Prevalence of HPV cervical infections among imprisoned women in Barcelona, Spain

EDITOR—The penitentiary centres in Spain harbour inmates in whom the combination of HPV infection, history of injecting drug use, and prostitution is common.1 Extensive protocols to detect sexually transmitted diseases and tuberculosis are implemented in these centres; however, human papillomavirus (HPV) infections and related lesions are not routinely searched for. Although Spain is characterised by a very low incidence of cervical cancer,2 a high rate of cervical cancer has been reported recently among the AIDS female population in Catalonia.3 We carried out a study aiming to characterise HPV cervical infection and related cervical lesions among women with many potential risk factors for cervical neoplasia. The study was done in the only institution in Barcelona where women are imprisoned. The population consisted of 157 women attending the medical office of the prison between February and December 1996 and represented 90% of all women staying in prison for more than 3 days. Women who agreed to participate underwent a gynaecological examination, collection of cervical cells, a structured interview by a trained nurse, determination of HPV, hepatitis B and C serostatus, and detection of HPV DNA in the cervical cells by means of PCR. L1 consensus primers MY09/MY11 were used with modifications as described by Hildesheim et al.1 HPV DNA was detected in 48% of the women. The prevalence of cervical abnormalities was 29.9%; 19 women had a cytological squamous cell of undetermined significance (ASCUS) and 28 women were diagnosed with squamous intraepithelial lesion (SIL), five of whom had a high grade lesion. All women with a SIL and 42% of those with an ASCUS were HPV positive. Prostitution was reported by 38.2% and injecting drug use by 64.3% women. HPV infection was detected in 56.1%. HPV detection was significantly related to HIV, to injecting drug use, to prostitution, and to hepatitis C positive serology. After adjusting for these variables, HPV detection remained significantly associated with HIV and with length of time injecting drugs (table 1). No association between HPV detection and other reproductive and sexual characteristics. In addition, HIV positive women had an increased risk to develop SIL compared with HIV negative women (POR=5.02, 95% CI=1.69–14.89). As previously reported, the risk for SIL increased with low CD4 T cell counts, although POR did not reach statistical significance.3

Data from an ongoing study in a nearby area indicate that the prevalence of cervical abnormalities in the general population is around 4% (manuscript in preparation). This is the first time that we have documented in Spain a group of women with a very high rate of HPV infection linked to injecting drug use and with a rate of pre-neoplastic cervical lesions about seven times higher than that observed in the general population.

While in prison these women were appropriately treated for HIV infection and for SIL. When out of prison or in jail, a gynaecological screening every 6–12 months should be organised and recommended.

Financial support: This work has been partially supported by the Spanish Ministry of Health, FIS No 98/056. We thank Mrs Anna Coma for her assistance with data managing and analysis.

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Table 1 Age adjusted prevalence odds ratios for human papillomavirus infection (HPV DNA) in the cervical cells by different characteristics

<table>
<thead>
<tr>
<th>HPV DNA Negative</th>
<th>HPV DNA positive</th>
<th>PORc</th>
<th>PORa</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Negative</td>
<td>No %</td>
<td>54</td>
<td>36.5</td>
<td>15</td>
</tr>
<tr>
<td>Positive</td>
<td>No %</td>
<td>31</td>
<td>36.5</td>
<td>57</td>
</tr>
<tr>
<td>Prostitution</td>
<td>No %</td>
<td>59</td>
<td>69.4</td>
<td>57</td>
</tr>
<tr>
<td>Yes</td>
<td>No %</td>
<td>26</td>
<td>30.6</td>
<td>34</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>No %</td>
<td>44</td>
<td>51.8</td>
<td>12</td>
</tr>
<tr>
<td>Yes</td>
<td>No %</td>
<td>41</td>
<td>48.2</td>
<td>60</td>
</tr>
<tr>
<td>Length of use:</td>
<td>0–9 years</td>
<td>22</td>
<td>26.5</td>
<td>26</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td></td>
<td>17</td>
<td>20.5</td>
<td>43</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Negative</td>
<td>49</td>
<td>59.8</td>
<td>21</td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td>33</td>
<td>40.2</td>
<td>46</td>
</tr>
</tbody>
</table>

PORc = age adjusted.
PORa = adjusted for age and the other variables in the table.


Accepted for publication 5 November 1999

Detection of penicillinase producing Neisseria gonorrhoeae strains in Cuba, 1995–8

EDITOR—Since the 1940s, penicillin has been recommended for the treatment of gonorrhoea. In the 1950s the first strain of Neisseria gonorrhoeae with reduced susceptibility to this antibiotic, as a result of chromosomal mutations, were isolated. In 1970 the first penicillinase producing Neisseria gonorrhoeae (PPNG) strains emerged in South East Asia and Africa, causing high level resistance to penicillin (MIC > 10 µg/ml).1 In Cuba, the first report of a PPNG strain was made in 1986 (C Almanza, personal communication). We report here on the proportion of PPNG strains received at the Neisseria Reference Laboratory, Tropical Medicine Institute “Pedro Kouri” (IPK), Cuba between January 1995 and December 1998.

