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

EDITOR,—The penitentiary centres in Spain harbour inmates in whom the combination of HIV 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 HIV, hepatitis B and C serostatus, and 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.4

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 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 98/054.

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></th>
<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></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>54 63.5</td>
<td>15 20.8</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31 36.5</td>
<td>57 79.2</td>
<td>7.3</td>
<td>4.7</td>
<td>1.96–11.4</td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>59 69.4</td>
<td>38 52.8</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26 30.6</td>
<td>34 47.2</td>
<td>2.0</td>
<td>1.2</td>
<td>0.5–2.5</td>
</tr>
<tr>
<td>Prostitution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>44 51.8</td>
<td>12 16.7</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>41 48.2</td>
<td>60 83.3</td>
<td>5.4</td>
<td>2.4</td>
<td>0.98–6.1</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>22 26.5</td>
<td>26 36.6</td>
<td>4.2</td>
<td>2.2</td>
<td>0.8–6.0</td>
</tr>
<tr>
<td>Yes</td>
<td>17 20.5</td>
<td>43 65.5</td>
<td>7.0</td>
<td>2.9</td>
<td>1.0–8.2</td>
</tr>
<tr>
<td>Length of use:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–9 years</td>
<td>49 59.8</td>
<td>21 31.3</td>
<td>1</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>≥10 years</td>
<td>33 40.2</td>
<td>46 68.7</td>
<td>3.1</td>
<td>1.2</td>
<td>0.5–2.9</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 strains of Neisseria gonorrhoeae with reduced susceptibility to this antibiotic, as a result of chromosomal mutations, were isolated, and in 1970 the first penicillinase producing Neisseria gonorrhoeae (PPNG) strains emerged in South East Asia and Africa, causing high level resistance to penicillin (MIC ≥ 16 µg/ml). 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 the laboratory. 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.2 To our knowledge it is the first study developed in Cuba, analysing the β lactamase activity of N gonorrhoeae isolated from different provinces indicating 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 1972.3 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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Correspondence to: Dr Rafael Llanes Caballero

Table 1. Distribution of Cuban PPNG and non-PPNG strains from 1995 to 1998

<table>
<thead>
<tr>
<th>Year</th>
<th>No of gonococci examined</th>
<th>Non-PPNG strains</th>
<th>PPNG strains</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>63</td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>1996</td>
<td>21</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>1997</td>
<td>21</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>1998</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>61</td>
<td>49</td>
</tr>
</tbody>
</table>

Table 2. 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>Donorvaginitis</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>
</tbody>
</table>

| NON-ULCERATIVE STDs | | | |
| Condyloma acuminatum | 184 | 13 | 7 |
| Balanoposthitis | 75 | 2 | 2.66 |
| Gonorrhoea | 36 | 1 | 0.28 |
| Molluscum contagiosum | 27 | 3 | 11.1 |
| Non-gonococcal urethritis | 27 | 0 | 0 |
| Vaginosis | 23 | 1 | 0.26 |
| All non-ulcerative STDs | 368 | 18 | 4.9 |

All STD clinic attenders* | 981 | 40 | 4 |

*The discrepancy in total is due to the presence of more than one STD in some patients.

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 infection. The trends of HIV infection in these attenders at Chandigarh (north India)—

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 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 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). Twentyeight (70%) seropositive patients had one STD, while the remaining 22 (55%) had more than one STD; 18 (45%) seropositive patients had STDs with any 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 intranational variation in HIV epidemic status. Comparison of our data on HIV prevalence with STD clinics of different regions of the country has highlighted 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%. Although in our study we found that a high proportion of HIV positive patients were truckers, who generally acquired infection from CSWs in the 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. 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. This calls for an immediate vigorous intervention programme to be introduced in this region.

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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 in the world. The spread of HIV is predominantly by 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. We conducted a pilot study to assess the relation 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 by VDRL (Serologist, India) and confirmed by TPHA (Inmunotrop, Omega Diagnostic Ltd, UK). Sera that tested positive for syphilis were tested for HIV without identifying the patient. Individual informed consent for HIV was not obtained as results were not aimed to be linked to the identity of those tested. Serum was tested first with one ELISA/rapid/simple (ERS) assay, utilising either of the different enzyme linked immunosorbent assays (ELISA). 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. Of 281 sera tested, 48 (17%) were seropositive for syphilis. HIV antibody was detected in sera of six (12.5%) patients who were seropositive for syphilis (table 1). None of the 235 patients with negative syphilis serology tested...
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 genital 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. 3 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. Break in the epithelial surface of a genital ulcer may be an important 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.

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<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>4/49 (12.2%)</td>
<td>1/49 (2.0%)</td>
<td>0/49 (0%)</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>

*Intrauterine death, still birth, repeated abortions.

