GUM clinic as experienced in our department, especially as FP practitioners have been requested for need for collaboration between the two specialties to provide a comprehensive sexual health service for women.1

In conclusion, the integration of FP services within GUM with staff trained in both specialties is an alternative, cost-effective, and mutually beneficial, means of providing coordinated sexual health care for women combining contraceptive provision with STD/HIV/cervical cytology screening.

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Rectal gonorrhoea as an independent risk factor for HIV infection in homosexual males

We read with interest the recent study by Craib and colleagues1 which demonstrated an association between HIV seroconversion and rectal gonorrhoea in homosexual men. Because of the shared risks of sexual behaviour for both conditions2 and methodological problems3 it has not been possible to show that the relationship between sexually transmitted diseases (STDs) and HIV transmission is causal although this is believed to be the case.4 We studied the association between non-ulcerative STDs and HIV seroconversion retrospectively in homosexual men attending the Department of Genitourinary Medicine in Bristol and our findings are in agreement with Craib and colleagues and add further support to the belief that STDs facilitate the transmission of HIV. This has important implications for health intervention programmes in homosexual men.

All homosexual HIV antibody positive men, up to February 1994, who had had a previous negative test were identified; these were matched with controls who had had a negative test, for age and date of the case’s positive test. Twenty cases and 40 controls were identified.

No information was available on frequency of anal intercourse or number of partners per year. To attempt to reduce the confounding effects of risk sexual behaviour for both STDs and HIV we categorized sexual behaviour into higher and lower risk groups according to whether the relationship was open or closed respectively. Men who had more than one sexual partner at any given time were recorded as being in an open type relationship, and men who were documented to have a (serial) monogamous relationship were considered to be in a closed type relationship.

The following was recorded from the notes: age; dates of the positive and last negative test for the cases and date of test for the controls; type and number of STDs. Condom usage which was recorded as always, sometimes or never.

The median age of cases was 26 years (range 17-49); this was not statistically different from the controls. The median test interval was 20 months (range 1-61), in the controls the mean difference from the matching test date was 5-45 months (SD 6.23).

There was shown to be no difference in incidence of hepatitis B or syphilis between the two groups. Two (10%) of 20 cases and three (7-5%) of 40 controls had had hepatitis B. One (5%) of 20 cases and no controls had had syphilis. None of the index patients acquired these infections during the study period.

To assess the role of STDs in facilitating HIV infection we considered only those which are present on the genital epithelium/mucosa that is, gonorrhoea, genital warts, genital herpes and non-specific urethral thrush. STDs were recorded during the study period of the patients and for an equivalent time period for the controls.

We considered all patients with no documented history of an STD infection as being "negative" and four patients (20 cases and 2 controls) showed a significant relationship with risk of seroconversion (p < 0.01). Information on STDs was not available in eight of the index patients since their negative HIV test. Six (30%) of 20 cases and 3 (7.5%) of 40 controls had had at least one STD. Open relationship type also carried a significant increased risk of seroconversion (p < 0.02). Sixteen (80%) of 20 cases and 18 (45%) of 40 controls were in the high risk group.

In order to control for the confounding factors that males in open relationships are theoretically more likely to become infected with STDs and HIV we carried out Mantel-Haenszel multivariate analyses which showed independently associated (odds ratio = 5-91 CI 1-43-24-5) with HIV seroconversion as was open type relationship (odds ratio = 8-41 CI 1-32-53-4).

Use of condoms was not statistically significant between cases and controls. Information was not available in two index patients and four controls. Of the index patients two (11%) always used condoms, three (15%) sometimes used them and one (5%) never used them compared with three (8-3%), six (17%) and 27 (75%) respectively of the controls.

Whilst this is a retrospective study and the long term use of condoms might not reflect current sexual behaviour there is evidence that risk behaviour among young homosexual men is still high despite on-going HIV prevention programmes.6 New approaches are therefore urgently needed. Much interest is currently focused on the prevention, treatment and control of STDs as a means of reducing HIV transmission in heterosexual populations from the developing world.4 Our findings support the conclusions of Craib and colleagues that health intervention programmes are needed which are designed to control gonorrhoea. In addition they suggest that these programmes should also be directed at other high risk groups that provide support for the continued development and expansion of such programmes in all sexually active individuals.

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A case cluster of possible tissue invasive gonorrhoea

I read with great interest the report by Brook et al of a case cluster of five cases of invasive gonococcal infection.1 The authors apparently are unaware of a similar report published over twenty years ago.2 We described a cluster in which a male patient with gonorrhoea infected seven of eight female contacts. Two other female partners could not be located. Among the seven infected women, two had disseminated gonococcal infection, four had pelvic inflammatory disease, and one had a Bartholin gland abscess. Three weeks after successful treatment of his urethritis, the male index case returned with disseminated gonococcal infection, having resumed intercourse with some of the same partners prior to their diagnosis and treatment.