In all, 110 strains of N gonorrhoeae isolated from 10 of the 14 Cuban provinces were examined for their β lactamase activity by the chromogenic method (Nitrocefin, Oxoid). These strains were transported to the IPK using a novel transport and conservation medium for gonococci developed at our laboratory.4 N gonorrhoeae WHO E and WHO A were used as positive and negative control strains, respectively. All strains were identified as gonococci by standard procedures.1 Table 1 shows the distribution of Cuban PPNG and non-PPNG strains detected in our laboratory during 1995–8. The PPNG strains predominated, totally (61/110, 55.5%). The percentage of PPNG strains was high in all years analysed.1 To our knowledge it is the first study developed in Cuba, analysing the β lactamase activity of N gonorrhoeae isolated from different provinces and showing that a high percentage of PPNG strains was found. Previous studies developed in specific Cuban hospitals in Havana City have revealed a lower percentage of PPNG strains (M Berroa et al, 1988; C Almanza et al, 1988, personal communications).

Penicillin has been the drug of choice for treatment of gonococcal infections in Cuba since 1972.2 The results of this study indicate that any policy to treat such infections should not include penicillin or other similar drugs. Other antimicrobials recommended by the World Health Organisation for treatment gonorrhoea—for example, spectinomycin, cephalosporins, quinolones, and azithromycin.
have been recently evaluated in Cuba with good results (R Llanes, et al, unpublished data, 1999).

We thank Lic D Guzman, Lic Y Gutierrez, and O Gutierrez for their technical support during this study and Dr A Llop for her revision.

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Accepted for publication 5 November 1999

Rising HIV prevalence in STD clinic attenders at Chandigarh (north India)—a relatively low prevalence area

Editor. — The patients attending the STD clinics are at risk of having concurrent HIV infection. The trends of HIV infection in these patients may reflect the trends of HIV epidemic in the community. We have analysed the HIV status of 981 patients (524 males, 157 females) who attended our STD clinic from January 1993 to July 1999 (about 6½ years). The screening for HIV was done by ELISA. Those who were found positive were tested by repeat ELISA utilising another blood sample and considered HIV seropositive only, if both samples were found positive. The STDs were diagnosed by appropriate laboratory tests. The majority of the attenders had STDs; however, a small but significant proportion of patients had psychosocial disorders and other non-sexually transmitted genital diseases. Four per cent of the 981 patients—that is, 40 patients (26 males, 14 females)—were found to be seropositive for HIV. The annual prevalence showed a rising trend (1993, 0.56%; 1994, 4.4%; 1995, 2.4%; 1996, 4%; 1997, 4.4%; 1998, 5.7%; and January to July 1999, 8.7%). The prevalence of HIV seropositivity in different STDs is shown in table 1. Large proportions of seropositive patients were truckers (15/40, 37.5%) and housewives (12/40, 30%). Among 12 housewives, four were wives of truckers. All of the 26 seropositive male patients confessed to at least one sexual contact with commercial sex workers (CSWs). Twenty eight (70%) seropositive patients had one STD, while the remaining 12 (30%) patients had more than one STD; 18 (45%) seropositive patients had STDs with either atypical morphologies or unusual severity, the remaining 22 (55%) presented with usual morphologies.

India is a country with a wide variation in geographical, cultural, and behavioural patterns. This is also reflected in the trends of current HIV epidemic in the various regions of the country. We believe that no other country has such a high intranation variation in HIV epidemic status. Our data on HIV prevalence with STD clinics of different regions of the country highlights this difference. The high HIV prevalence zones of the country include western and southern zones, where HIV prevalence among STD clinic attenders varies from 15% to 33%. On the other hand, in eastern and northern zones, it is still low and varies from 0.2 to 4%.1 3–5

In our study we found that a high proportion of HIV positive patients were truckers, who generally acquired infection through CSWs from the highways to Bombay or Chennai, two metropolitan cities of the western and southern zones respectively. These long distance truckers have a high risk sexual behaviour and contribute in the spread of HIV infection throughout the country in a short time.4 5

Even though the present figures for HIV seropositivity in STD clinic attenders are not very high, the HIV epidemic in this region is now progressing at an alarming rate. In our study, the prevalence in our STD clinic increased from 0.56% in 1993 to 8.7% in 1999 (to July). This indicates that northern India is entering from a low level epidemic (HIV prevalence less than 5% in STD patients) to a concentrated epidemic.1 This calls for an immediate vigorous intervention programme to be introduced in this region.

Correspondence to: Dr Rafael Llanes Caballero


HIV seropositivity in women with syphilis in Delhi, India

Editor. — There has been a progressive rise in the prevalence of human immunodeficiency virus (HIV) infection in India, which currently has the largest number of HIV infected people. The spread of HIV is predominantly due to heterosexual transmission in India. Sexually transmitted disease (STD), particularly genital ulcer disease (herpes, syphilis, and chancroid), has an important role in the transmission of HIV, and the two have been observed to be interrelated.1 2 We conducted a pilot study to assess the relationship between syphilis and HIV infection among non-pregnant women attending gynaecology and STD clinics of our hospital. From June 1998 to July 1999, sera from 281 non-pregnant women were tested for HIV and syphilis using a diagnostically validated test. All reactive samples were retested using a different assay. Samples that were reactive in all the three tests were considered HIV antibody positive. A sample that was non-reactive on the first test was considered HIV negative. As was a sample that was reactive in the first and non-reactive in the next test.

