Successful treatment of recalcitrant condyloma with topical cidofovir

EDITOR,—Despite the high prevalence of condylomata acuminata, their treatment remains unsatisfactory for both patients and physicians. Epidemiological studies estimated the prevalence of genital warts between 1–3% with a peak occurring in young adults. As a consequence, the economic burden of human papillomavirus (HPV) infection in the United States is estimated to exceed $8.5 billion per year. Current treatments rely on the ablation of warts (cryotherapy, laser vaporisation, electrodissection, or trichloroacetic acid) or the interruption of cell division (podophylox, intralesional or systemic interferon, and 5-fluorouracil). Recently, imiquimod has been successfully used as a topical immune response modifier for the treatment of external anogenital warts. However, there remains a substantial number of patients who fail to respond to traditional and newer drugs. We report on such a patient with recalcitrant condylomata acuminata on the glans and shaft of the penis who was successfully treated using the novel virustatic cidofovir as a 1.5% gel.

A 48 year old man with a 2½ year history of condylomata acuminata had received laser treatment, podophylox, and imiquimod. The patient’s history was remarkable for diabetes mellitus. He presented with numerous, flesh coloured, flat topped papules in a circular manner on the outer preputium and the glans. On the coronary sulcus had a more verruciform appearance (fig 1). On histological analysis, the typical picture of acanthosis, papillomatosis, and numerous koilocytes was seen. Papillomavirus typing revealed HPV-43 by nested PCR using consensus primers.

Cidofovir was evaluated in the indicator patient at 1.5% cidofovir in a viscous gel (propylene glycol, parabene). Initially, the patient was treated on an outpatient basis with two applications of cidofovir gel per week to the respective lesions without any side effects. Thereafter, the patient was instructed to apply the gel three times a week by self application. At week 6 the patient presented with small erosions surrounded by a marked erythema on all treated sites (fig 1). The lesions were painful. Condylomata were still present in the corona sulcus. At this point treatment was stopped and antiseptic treatment was given with betadine solution once a day. Seven weeks later (week 13) all lesions had completely healed (fig 1). Neither scarring nor dysaesthesia were noted. No recurrence has occurred since. Cidofovir, 1-(S)-3-hydroxy-2-(phosphono-methoxy)-propylcytosine, is a member of a new class of antiviral agents (phosphonylethylcytosine analogues). It shows potent in vitro activity against a broad spectrum of herpesviruses, including human cytomegalovirus (CMV), HSV-1 and HSV-2, and adenoviruses. Recent in vitro and in vivo studies have demonstrated activity against papillomavirus and poxvirus. Cidofovir is a nucleotide analogue of deoxyctydine monophosphate (dCMP). Analogous to the metabolism of dCMP to dCTP, cidofovir is converted to the active cidofovir diphosphate that inhibits viral DNA polymerase. Cidofovir into cells is slow, but the intracellular half life of the various metabolites is between 6 and 87 hours, thus allowing infrequent dosing. Compared with the general mechanism of activation of ganciclovir, which requires phosphorylation by the virus encoded UL97 gene, cidofovir does not depend on viral infection for its phosphorylation and can therefore prime cells to an antiviral state (prophylaxis).

The metabolism of cidofovir is negligible, since the majority (>80%) is recovered unchanged in the urine. The principal systemic toxicity (nephrotoxicity) can be avoided by topical application. This initial case report suggests that topical cidofovir may represent a valuable addition to the armamentarium of hard to treat condyloma. However, a careful evaluation of the dose and frequency of cidofovir application is warranted.

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Bladder carcinoma presenting to genitourinary medicine departments

EDITOR,—Large numbers of patients are seen in departments of genitourinary medicine with symptoms suggestive of an inflammation of the genitourinary tract. Although bladder neoplasms typically cause painless haematuria, in a subgroup of patients they cause other urinary symptoms that may produce diagnostic confusion. We identified five patients who were referred to the genitourinary medicine service, and who were found to have bladder carcinoma (see table 1). Four of the patients presented to the genitourinary medicine department at High Wycombe (5500 new attendances per annum) between 1991 and 1998; the fifth patient presented to the Oxford genitourinary medicine department (9000 new attendances per annum) in 1997. None of the patients had an occupational history that placed them at higher risk for bladder cancer.