In 1973 we lacked the ability to definitively prove that all of our patients were infected with the same strain of Neisseria gonorrhoeae. However, the epidemiological circumstances made it clear that most or all of the patients in fact shared a common strain. We also cited several other reports from 1940 to 1972 that documented complications of gonococcal disease in couples or in mother-infant pairs.3,4 Collectively, these reports provided the first hint of variations in pathogenicity among gonococci. There is nothing new under the sun (to coin a phrase)!5

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Pseudomonas aeruginosa infections and HIV

Ali, et al6 provide an interesting overview of their experience over a five year period with pseudomonas infections in HIV seropositive patients. Their report of an increase in the frequency of both pneumonic and septicaemic diseases due to this organism concurs with other recent studies. Two points arise however, which merit further discussion. A report from this centre is incorrectly referred to as illustrating that pneumonias due to Staphylococcus aureus and pseudomonal acquired gram-negative organisms occur with increased frequency in patients with indwelling central venous catheters (CVCs). In fact, what the quoted study demonstrated was an increased frequency of both pseudomonas as an isolate in the blood cultures of HIV seropositive patients with septicemia (found in 19 of 52), especially those with indwelling CVCs; in only two of these patients was a positive blood culture result of a pseudomonas pneumonia. In the same study an apparent association with concurrent CMV infection was cautiously suggested, but the results of Ali et al do not support this.

More importantly, their conclusion that the use of systemic peneumocystitis prophylaxis is an independent risk factor for the development of Pseudomonas aeruginosa pneumonia is erroneous and is not supported by the data provided. As the authors note, the affected patient group were all in the advanced stages of HIV disease with low CD4 counts. Not surprisingly therefore, the vast majority were also on Pneumocystis carinii prophylaxis. However, without showing an increased risk for this group over a similarly severely immunosuppressed matched group not taking PCP prophylaxis (which for obvious reasons would be difficult to gather), this conclusion cannot be drawn. The low CD4 count, on the other hand, may be the relevant variable.

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Carcinoma of the penis: A cluster of cases in young men

The authors of the recent article Carcinoma of the penis in a HIV positive patient emphasise that this malignancy is rare in the immuno-competent population, especially among young men. Indeed, in 1989 (the most recent year for which figures are available) there were only 45 notified cases in men under the age of 50 years in England and Wales.

It may therefore be of interest to report that recently, in the space of seven months, no fewer than four apparently immunocompetent men presented to this department with penile ulcers or non-healing ulcerations, with ulcers suggesting malignancy. The men's ages ranged from 34 to 48 years. Although none had a HIV test, they were all heterosexual with no high risk factors for HIV infection. Two of the four had clinical appearances suggestive of lichen sclerosus, a third had a history of genital warts and all were uncircumcised.

9 Vercocia C, Fraschetti S, Decarli A, et al. Sexual factors, venereal disease and risk of Intersputal and invasive cervical neo-

Pneumococcal vaccine and HIV infection

Helberg and colleagues1 state "An association between cervical dyskaryosis, as well as the role of HPV in cervical cancer in situ and in invasive cancer, has been demonstrated." They quote Fraschetti and colleagues2 in support of this claim.

Sheppard and colleagues3 report the psychological distress of patients diagnosed with genital warts for whom "...there is the fear of the link between genital warts and cervical cancer".

The paper which is frequently quoted as establishing a link between genital warts and cervical cancer by Fraschetti and colleagues did no such thing. These authors studied women attending a gynaecological medicine clinic, who had smears taken.

Among the women attending with genital warts there was a significant excess of smears showing "superficial dyskaryosis". None of these women had evidence of high grade CIN and certainly none of them had cervical cancer. All of the more severe cytological abnormalities occurred in women with trichomomas and gonorrhoea.

Having reviewed a retrospective study, two of the authors returned to Italy where they conducted a more rigorous study4, which demonstrated no evidence of an association between genital warts and subsequent cervical cancer. Ever since discovering the second negative paper it has always amazed me how widely quoted is the first paper by these authors, whilst the second is almost universally ignored. Is it because the first paper was in a British journal and the second one in an American journal? Did the first paper have a "snappier title" or was it because the first paper confirmed people's prejudices and the second didn't? The original of an association was further refuted by our own work.5

Could it be that the myth of genital warts needs the same treatment as the other myth about cervical cancer—that "it has been proven for 150 years now that women can occur in virgins"—finally debunked in 1991?6

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4 Vercocia C, Fraschetti S, Decarli A, et al. Sexual factors, venereal disease and risk of Intersputal and invasive cervical neo-

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