Table 1 Frequency of HIV seropositivity in different sexually transmitted diseases

<table>
<thead>
<tr>
<th>STDs</th>
<th>No screened</th>
<th>HIV seropositive (%)</th>
<th>Seropositivity rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcerative STDs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital herpes</td>
<td>188</td>
<td>19</td>
<td>10.1</td>
</tr>
<tr>
<td>Syphilis</td>
<td>107</td>
<td>6</td>
<td>5.6</td>
</tr>
<tr>
<td>Chancroid</td>
<td>21</td>
<td>1</td>
<td>4.76</td>
</tr>
<tr>
<td>Donovanosis</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lymphogranuloma venereum</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All ulcerative STDs</td>
<td>322</td>
<td>25</td>
<td>7.6</td>
</tr>
<tr>
<td>Non-ulcerative STDs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condyloma acuminata</td>
<td>184</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Balanoposthitis</td>
<td>75</td>
<td>2</td>
<td>2.66</td>
</tr>
<tr>
<td>Granuloma crustosum</td>
<td>30</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Molluscum contagiosum</td>
<td>27</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td>Non-gonococcal urethritis</td>
<td>27</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vaginosis</td>
<td>23</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>All non-ulcerative STDs</td>
<td>368</td>
<td>18</td>
<td>4.9</td>
</tr>
<tr>
<td>All STD clinic attenders*</td>
<td>981</td>
<td>40</td>
<td>4.1</td>
</tr>
</tbody>
</table>

The discrepancy in total is due to the presence of more than one STD in some patients.
positive for HIV antibody. This was highly significant (p<0.001, Fisher's exact test).
Presence of HIV antibody was associated with genital ulcer in 23.5% women, followed by vaginal growth and vaginal discharge in 16.6% and 11.1% respectively.

There is a higher prevalence of STD and HIV infection among men compared with women. HIV seropositivity has been associated with a reactive serological test for syphilis among males. This could be probably due to higher percentage of male attendance in STD clinics.4 We therefore undertook this study to evaluate if some association exists between syphilis and HIV among non-pregnant women attending the gynaecology clinic, as well as the STD clinic. Untreated STDS, especially those with ulcerative disease, can enhance both susceptibility of a person to HIV infection as well as infectivity of HIV positive individual. Breach in the epithelial surface of a genital ulcer may be an import factor in the transmissibility of HIV. This is evident from our results where incidence of positive serology for HIV was highest among women with genital ulcer (23.5%). Our study demonstrates a significant association between positive serology for syphilis and presence of HIV infection. We feel that the diagnosis of syphilis in non-pregnant women may act as a marker to detect the presence of HIV infection.

### Immune reconstitution CMV pneumonitis

*Editor,—A 41 year old white homosexual man presented in late July 1999 with a 5 day history of exertional dyspnoea, non-productive cough, fever with sweats, and anorexia. An empirical course of broad spectrum antibiotics did not improve his symptoms and his CD4+ count was 195 × 10^9/l. At this time he had developed a 1 cm left upper lobe pulmonary nodule. He had been found to be HIV-1 antibody positive in August 1991; cutaneous Kaposi's sarcoma defined AIDS in June 1992. In May 1995 biopsy of the right parotid gland showed focal areas of inflammatory changes consistent with cytomegalovirus (CMV) infection. Pneumoperitoneum and colitis were treated with intravenous ganciclovir for 2 weeks; no maintenance therapy was given. At this time the CD4 count was 130 × 10^9/l. In October 1996 the patient had developed a right upper lobe pneumonitis. He had a complex antiretroviral history, having taken combinations of reverse transcriptase inhibitors and protease inhibitors. He had discontinued all antiretroviral therapy 2 years after the onset of symptoms. The patient had failed to maintain CD4 counts and HIV viral load had risen: co-trimoxazole was given for 3 months and CD4 count had fallen to 70 cells × 10^9/l. Two weeks before the onset of respiratory symptoms the patient had recommenced antiretroviral therapy with d4T, 3TC, and amprenavir/ saquinavir. Four weeks after starting antiretroviral therapy viral load had fallen to 1500 copies/ml and CD4 had risen to 170 cells × 10^9/l. A computed tomography (CT) scan of the thorax 4 weeks after the onset of respiratory symptoms and 6 weeks after starting antiretroviral therapy showed focal areas of ground glass shadowing, largely in the left upper lobe but also involving other lobes; in addition, chronic changes resulting from the previous episode of pneumonia were noted, including multifocal fibrotic change with thickened interlobar septae, cystic air spaces, and minor bronchiectasis involving all lobes. Repeat CT of the thorax at this time showed 200 copies/ml and CD4 = 160 cells × 10^9/l. At bronchoscopy, performed after 8 weeks of antiretroviral therapy, the endobronchial appearances were normal. Bronchoalveolar lavage (BAL) was performed from the left upper lobe. Analysis of BAL fluid revealed a lymphocytic reaction; many cells had intranuclear/cytoplasmic inclusions typical of CMV infection. In situ hybridisation for CMV was positive for mononuclear and for culture for bacteria, mycobacteria, P carini and other fungi were negative. Intravenous ganciclovir 10 mg/kg per day was given for 21 days, in addition, antiretroviral therapy and co-trimoxazole were continued. With this there was a rapid defervescence of fever, a reduction in exudation in right upper lobe pneumonia, and improvement in SaO2, to >98% on air. Repeat CT of the thorax after 3 weeks of intravenous ganciclovir showed an improvement in ground glass shadowing and persistence of the chronic changes. The patient was subsequently maintained on oral ganciclovir.