Men with bladder carcinoma typically present in later life (median age 70 years), but the condition may occur at younger ages. A subgroup of patients develop frequency, urgency, and dysuria—symptoms usually associated with bladder infection. Rarely, penile and perineal pain mimicking prostatitis may be a presenting feature, as in patients 3 and 4, who have been described in more detail elsewhere.

Non-specific urethritis (NSU) is diagnosed commonly in genitourinary medicine clinics in men of all ages. In this series, patient 2 was referred with presumed NSU, and patient 4 had attended previously with a diagnosis of NSU. 2 years before the bladder cancer was diagnosed (at that time there were 5–10 white cells/high power field (>1000) on a urethral smear, and a chlamydia ELISA test and cultures for Neisseria gonorrhoeae were negative; no haematuria was detected). Both patients were subsequently noted to have neoplastic infiltration in the bladder neck area and prostatic urethra.

In all five cases a detailed process of microscopic haematuria was noted at presentation; in patient 4 this was never greater than a trace on dipstick testing. Patient 1 reported intermittent painless macroscopic haematuria at presentation; he was referred by his general practitioner with suspected

Figure 1 Condylomata acuminata with some lesions in the coronary sulcus having a more verruciform appearance.
genitourinary infection, rather than suspected neoplasia, because of his young age (26 years).

Bladder neoplasia is especially liable to cause irritative symptoms when represented by, or associated with, carcinoma in situ of the bladder urothelium. \(^1\) Urine cytology may be useful in this subgroup, and was abnormal in all three of the five patients in whom it was requested. When this process involves the prostatic urethra, symptoms mimicking prostatis may arise. Early diagnosis of bladder neoplasia is of prognostic importance, and the presence of carcinoma in situ or prostatic involvement by bladder carcinoma are poor prognostic features for which radical surgery may be required. \(^1,\)\(^4\)

These cases highlight the importance of careful follow up of patients presenting with persistent irritative-type symptoms, especially in an older age group, when specific tests for genitourinary infection are negative, and where microscopic haematuria is a feature. Bladder carcinoma should be considered in this subgroup; urine cytology and referral for cystourethroscopy may be indicated. Although rare in younger adult males, bladder cancer should not be ruled out in men under the age of 45 years, and our experience strengthens the case for continuing with routine urine testing in genitourinary medicine clinics.

The patient was diagnosed with asymptomatic HIV infection in February 1987 when she was aged 50 years. Her CD4 count was 690 \(\times 10^3\)/l at this time. HIV infection was acquired in a sexual encounter with a bisexual male partner. In December 1990 the CD4 lymphocyte count had fallen to 190 \(\times 10^3\)/l and zidovudine monotherapy was started. This was continued until 1996 when she was prescribed a combination regimen. Co-trimoxazole was given for Pneumocystis carinii prophylaxis, but the patient deferred starting this until December 1992.

In February 1990 the patient was admitted to another hospital with an acute myocardial infarction which was successfully thrombolysed. Fasting lipids were within the normal range. There were no cardiac risk factors apart from smoking.

In September 1995 the patient experienced a syncopal episode. An echocardiogram revealed a mass in the left atrium consistent with a left atrial myxoma. A coronary angiogram showed normal coronary arteries. Surgical resection of the myxoma was recommended.

In December 1995 the patient’s CD4 count was 64 \(\times 10^3\)/l, but apart from oral candidiasis there had been no HIV related problems since diagnosis. Two leading UK HIV physicians were asked if they considered surgery to be advisable. They estimated the patient’s likely survival from HIV disease to be 1–4 years. The risks of major heart surgery had to be balanced against the likelihood of recurrent symptoms from the myxoma in the next 1–4 years. The patient and her physician agreed to proceed with surgery.