**Immune reconstitution CMV pneumonitis**

Eston,- – 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 CD4 count had fallen to 70 cells × 10^6. Two weeks after 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 count had fallen to 70 cells × 10^6. 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 reached 170 cells × 10^6. A computed tomography (CT) scan of the thorax 4 weeks later showed a dense consolidation involving the upper lobe and also involving other lobes; in addition, chronic bronchiectasis resulting from the previous episode of pneumonia were noted, including multifocal fibrotic change with thickened interlobar septae, cystic air spaces, and bronchiectasis involving all lobes. Repeat viral load at this time was 200 copies/ml and CD4 = 160 cells × 10^6. At bronchoscopy, performed after 8 weeks of antiretroviral therapy, the endobronchial appearances were normal. Bronchovascular 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 in mononuclear cells and 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 cotrimoxazole were continued. With this therapy there was a rapid defervescence of fever, a reduction in exertional dyspnoea 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 diagnostic was made in the context of a rapidly falling viral load and an increase in CD4 count indicating partial immune reconstitution.

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

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1 Autran B, Garcelan G, Li TS et al. Positive effects of combined antiretroviral therapy on CD4+ T cell homeostasis and function in advanced HIV disease. Science 1997;277:112-16.


Accepted for publication 26 November 1999

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 conditions 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 difficulty of differentiating non-venereal from venereal treponematosis. We are constantly reminded that syphilis reporting may be distorted by this issue but other pertinent issues such as the unitarian theory of treponematosis, 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 epidemic of Donovanosus 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 Botswana 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 genitourinary 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 related 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 statement (and considers all the conflicting evidence) the handbook turns into a weighty unmanageable tome. Mostly, the authors have managed a sensible compromise. 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: isidsbo@aol.com).

Sexually Transmitted Diseases in a Changing Europe, 14–15 April 2000, Rotterdam, The Netherlands Further details: Medison, Organisation for Medical Congresses, PO Box 113, 5660 AC Geldrop, Netherlands (tel: +31-(0)-40-2852212; fax: +31-(0)-40-2851966; email: MEDISON@IAehv.nl).

20th Scientific Conference of Venereological Section of the Polish Society of Dermatologists, Bialystok, 28–30 April 2000 The conference will be on epidemiological and clinical aspects of sexually transmitted infections. 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, Lane Cove, 2066 NSW, Australia (tel: 02 9418 9396/97; fax: 02 9418 9398; email: dartconv@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.uunet.be).
**XIII International AIDS Conference, 9–14 July 2000, Durban, South Africa**

Further details: Congres Sweden AB, PO Box 5619, Linneugatan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 661 91 25; email: aids2000@congress.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: Hattai Secretariat, Dr Veerapol Chayandeep, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songklah 90110, Thailand (fax: (66-74) 446 361; email: everapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bangkok 10120, Thailand (fax: (66-2) 286 3013; email: pthanit@email.ksc.net).

**Consortium of Thai Training Institutes for STDs and AIDS—International Reunion and Refresher Course on Sexual Health, Lee Garden Plaza Hotel, Hat Yai, Thailand 24–26 November 2000**

Further details: Hattai Secretariat, Dr Veerapol Chayandeep, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songklah 90110, Thailand (fax: (66-74) 446 361; email: everapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bangkok 10120, Thailand (fax: (66-2) 286 3013; email: pthanit@email.ksc.net).

**CURRENT PUBLICATIONS**

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

**Gonorrhoea**

Chlamydya

Candida

Bacterial vaginosis

Pelvic inflammatory disease

Sperson and other treponematoses

Herpes

Human papillomavirus infection

Other sexually transmitted infections

Public health and social aspects

Microbiology and immunology

Pathology

Miscellaneous

**Predicting Neisseria gonorrhoeae and Chlamydia trachomatis infection using risk scores, physical examination, microscopy and leukocyte esterase urine dipsticks among asymptomatic women attending a family planning clinic in Kenya.**

M. Bi JYNDALL, N. AEBULA, J. JANDA et al. Sex Transm Dis 1999;26:376–82

**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 gonococcal- 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.**


**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.**


**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.**

L. BACHMANN, C. RICHEY, K. WITNES et al. Sex Transm Dis 1999;26:496–9

**Complementation of and duration of time before treatment after screening women for Chlamydia trachomatis infections.**


**Control of Chlamydia trachomatis infections in female army recruits: cost-effectiveness screening and treatment in training cohorts to prevent pelvic inflammatory disease.**


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?


The impact on accuracy and cost of ligase chain reaction testing by pooling urine specimens for the diagnosis of Chlamydia trachomatis infections.


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Pelvic inflammatory disease

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