The diagnosis of CMV pneumonitis was made by identifying CMV as the sole pathogen in BAL fluid and the improvement in symptoms, SaO2, and CT appearances with ganciclovir as monotherapy. This diagnosis was made in the context of a rapidly falling viral load and an increase in CD4 count indicating partial immune reconstitution.

Partial restoration of cell mediated immunity induced by antiretroviral therapy, as shown by recovery of part of CD4 T cell reactivity to memory antigens,5,6 may cause development of sufficient inflammatory responses to produce symptoms and signs in patients latently infected with opportunistic infections. Reactivation mycobacterial lymphadenitis,7 cryptococcal meningitis,8 and CMV retinitis9 have been described. The case described here suggests CMV pneumonitis should be added to the list of immune reconstitution phenomena.

**R F MILLER**

**P J SHAW**


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**Table 1 Details of patients undergoing serological test for syphilis**

<table>
<thead>
<tr>
<th>Clinical diagnosis</th>
<th>No of samples (%)</th>
<th>Positive for syphilis serology</th>
<th>Positive for HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous pregnancy loss*</td>
<td>89/281 (31.6)</td>
<td>16/89 (17.9%)</td>
<td>0/16 (0%)</td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td>101/281 (55.8)</td>
<td>9/101 (8.9%)</td>
<td>1/9 (11.1%)</td>
</tr>
<tr>
<td>Genital growth</td>
<td>49/281 (14.9)</td>
<td>4/49 (12.2%)</td>
<td>1/6 (16.6%)</td>
</tr>
<tr>
<td>Genital ulcer</td>
<td>42/281 (14.9)</td>
<td>17/42 (40.47%)</td>
<td>4/17 (23.5%)</td>
</tr>
</tbody>
</table>

*Intracerebral death, still birth, repeated abortions.

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**BOOK REVIEWS**


A book with a title such as this one makes it difficult for the author to decide what to exclude. This book certainly fulfils its major objective of providing an easy reference manual for the diagnosis and management of common gynaecological conditions. It deals with almost all the gynaecological problems that could be encountered in the community and the common gynaecological problems in hospital medicine. Overall, the topics covered are well presented with special points highlighted.
The use of pictures relating to almost all the conditions dealt with by the book breaks up what would otherwise be a book of lists. The use of two different views of the same woman exercising on a treadmill certainly made me smile. The first picture tells us she is an intensively training sportswoman who may develop amenorrhoea and osteoporosis with stress fractures while the second picture, on a page dealing with advice to women who do not want HRT, reveals she is a grandmother taking regular exercise.

From a genitourinary medicine trainee point of view, I would have liked to see a more comprehensive chapter on pelvic infections and sexually transmitted diseases (this is the second smallest chapter in the book), and would have preferred this chapter to follow the one on vaginal and vulval problems. I am, however, glad to see that the role of the genitourinary clinic in the management of pelvic infections is emphasised.

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These two books provide histories of STDs and HIV in nine sub-Saharan African countries and another 11 countries in the Asia-Pacific region. The contributors are mostly historians or social scientists and the historical accounts take the reader up to 1995. Each volume is divided up into well referenced scholarly monographs on individual countries and individual chapters will be of considerable interest to anyone with an interest in sexual health in the countries studied. The number of readers of this journal who will want to read both books throughout is likely to be much less, given that these books are fairly specialist medical historical studies written mainly by historians for historians. The decision of the editors to treat each country separately has led inevitably to much repetition of certain themes. Many chapters rehearse the familiar story of how governments have responded to public pressure to regulate prostitution and the difficulties of demonstrating whether such efforts have had any real impact on STD transmission. The most interesting example in this context is the account of the attempts to eradicate prostitution and STDs in China, a subject which is particularly difficult to separate in the way they are discussed. However, the lack of specificity of older serological test methods, the impossibility of determining the mode of transmission from serological results or, in many instances, from observed clinical manifestations, receive rather patchy and inconsistent coverage. A third recurring theme is the unreliability of passive reporting systems. While this is often acknowledged, contributors still feel obliged to cite whatever data they can unearth and to discuss observed trends that are unlikely to bear much relation to any true epidemiological situation.

What is there in these books for the clinician or epidemiologist with an interest in STDs? There is no shortage of entertaining anecdotes such as the expatriate doctor in Uganda who had himself publicly injected with mercury to demonstrate his faith in this treatment. The account of regular penicillin injections for prostitutes in Indonesia will interest those who are following studies of targeted periodic presumptive treatment in Africa such as the Lesedi Project. Having worked in Papua New Guinea, I was interested to see what was written about spectacular epidemics of gonorrhoea that affected the Marind-anim tribe in the 1920s. I felt that the account given failed to bring alive the unique nature of this epidemic and the campaign to control it. The main problem for more clinically oriented readers is the wealth of innovative approaches to STD and HIV control that have been explored in these countries since 1995 and which are too recent for inclusion in these volumes. The accounts of HIV go little further than the difficulties experienced in galvanising governments out of denial and into action. For detailed accounts of the Ghana and Rakai trials and their impact on policy and for the discussion of more topical controversies such as the possible role of polio vaccine development in the Congo in triggering the HIV pandemic we will have to look to future historians.