On 4 December 1995 the patient underwent surgical resection of a pedunculated left atrial myxoma. Histological examination confirmed a benign atrial myxoma. The procedure was uncomplicated and she was discharged from hospital 4 days later. Annual cardiac review including an echocardiogram has shown no evidence of recurrence up to the present time. She remains free from cardiovascular symptoms. Her HIV disease is managed with combination therapy that consists of stavudine, lamivudine, and efavirenz. Current CD4 count is 564 \(\times 10^3\)/l and viral load less than 50 copies/ml (Chiron bDNA v3.0).

Atrial myxoma is a rare tumour that is considered to be best treated with surgical resection. Recurrence and metastases have been described. \(^1\) The myocardial infarction suffered by the patient may have been an embolic manifestation of the myxoma, and the normal serum lipids and normal coronary angiogram almost 4 years later would support this hypothesis.

In 1995 expert opinion provided a very guarded prognosis for someone with a CD4 count of 60 \(\times 10^3\)/l who had been exposed to a single antiretroviral agent, zidovudine. Today there would be less debate over the merits of such a surgical procedure in this scenario, and this case demonstrates the excellent outcome that can be achieved with major surgery despite profound immunosuppression. The proved benefits of HAART (highly active antiretroviral therapy) have made it unacceptable to deny major surgical interventions to individuals with HIV.

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The association between receptive cunnilingus and bacterial vaginosis

EDITOR,—We are puzzled by the surprisingly little, if any, serious work done to explain the epidemiological enigma of high prevalence of bacterial vaginosis (BV) in lesbians, \(^1\) and the oft observed, but as yet unconfirmed association between BV and receptive cunnilingus in women in general.

In a detailed study of 17 consecutive lesbians attending the department of genitourinary medicine at the Royal Sussex County Hospital in Brighton, bacterial vaginosis was found in six women (35%). Of nine lesbians who practised receptive cunnilingus in the previous 4 weeks, six (67%) had BV. By contrast, no BV was present in all eight women who did not practise oral sex (table 1).

In a parallel prospective study of 256 consecutive heterosexual female patients attending the same department, 55 (21%) were diagnosed as having BV. Of 111 women who practised receptive cunnilingus in the previous 4 weeks, 41 (37%) had BV. Of 145 women who did not have oral sex, only 14 (10%) had BV (table 1). In both groups there was strong association between BV and also receptive cunnilingus.

The evidence associating bacterial vaginosis with oral sex is too strong to be ignored and repeatedly dismissed. The mouth is full of much smaller quantities, lactobacilli. These organisms are part of normal flora in the mouth, but are they normal to the vagina? Might the tiny amount of lactobacilli be enough to act as a phage which destroys the
endogenous healthy vaginal lactobacilli? In an interesting hypothesis, Blackwell described the possible effect of biochemical and microbial abnormalities in the vagina on BV recurrence. She also quoted Berger’s description of concordant vaginal flora in lesbian couples, suggestive of a mechanical transfer of an infectious agent. Is it not possible for mouth organisms or hostile salivary enzymes to induce biological and microbial abnormalities in the vagina? Furthermore, mechanical transfer of infectious agents in lesbian couples is most likely to occur via cunnilingus, a not uncommon practice among lesbians.

Cunnilingus is a common fact of sexual life. The dynamics of this practice vary considerably. If association between BV and oral sex is ever confirmed, would the degree of tongue penetration be a factor and should it be incorporated in the aetiology equation? Further and more extensive studies are certainly indicated.

Table 1 BV prevalence results

<table>
<thead>
<tr>
<th>Category</th>
<th>No of women</th>
<th>BV diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesbians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practised receptive</td>
<td>17</td>
<td>6 (35%)</td>
</tr>
<tr>
<td>cunnings in previous</td>
<td>9</td>
<td>6 (67%)</td>
</tr>
<tr>
<td>4 weeks</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Heterosexual women</td>
<td>256</td>
<td>55 (21%)</td>
</tr>
<tr>
<td>Practised receptive</td>
<td>111</td>
<td>41 (37%)</td>
</tr>
<tr>
<td>cunnings in previous</td>
<td>145</td>
<td>14 (10%)</td>
</tr>
</tbody>
</table>

Only when it becomes widely known in a clinic that such confidentiality is thoroughly pursued will counterproductive fears be eliminated. With understanding and cooperation it can be done.

