Letters to the Editor

HIV seropositivity in a geriatric medical unit

Sir,

Human immunodeficiency virus (HIV) infection is classically associated with young age-groups; one large study of male homosexuals yielded a mean of age of 33 years for seropositive cases (range 19-55 years).¹ This is echoed in the statement from the Center for Disease Control that 'HIV infection, like AIDS, occurs primarily among young and early middle aged adults'.² We present a case of HIV infection diagnosed following admission to a geriatric medical unit which emphasizes that awareness of HIV infection is necessary in all age groups.

A 73 year old bachelor presented with confusion of one week's duration, against a background of chronic alcoholism with gradual overall deterioration over two years. Six weeks previously he had been admitted briefly under a general medical team following a fall. On admission to our acute assessment unit, following further falls, the patient was drowsy and disoriented and no collateral history was available. On examination, bilateral hyperreflexia and flexor plantar reflexes were noted. A subdural haematoma was suspected but before any appropriate investigations were performed the patient had a cardio-pulmonary arrest. Immediate but unsuccessful resuscitation, including endotracheal intubation and insertion of three intravenous cannulae, with attendant leakage of blood, was initiated by a team of six doctors and nurses. Post-mortem examination confirmed the clinical diagnosis of subdural haematoma.

Several days later the family practitioner received notification of a positive HIV antibody assay on the patient, whom he knew had been an active homosexual up to 3 years previously. In view of the patient's general decline he had sent off a HIV antibody assay a few days before admission to our unit. As he considered a positive result unlikely, this was not mentioned in the referring letter. The medical team involved in the first admission were informed; although aware of his homosexuality, they had not recognized its potential diagnostic implications.

This is the first case of non-transfusion related HIV infection reported from an acute geriatric medical unit. That the patient's homosexuality was not noted in any communications between the doctors concerned emphasizes that sexually-acquired HIV infection is unexpected in the elderly. Clinical and pathology staff had contact with blood and other body fluids, while totally unsuspecting HIV infection. This has wide implications, not only for those working in geriatric units, but for clinical and laboratory staff in other specialties with elderly patients. Homosexuality is not uncommon in the elderly; it is estimated that there may be one million male homosexuals over the age of 65 in the United States,³ although their decreased sexual activity, more restricted sexual repertoire and longer monogamous relationships⁴ may confer some relative protection from HIV infection. The protean manifestations of the acquired immunodeficiency syndrome⁵ underline the need for heightened

awareness of the possibility of HIV infection in the elderly, and a sexual history should not be omitted in this age-group.

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Post-herpetic abdominal wall herniation

Sir,

Herpes zoster generally involves the sensory nerves. Occasionally it affects motor nerves in the segments corresponding to the involved sensory dermatomes, causing a flaccid paralysis. While well recognized in herpes zoster of the extremities or cranial nerves, this phenomenon is rare in the trunk area.¹ We report a case of segmental herpes zoster paralysis presenting as an abdominal wall hernia.

A 45 year old male presented with a swelling in the right lumbar region. It had developed suddenly over the previous 24 hours, and had been preceded 10 days earlier by a painful herpes zoster eruption in that area.

On examination, a reducible swelling, 12cm in diameter, centred on the anterior axillary line and made prominent by coughing, protruded through an area of flaccid muscle in the right lumbar area. Overlying this swelling was a tender, erythematous, macular rash, in the distribution of the T10/11 dermatomes. Superficial abdominal reflexes were absent on the right side. Over the ensuing 3 months this swelling gradually resolved completely.

Herpes zoster generally affects the sensory nerves, but Broadbent in 1966² was the first to report motor involvement. This case illustrates that segmental abdominal wall paralysis presenting as a hernia, may follow herpes zoster. The relative rarity of zoster paresis in the trunk may be due to overlap of innervation, most dermatomes and myotomes in this area being supplied by three or four