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This book is a terrific read and should be read cover to cover by all practising genito-urinary medicine physicians and trainees. Generally the quality of the writing is excellent. Genitourinary medicine is a rapidly advancing field so read the book now before it becomes out of date. Already the incubation period of the text shows in places. Some statistics relate to 1992 where 1997 figures are available. Some statements are also slightly out of date.

In a book of this size the referencing presents a challenge. If one references every difficulty of demonstrating whether such evidence the handbook turns into a weighty and unmanageable tome. Mostly, the authors have managed a sensible compromise. Statements that are uncontroversial or old hat are not referenced. Statements that are uncontroversial or old hat are not referenced. Occasionally more controversial statements remain unreferenced. This may present a problem for the trainee. There are also some surprising omissions. I could find no descriptions of desquamative vaginitis or focal vulvitis. However, I believe that this handbook could serve as an excellent basis for discussions between trainer and trainee and stimulate further reading around these topics.

Get this book. You will enjoy it. A number of chapters are absolute gems.

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NOTICES


9th International Congress on Infectious Diseases, 9–12 April 2000, Buenos Aires, Argentina Further details: International Society for Infectious Diseases, 181 Longwood Avenue, Boston, MA 02115, USA (tel: (617) 277-0551; fax: (617) 731-1541; email: isidsbus@aol.com).

 Sexually Transmitted Diseases in a Changing Europe, 14–15 April 2000, Rotterdam, The Netherlands Further details: Mediscon, Organisation for Medical Congresses, PO Box 113, 5600 AC Geldrop, Netherlands (tel: +31-(0)40-2852212; fax: +31-(0)40-2851966; email: MEDISCON@IAEhv.nl).

20th Scientific Conference of Venereological Section of the Polish Society of Dermatologists, Bialystok, 28–30 April 2000 Further details: Dept Dermatology and Venereology, Sw Rocha 3, 15-879 Bialystok, Poland (tel/fax: (085) 7422778; email: bozchod@amb.ac.bialystok.pl).

Joint meeting of the MSSVD and the ASTDA, 3–7 May 2000, Baltimore Marriott Inner Harbor Hotel, Baltimore, Maryland, USA Further details: Dr Keith Radcliffe, honorary assistant secretary, MSSVD (fax: +44(0) 121-237 5729; email: k.w.radcliffe@bham.ac.uk).

Australasian Sexual Health Conference, Ven Troppo, Carlton Hotel, Darwin, Northern Territory, 21–24 June 2000 Further details: Shirley Corley, Conference manager, Dart Associates, PO Box 781, Lake Cove, 2066 NSW, Australia (tel: 02 9418 9396/97; fax: 02 9418 9398; email: dartconve@mpx.com.au).

6th ESC Congress on Contraception in the Third Millennium: a (R)Evolution in Reproductive and Sexual Health, Ljubljana, Slovenia, 28 June–1 July 2000 Further details: Orga-Med Congress Office, Mr Peter Erard, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.unet.be).
XIII International AIDS Conference, 9–14 July 2000, Durban, South Africa
Further details: Congress Sweden AB, PO Box 5619, Linnelegatan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 661 91 25; email: aids2000@congreso.se).

Consortium of Thai Training Institutes for STDs and AIDS—10th STDs/AIDS diploma course, Bangkok Hospital, Bangkok (30 Oct–12 Nov) and Prince of Songkla University, Hat Yai, Thailand (13–23 Nov) 30 October–23 November 2000
Further details: Hat Yai Secretariat, Dr Verapol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkhla 90110, Thailand (fax: (66-74) 446 361; email: cverapol@ratree.psu.ac.th)

Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bangkok 10500, Thailand (fax: (66-2) 286 3013; email: plthanit@email.ksc.net).

Further details: Congrex Sweden AB, PO Box 5619, Linnelegatan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 661 91 25; email: aids2000@congreso.se).

Gamut of Thai Training Institutes for STDs and AIDS—International Reunion and Refresher Course on Sexual Health, Lee Garden Plaza Hotel, Hat Yai, Songkla 90110, Thailand (13–23 Nov) 30 October–23 November 2000
Further details: Hat Yai Secretariat, Dr Verapol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkhla 90110, Thailand (fax: (66-74) 446 361; email: cverapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bangkok 10120, Thailand (fax: (66-2) 286 3013; email: plthanit@email.ksc.net).

CURRENT PUBLICATIONS

Selected titles from recent reports published worldwide are arranged in the following sections:

Gonorrhea
Chlamydia
Candidiasis
Bacterial vaginosis
Pelvic inflammatory disease
Sarcoids and other trophematoses
Hepatitis
Herpes
Human papillomavirus infection
Cervical cytology and colposcopy
Other sexually transmitted infections
Public health and social aspects
Microbiology and immunology
Lymphology
Miscellaneous

Gonorrhea

Increase in oral sex and pharyngeal gonorrhoea: an unintended effect of a successful condom promotion programme for vaginal sex.

Cervical wet mount as a negative predictor for gonococci- and Chlamydia trachomatis-induced cervicitis in a gravid population.

Experimental transmission of Neisseria gonorrhoeae from pregnant rat to fetus.