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Sexual partner reduction and HIV infection

Editor,—We recently conducted a national urban random sample survey of 1400 men of sexually active age in the Dominican Republic to measure possible change in sexual behaviour. This sexual behaviour change (SBC) survey was prompted by results from the 1996 demographic and health survey, which found that 84.8% of a national random sample of Dominican men claimed that they had changed their behaviour in some way because of their fear of, or concern about, AIDS. The proportion of respondents reporting behaviour change such as becoming monogamous or reducing their number of sexual partners was about triple the proportion reporting condom adoption. In our SBC survey, 79% of respondents claimed to have changed behaviour because of concern about AIDS. A majority (52.2%) said they had become monogamous or reduced their number of sexual partners. This was followed by condom adoption (14.6%), only having sexual relations with a person they know (13.9%), avoiding relations with “prostitutes” (9.0%), or becoming abstinent (1.6%). A small proportion (2.8%) had not yet begun to have sexual relations. In the Dominican DHS findings, we see that most answers are classifiable as behaviour change, as distinct from condom adoption. This follows a pattern found in recent studies in countries such as Uganda and Zambia. A recent review of findings from behavioural change surveys in 16 countries in Africa, Latin America, and the Caribbean shows that partner reduction is more often reported than condom adoption. If sizeable numbers of men reduce their number of sexual partners, can this have significant impact on HIV infection rates? Urban HIV seroprevalence among the general or low risk Dominican population seems to have stabilised at the 1.0–2.0% level since 1995, according to the US Census Bureau. Recent studies that have modelled the impact of different interventions on HIV infection rates in east Africa suggest that reduction in number of partners can have a great impact on averting HIV infections, in fact greater than either condom use or treatment of STDs. Of course, impact of partner reduction on HIV infection rates would be especially strong where there is relatively high HIV seroprevalence among potential partners. In view of these modelling studies as well as population based surveys such as the two cited from the Dominican Republic, perhaps there ought to be greater equity in resource allocation between HIV/AIDS prevention programmes promoting behaviour change—such as monogamy/ fidelity or at least reduction of number and frequency of change of sex partners—and far more familiar programmes that promote and provide condoms.

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Features of AIDS and AIDS defining diseases during the highly active antiretroviral therapy (HAART) era, compared with the pre-HAART period: a case-control study

Editor,—To assess the features of AIDS defining illnesses during the HAART era versus those observed before the introduction of HAART, the characteristics of 72 consecutive patients diagnosed in 1997–9 compared with those of 144 subjects randomly selected from the 436 patients diagnosed from 1985 to 1995, in a case-control study.

