who have already had an episode of PCP. Pentamidine by aerosol appears to be effective and minimally toxic. Inhaled pentamidine is presently the treatment of choice for secondary prophylaxis and should be offered to all patients who have recovered from acute PCP.

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Diagnosis and Treatment of Syphilis in HIV-Infected Patients

The diagnosis of syphilis in patients with normal immune responses has been relatively straightforward because of the sensitivity of nontreponemal screening tests (VDRL, RPR) and the specificity of treponemal confirmatory tests (FTA-ABS, MHA-TP). Treatment regimens have remained unchanged for many years. Recently, however, concern has been raised about both the accuracy of serologic tests for syphilis and the adequacy of standard syphilis therapies, especially in the HIV-coinfected patient.[1-3]

Most HIV-infected patients have normal serologic responses to *Treponema pallidum*. However, the altered immune responses characteristic of HIV infection have resulted in both false-positive nontreponemal tests and, more importantly, false-negative tests in some patients with asymptomatic and symptomatic HIV infections. Particularly striking are a few cases of biopsy-confirmed secondary syphilis with negative syphilis serologies. Therefore, patients with negative serologic tests but clinical findings suggestive of primary and secondary syphilis should have special tests performed, including dark-field microscopy and fluorescent antibody staining of lesion exudate and examination of stained biopsy tissue.

Subclinical infection of the central nervous system (CNS) occurs in about 40 percent of patients with early syphilis. The Centers for Disease Control position is that standard treatment of early syphilis with one injection of 2.4 million international units (mIU) of benzathine penicillin G is adequate. However, considerable disagreement exists, and many authorities believe this regimen is not reliably effective in eradicating CNS infection because of its inadequate CNS penetration. Regimens known to have adequate CNS penetration include 10 days of either aqueous procaine penicillin G, 2.4 mIU intramuscularly once daily, along with probenecid, 500 mg orally 4 times daily, *or* aqueous crystalline penicillin G, 2 to 4 mIU intravenously every 4 hours (12 to 24 mIU daily). Whether 2 or 3 weekly doses of benzathine penicillin G are effective has not been determined.

Treatment of latent syphilis should be preceded by cerebrospinal fluid (CSF) examination whenever possible. Evidence of neurosyphilis (leukocytes greater than 5×10^6/L [5 leukocytes/mm^3], CSF protein greater than 0.40 g/L, or reactive CSF-VDRL) should prompt therapy for neurosyphilis with aqueous penicillin G as above. When no CSF abnormalities are present, the diagnosis remains somewhat in doubt, because normal CSF cell counts, protein levels, and negative syphilis serologies may occur in patients with neurosyphilis. In HIV-coinfected patients, treatment is controversial. Therapy with a regimen known to have adequate CNS penetration is most reliable in eradicating possible infection.

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Careful follow-up with serum serologies and in many cases CSF studies is essential. Patients with syphilis and risk factors for HIV infection should be offered confidential testing for HIV with informed consent. The references listed below can provide further guidance on difficult cases.

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Editorial Comment

This article represents the first in an anticipated series of papers, the objective of which is to bring to the reader updated information about AIDS. Dr. Ronald Goldschmidt of the Department of Family and Community Medicine at the University of California, San Francisco, has agreed to provide current brief reviews of clinically significant topics related to AIDS. The topics are selected on the basis of their importance and their applicability to family physicians. They will be derived from current available information in the medical literature.

It is our hope that this feature will be useful to readers who are likely to assume the responsibility for providing primary care to HIV-infected persons. Because AIDS is clearly an important public health problem and current research efforts are likely to produce new and applicable information, the editors believe this feature has the potential to assist the readers to maintain competence in this rapidly changing field.

Your comments are welcome.

Paul R. Young, M.D.
Lexington, KY

The International Center for Family Medicine, which is an organization representing Family Medicine in the entire Western Hemisphere, Spain, and Portugal will have its triennial meeting at Costa Do Estoril, Portugal on May 24, 25, and 26, 1990.

North American family physicians are welcome.

Registration fees are as follows:

- Active Members ICFM $ 60 (until 12/31/89) or $100 (after 12/31/89)
- Nonmembers ICFM $150 (until 12/31/89) or $200 (after 12/31/89)

Information concerning this meeting or joining the International Center for Family Medicine can be obtained by writing to:

Nicholas J. Pisacano, M.D.
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