Comparison of direct inoculation and copan transport systems for isolation of Neisseria gonorrhoeae from endocervical specimens.

T lymphocyte response to Neisseria gonorrhoeae porin in individuals with mucosal gonococcal infections.
SD SIMPSON, Y HO, PA RICE, LM WETZLER. J Infect Dis 1999;180:762–73 38

Decreased azithromycin susceptibility of Neisseria gonorrhoeae due to mtrR mutations.

The farAB-encoded efflux pump mediates resistance of gonococci to long-chained antibacterial fatty acids.
EH LEE, WM SHAFER. Mol Microbiol 1999;33:839–45 40

Chlamydia

Partner notification for chlamydial infections among private sector clinicians in Seattle-King County: a clinician and patient survey.

Patterns of Chlamydia trachomatis testing and follow-up at a university hospital medical center.
LH BACHMANN, CM RICHEY, K WAITES et al. Sex Transm Dis 1999;26:496–9

Completeness of and duration of time before treatment after screening women for Chlamydia trachomatis infections.
G FOGLIA, P RHODES, M GOLDBERG, ME STLOUIS. Sex Transm Dis 1999;26:421–5

Control of Chlamydia trachomatis infections in female army recruits: cost-effectiveness screening and treatment in training cohorts to prevent pelvic inflammatory disease.
MR HOWELL, JC GAYDOOL, KT MCKEE et al. Sex Transm Dis 1999;26:519–26

Lack of association between serum antibodies to Chlamydia trachomatis and a history of recurrent pregnancy loss.

How adequate is adequate for the collection of endocervical specimens for Chlamydia trachomatis testing?
IL REEVE, KA GERSHMAN, JK KELLEY et al. Sex Transm Dis 1999;26:579–83

The impact on accuracy and cost of ligase chain reaction testing by pooling urine specimens for the diagnosis of Chlamydia trachomatis infections.
J KREPEL, J PATEL, A SPRONSTON et al. Sex Transm Dis 1999;26:504–7

Ability of the Digene Hybrid Capture II test to identify Chlamydia trachomatis and Neisseria gonorrhoeae in cervical specimens.

Impact of reference standard sensitivity on accuracy of rapid antigen detection assays and a leukocyte esterase dipstick for diagnosis of Chlamydia trachomatis infection in first-void urine specimens from men.

Antimicrobial susceptibility testing of Chlamydia trachomatis using a reverse transcriptase PCR-based method.

Detection of Chlamydia trachomatis endocervical infections by ligase chain reaction versus ACCESS Chlamydia antigen assay.

Antibody response to the chlamydial heat-shock protein 60 in an experimental model of chronic pelvic inflammatory disease in monkeys (Macaca nemestrina).
DW PEELING, DL PATTON, YTC SWENNEY et al. Infect Dis 1999;180:774–9

Role of gamma interferon in controlling murine chlamydial genital tract infection.

Lower prevalence of Chlamydia pneumoniae DNA compared with Chlamydia trachomatis DNA in synovial tissue of arthritics patients.
HR SCHUMACHER, HC GERARD, RK ARAYSSI et al. J Infect Dis 1999;180:1889–93

Lack of cell wall peptidoglycan versus penicillin sensitivity: new insights into the chlamydial anomaly.

The effect of doxycycline treatment and the development of protective immunity in a murine model of chlamydial genital infection.
Double-blind comparison of trovafloxacin and doxycycline in the treatment of uncomplicated chlamydial urethritis and cervicitis.
WM McCORMACK, ZA DALU, DH MARTIN et al. Sex Transm Dis 1999;26:531–6

In-vitro activity of gatifloxacin against Chlamydia trachomatis and Chlamydia pneumoniae.
PM ROBIN, MR HAMMERSCHLAG. J Antimicrob Chemother 1999;44:549–52

Identification and characterization of a Chlamydia trachomatis early operon encoding four novel inclusion membrane proteins.
MA SCIDMORECARLSON, EI SHAW, CA DOOLEY et al. Mol Microbiol 1999;33:753–65

Pelvic inflammatory disease

The association of interleukin 6 with clinical and laboratory parameters of acute pelvic inflammatory disease.

Syphilis and other treponematoses

Incident syphilis among women with multiple admissions to jail in New York City.

Enzyme-linked immunospot assay for the diagnosis of active Treponema pallidum infection during the various stages of syphilis.
IL TABIRE, RK LEW, P TAMBE et al. Sex Transm Dis 1999;26:426–30

The use of Western blotting as the confirmatory test for syphilis in patients with rheumatic disease.
PT MURPHY, R GIOBBI, R KUBOTA et al. J Rheumatol 1999;26:2448–53

T-cell responses to Treponema pallidum subsp pallidum antigens during the course of experimental syphilis infection.

Immunization with Treponema pallidum outer membrane vesicles induces high-titer complement-dependent treponemalidical activity and aggregation of T-pallidum rare outer membrane proteins (TROMPs).

Hepatitis

Cost-effectiveness analysis of hepatitis A vaccination strategies for adults.
JB OCONNOR, TP IMPERIALE, ME SINGER. Hepatology 1999;30:1077–81

The Denver school-based adolescent hepatitis B vaccination program: a cost analysis with risk simulation.