An impressive drop in AIDS diagnosis was seen shortly after the introduction of HAART, with only 38, 21, and 13 cases per 100000 patient years observed in 1997, 1998, and 1999 respectively, versus a mean frequency >60 cases per 100000 patient years, demonstrated during the pre-HAART era. The tendency towards an increased incidence of female sex was shown in 1997–9 compared with 1985–95 (33.3% versus 27.1%), together with a rise of mean CD4 lymphocyte count (860 (SD 194) versus 72.1 (93.7) cells x100/ul), while an increase in the mean patient age was highly significant (39.8 (8.3) versus 34.6 (7.7) years; p<0.001). When considering the exposure to HIV infection, drug abuse became significantly less important in the HAART era (p<0.05), while heterosexual transmission was notably increased (34.7% versus 13.2% of cases; p<0.0003). The distribution of AIDS defining disorders during the HAART era showed an tendency to a reduction in cytomegalovirus, cryptococcosis, mycobacteriosis, cryptosporidiosis, and HIV encephalopathy, while a relative increase in pneumocystosis, toxoplasmosis, and Kaposi’s sarcoma was observed (table 1). However, while pneumocystosis, Candida esophagitis, neurotoxoplasmosis, and Kaposi’s sarcoma were stable (table 1). However, while pneumocystosis, Candida esophagitis, neurotoxoplasmosis, and Kaposi’s sarcoma were stable (table 1). However, while pneumocystosis, Candida esophagitis, neurotoxoplasmosis, and Kaposi’s sarcoma were stable (table 1). However, while pneumocystosis, Candida esophagitis, neurotoxoplasmosis, and Kaposi’s sarcoma were stable (table 1). However, while pneumocystosis, Candida esophagitis, neurotoxoplasmosis, and Kaposi’s sarcoma were stable (table 1). However, while pneumocystosis, Candida esophagitis, neurotoxoplasmosis, and Kaposi’s sarcoma were stable (table 1). However, while pneumocystosis, Candida esophagitis, neurotoxoplasmosis, and Kaposi’s sarcoma were stable (table 1). However, while pneumocystosis, Candida esophagitis, neurotoxoplasmosis, and Kaposi’s sarcoma were stable (table 1).
majority of cases identified during the severe immunodeficiency are still frequent. However, opportunistic diseases related to a neurotoxoplasmosis. However, this increase was found during the HAART era for all able trend to increased mean CD4+ count 1997–9, versus 13.2% and 7.9% respectively, cephalopathy and wasting syndrome), Neoplasms and HIV related disorders (en-p<0.007), together with cryptosporidiosis. frequency during the pre-HAART era), Only seven of the 72 patients who developed an AIDS defining event in subjects who were treated with HAART for more than 3 months probably because of small patient samples. of multiple AIDS defining events was demon-adherence (25 patients). Refused HAART or carried out it with poor transmission compared with injecting drug patient age, a greater role for heterosexual increased incidence of women, a higher infection may definitively improve the epidemiology of AIDS; a continued surveil-ance of AIDS related disorders remains critical for the implementation of therapeutic and prophylactic strategies.

<table>
<thead>
<tr>
<th>AIDS defining diseases</th>
<th>No of diseases (%)</th>
<th>Mean CD4+ count (cells/µl)</th>
<th>No of diseases (%)</th>
<th>Mean CD4+ count (cells/µl)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Pneumocystis carinii pneumonia</em></td>
<td>40 (26.5)</td>
<td>58.6 (49.0)</td>
<td>22 (28.9)</td>
<td>62.4 (72.1)</td>
</tr>
<tr>
<td><em>Oesophageal candidiasis</em></td>
<td>21 (13.3)</td>
<td>71.3 (62.6)</td>
<td>16 (20.1)</td>
<td>129.9 (98.1)</td>
</tr>
<tr>
<td><em>Neurotoxoplasmosis</em></td>
<td>17 (11.3)</td>
<td>79.9 (62.1)</td>
<td>9 (11.8)</td>
<td>75.6 (39.2)</td>
</tr>
<tr>
<td><em>Kaposi’s sarcoma</em></td>
<td>15 (9.9)</td>
<td>98.1 (101.3)</td>
<td>7 (9.2)</td>
<td>133.3 (68.3)</td>
</tr>
<tr>
<td><em>Cryptococcosis (meningitis or disseminated disease)</em></td>
<td>7 (4.6)</td>
<td>81.1 (54.9)</td>
<td>2 (2.6)</td>
<td>102.0 (29.7)</td>
</tr>
<tr>
<td><em>HIV encephalopathy (AIDS-dementia complex)</em></td>
<td>4 (2.6)</td>
<td>25.2 (19.4)</td>
<td>0 (--)</td>
<td>--</td>
</tr>
<tr>
<td><em>Estrapulmonary cryptococcosis</em></td>
<td>6 (4.0)</td>
<td>62.4 (51.0)</td>
<td>1 (1.3)</td>
<td>78</td>
</tr>
<tr>
<td><em>Disseminated mycobacteriosis</em></td>
<td>5 (3.3)</td>
<td>38.4 (41.1)</td>
<td>5 (6.6)</td>
<td>121.2 (54.0)</td>
</tr>
<tr>
<td><em>Wasting syndrome</em></td>
<td>5 (3.3)</td>
<td>116.3 (41.1)</td>
<td>4 (5.3)</td>
<td>125.9 (71.2)</td>
</tr>
<tr>
<td><em>Non-Hodgkin’s lymphoma or primary CNS lymphoma</em></td>
<td>4 (2.7)</td>
<td>38.3 (10.2)</td>
<td>0 (--)</td>
<td>--</td>
</tr>
<tr>
<td><em>Cryptosporidiosis</em></td>
<td>3 (2.0)</td>
<td>148.2 (51.4)</td>
<td>5 (6.6)</td>
<td>289.3 (71.2)</td>
</tr>
<tr>
<td><em>Tuberculosis (pulmonary or disseminated disease)</em></td>
<td>3 (1.6)</td>
<td>55.3 (48.9)</td>
<td>4 (5.3)</td>
<td>73.3 (101.1)</td>
</tr>
</tbody>
</table>

