENT DEMOGRAPHICS OF AIDS IN THE UNITED STATES

AIDS has become one of the leading causes of death among men and women and is the second leading cause of death among men 25 to 44 years of age, surpassing heart disease, cancer, suicide, and homicide. In 1992, AIDS is likely to be ranked as one of the five leading causes of death among women. The grimness of the statistical scenario depends on the geographical area. In San Francisco, New York City, Los Angeles, and Baltimore, AIDS is the leading cause of death among young adult men. In New York and New Jersey it is the leading cause of death among black women ages 15 to 44. AIDS is also the leading cause of death among Hispanic children in New York State and the second leading cause of death among black children there.

The growth of the epidemic has had a devastating effect on health expenditures in this country. In 1989, private insurers paid out an estimated $1 billion for AIDS-related claims, an increase of 71% over the previous year. In 1993, it is estimated that over $15 billion will be spent on medical care related to AIDS.

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COMMON CNS INFECTIONS IN AIDS

Central nervous system (CNS) toxoplasmosis and cryptococcal meningitis are the most common opportunistic infections affecting the CNS in AIDS patients. Both conditions can be treated successfully, but life-long maintenance therapy is necessary. Toxoplasmosis usually arises as a reactivation of a latent, probably asymptomatic, primary infection caused by *Toxoplasma gondii*. Patients often have hemiparesis, aphasia, or seizures during a subacute course of several days to weeks. Enhancing abscesses are usually apparent on magnetic resonance imaging or computed tomography and occur predominantly in the basal ganglia and gray-white junction. Empiric therapy is the recommended course of action when such lesions are seen.

The symptoms of cryptococcal meningitis in AIDS patients are similar to those seen among the immune-competent host. Fever, stiff neck, and headache are usually present. Occasionally, AIDS patients with cryptococcal meningitis will present with headache or lethargy alone. Cryptococcal antigen is elevated in the cerebrospinal fluid and serum. Antifungal therapy is usually successful.

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