Pathogenesis of chronic hepatitis C: immunological features of hepatic injury and viral persistence.

Herpes

A prospective study of new infections with herpes simplex virus type 1 and type 2.

Is sexual transmission an important pattern for herpes simplex type 2 virus seroconversion in the Spanish general population?

Quality of life and use of health care among people with genital herpes in France.
R TABOULET, B HALIOUA, JE MALEIN. Acta Derm Venereol 1999;79:380–4

The differential impact of training stress and final examination stress on herpes-virus latency at the United States Military Academy of West Point.

College students’ attitudes regarding vaccination to prevent genital herpes.

Ecthyma secondary to herpes simplex virus infection.
A KINTAVASADI, FA TAUSK, HC NOUSARI. Clin Infect Dis 1999;29:454

Acquired lymphedema of the hand due to herpes simplex virus type 2.
DF BUTLER, PJ AMLOUF, BC BATE, CI STETSON. Arch Dermatol 1999;135:1125

Whole cell lysate enzyme immunoassays vs recombinant glycoprotein G2-based immunoassays for HSV-2 seroprevalence studies.

A double-blind, randomized study assessing the equivalence of valacyclovir 1000 mg once daily versus 500 mg twice daily in the episodic treatment of recurrent genital herpes.

Foscanet treatment of genital infection due to acyclovir-resistant herpes simplex virus 2 in a pregnant patient with AIDS: case report.
A ALVAREZMCLLDO, J HAYLIK, KE DREW. Clin Infect Dis 1999;29:937

The comparative effects of famciclovir and valacyclovir on herpes simplex virus type 1 infection, latency and reactivation in mice.
RA LEIBLANCED, L PESZNEAK, M GODLesKI, SE STRAUS. J Infect Dis 1999;180:594–9

Bacterial vaginosis

Is the lack of concurrence of bacterial vaginosis and vaginal candidiasis explained by the presence of bacterial amines?

Association of indicators of bacterial vaginosis with a female genital tract factor that induces expression of HIV-1.
Antiviral properties of isoborneol, a potent inhibitor of herpes simplex virus type 1.

Antitherpetic activity and mode of action of natural carrageenans of diverse structural types.

Givamide (cis-capsaicin) treatment of primary or recurrent experimental genital herpes.

γδ T cell response induced by vaginal herpes simplex 2 infection.

Humoral response to herpes simplex virus is complement-dependent.

LAT expression during an acute HSV infection in the mouse.

Inhibition of dendritic cell maturation by herpes simplex virus.

Human papillomavirus infection

Assessing gains in diagnostic utility when human papillomavirus testing is used as an adjunct to Papanicolaou smear in the triage of women with cervical cytologic abnormalities.

HPV testing in primary screening of older women.

Do HPV-negative cervical carcinomas exist—revisited.

Human papillomavirus is a necessary cause of invasive cervical cancer worldwide.
JMM Wallboomers, MV Jacobs, MM Manos et al. J Pathol 1999;189:12–9

Has the use of Pap smears reduced the risk of invasive cervical cancer in Guadalajara, Mexico?

Familial risks in cervical cancer: is there a hereditary component?
K Heiman, CH Dong, P Vahtinen. Int J Cancer 1999;82:775–81

Human papillomavirus infection, cervical dysplasia and invasive cervical cancer in Honduras: a case-control study.

Human papillomavirus-associated penile squamous cell carcinoma in HIV-positive patients.

Enhancement of the innate and cellular immune response in patients with genital warts treated with topical imiquimod cream 5%.

Intralesional or topical cidofovir for the treatment of recurrent genital warts.

Histologic and immunologic associations of an HPV16 variant in low-grade smears.

Seroprevalence of human papillomavirus type 16 in pregnant women.

Serum antibodies to human papillomavirus 16 proteins in women from Brazil with invasive cervical carcinoma.

Serological evidence for protection by human papillomavirus type 6 infection against HPV type 16 cervical carcinogenesis.

The integration of HPV-18 DNA in cervical carcinoma.

High prevalence of human papillomavirus type 58 in Chinese women with cervical cancer and precancerous lesions.

Asian-American variants of human papillomavirus type 16 DNA in cervical cancers.


Degenerate and nested PCR: a highly sensitive and specific method for detection of human papillomavirus infection in cutaneous warts.


Analysis by multiplex PCR of the physical status of human papillomavirus type 16 DNA in cervical cancers.


HPV typing and HPV16 E6-sequence variations in synchronous lesions of cervical squamous-cell carcinoma from Swedish patients.

Human immunodeficiency virus infection in vitro activates naturally integrated human papillomavirus type 18 and induces synthesis of the L1 capsid protein.

Chimeric virus-like particles of the human papillomavirus type 16 as a prophylactic and therapeutic vaccine.

A recombinant human papillomavirus type 16 L1-vaccinia virus murine challenge model demonstrates cell-mediated immunity against HPV virus-like particles.

Nasal immunization of mice with human papillomavirus type 18 virus-like particles or with the HPV-16 L1 gene elicits specific cytotoxic T lymphocytes in vaginal draining lymph nodes.

Macosol but not parenteral immunization with purified human papillomavirus type 18 virus-like particles induces neutralizing titers of antibodies throughout the estrous cycle of mice.

p53 codon 72 arg/pro polymorphism is not related to HPV type or lesion grade in low- and high-grade squamous intraepithelial lesions and invasive squamous carcinoma of the cervix.


E7-specific cytotoxic T cell tolerance in HPV-transgenic mice.


Establishment of the human papillomavirus type 16 life cycle in an immortalized human foreskin keratinocyte cell line.

ER Flores, BL Allenhoffmann, D Lee et al. Virology 1999;262:344–54

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C Deranits, S Goyat, S Garbay et al. Oncogene 1999;18:4538–45

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SY Li, S Labrecque, MC Gauzzi et al. Oncogene 1999;18:5727–37

Cervical cytology and colposcopy

Organised vs spontaneous pap-smear screening for cervical cancer: a case-control study.


Beliefs about Papanicolau smear and compliance with Papanicolau smear follow-up in adolescents.


Follow up of women with borderline cervical smears as defined by national guidelines.


The clinical significance of the poor correlation of cervical dysplasia and cervical malignancy with referral cytotologic results.


See-and-treat in the management of high-grade squamous intraepithelial lesions of the cervix: a resource utilization analysis.


Angiogenesis in cervical intraepithelial neoplasia and the risk of recurrence.


Hormone receptor status in cervical intraepithelial neoplasia: correlation with the stage of disease.


Atypical immature metaplastic-like proliferation of the cervix: diagnostic reproducibility and viral (HPV) correlates.


Abnormal Fhit expression in malignant and premalignant lesions of the cervix.


Factors influencing sexual partner referral for sexually transmitted infections in Uganda.

F Nuwaha, F Kambugu, PSJ Nsereka. Sex Transm Dis 1999;26:483–9

Providing low-cost sexually transmitted diseases services in two semi-urban health centers in Central African Republic: characteristics of patients and patterns of health care-seeking behavior.

KA Parker, EH Louman, RV Hawkins et al. Sex Transm Dis 1999;26:508–16


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Sexually transmitted diseases services in societies with limited resources.

A Ronald. Sex Transm Dis 1999;26:517–8

Condom use in young blacks and Hispanics in public STD clinics.


Sexually transmitted diseases and condom use among female freelance and brothel-based sex workers in Singapore.

ML Wong, KEW Chai, WL Chua, S Wee. Sex Transm Dis 1999;26:593–600

Predictors of condom use among patients with sexually transmitted diseases in Uganda.

F Nuwaha, E Paxelid, B Hojer. Sex Transm Dis 1999;26:491–5

Practice patterns for the elicitation of sexual history, education and counseling among providers of STD services: results from the gonorrea Community Action Project (GCAP).

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Microbiology and immunology

Roles of glycoproteins and oligosaccharides found in human vaginal fluid in bacterial adherence.


Identification of and hydrogen peroxide production by fecal and vaginal lactobacilli isolated form Japanese women and newborn infants.


Relationship between Ureaplasma urealyticum vaginal colonization and polymorphism in the interleukin-1 receptor antagonist gene.

A Jerez, M Galindo, S Durante et al. J Infect Dis 1999;180:912–4
Interleukin-1 inhibits gamma interferon-induced bacteriostasis in human uroepithelial cells.

Dermatology

Lesson of the week: child sexual abuse enquiries and unrecognised vulval lichen sclerosus et atrophicus.
PL WOOD, T BEVAN. BMJ 1999;319:899–900

Malignant melanoma of the vulva in a nationwide, 25-year study of 219 Swedish females: clinical observations and histological features.
BK RAGNARSSONOLDING, LR KANTERLEWENSOHN, B LAGERLOF et al. Cancer 1999;86:1273–84

Photodynamic therapy for inoperable vulval Paget's disease using δ-aminolaevulinic acid: successful management of a large skin lesion.

A study of the cutaneous manifestations of Behcet's disease in patients from the United States.

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The contribution of MIB 1 in the accurate grading of vulvar intraepithelial neoplasia.

Molecular pathology and clinicopathologic features of penile tumors: with special reference to analyses of p21 and p53 expression and unusual histologic features.
JY LAM, KW CHAN. Arch Pathol Lab Med 1999;123:895–904

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Miscellaneous

Professional relationships in sexually transmitted diseases research—Thomas Pauran Award Lecture.
KB JONES. Sex Transm Dis 1999;26:552–5

An overview of sexually transmitted diseases. Part I.

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Chancroid, primary syphilis, genital herpes and lymphogranuloma venereum in Antananarivo, Madagascar.

The prevalence of sexually transmitted pathogens in patients presenting to a Casablanca STD clinic.

Quinolones in sexually transmitted diseases: state of the art.
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Evaluation of the use of calendar bister packaging on patient compliance with STD syndromic treatment regimens.
JM WRIGHT, Y HTUN, G LEONO et al. Sex Transm Dis 1999;26:556–63

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SJ STAGNO, H FORSTER, J BELINSON. JAMA 1999;282:1291–5

Erectile dysfunction in the community: a prevalence study.

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Acceptability of a bioadhesive nonoxynol-9 gel delivered by an applicator as a rectal microbicide.
M GROSS, CL CELUM, SR TABET et al. Sex Transm Dis 1999;26:572–8

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Sexual orientation and youth suicide.
G REMAFEDI. JAMA 1999;282:1291–5

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Prevalence of HPV cervical infections among imprisoned women in Barcelona, Spain

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