| Table 1 AIDS defining events and mean CD4+ lymphocyte count at disease occurrence, in the two considered time periods |

<table>
<thead>
<tr>
<th>Years 1985–95</th>
<th>Years 1997–9</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(144 patients, 151 diseases)</em></td>
<td><em>(72 patients, 76 diseases)</em></td>
</tr>
</tbody>
</table>

frequency disappeared after the introduction of HAART (28 versus four overall cases; p=0.007), together with cryptosporidiosis. Neoplasms and HIV related disorders (en-cerebrospinal fluid, and wasting syndrome) showed a slightly increased frequency during the HAART era (16.8% and 9.2% during 1997–9, versus 13.2% and 7.9% respectively, during the pre-HAART period). A consider-ably larger rise in mean CD4+ count was found during the HAART era for all AIDS related illnesses considered, except neurotoxoplasmosis. However, this increase in CD4+ count was significant only for Can-dida (p<0.001), wasting syn-drome (p<0.03), and tuberculosis (p<0.03), probably because of small patient samples. Only seven of the 72 patients who developed AIDS since 1997 (9.7%) were effectively treated with HAART for more than 3 months before diagnosis; in the remaining 65 cases HIV infection was detected concurrently with an AIDS defining event in subjects who were unaware of their condition (40 cases), or refused HAART or carried out it with poor adherence (25 patients).

Although a sharp decline in the incidence of multiple AIDS defining events was demon-strated by the introduction of HAART, the distribution of primary AIDS associated dis-eases showed limited modifications.14 An increased incidence of women, a higher patient age, a greater role for heterosexual transmission compared with injecting drug addiction, and a rise in CD4+ count were disclosed by us in the HAART era compared with the pre-HAART period. Appreciable modifications of the spectrum of AIDS associ-ated illnesses were also observed during the HAART era (a drop of cytomegalovirusis, cryptocoecosis, mycobacteriosis, cryptosporidiosis, and HIV encephalopathy, with a parallel increase in pneumococcosis, oesopha-gal candidiasis, wasting syndrome, tuberculosis, and non-Hodgkin’s lymphoma), to-gether with a considerable trend towards an increased mean CD4+ count at diagnosis, as previously noted.15 Disorders which are directly or indirectly associated with HIV damage itself, AIDS related neoplasms, and opportunistic diseases occurring with a less profound immunodeficiency, show a substan-tially stable or even increasing incidence among newly diagnosed cases of AIDS. However, opportunistic diseases related to a severe immunodeficiency are still frequent among AIDS defining events, since the majority of cases identified during the HAART era occur in patients who are not aware of their disease, or fail HAART. Only early detection and aggressive treatment of HIV infection may definitively improve the epidemiology of AIDS; a continued surveil-lance of AIDS related disorders remains critical for the implementation of therapeutic and prophylactic strategies.

How do you begin to address the sexual health needs of commercial sex workers (CSWs)? Here you will find (most of) the answers. This immensely practical book is essential for those setting up an outreach service, or simply wishing to know more about commercial sex work. It is the outcome of a series of projects and work-shops, written by workers providing services to CSWs throughout Europe, and draws from the lessons learnt by these pioneering workers and clients. It is written with great clarity and frankness. The A4 layout is bold, imaginative, and attractive, with illustrations of promotional literature. Its European inclusiveness means that sadly it cannot be specific regarding, for example, the law as it applies to commercial sex. It does, however, give the broad framework within which providers must acquaint themselves wher-ever they work. It takes us through the steps; sources of funding, the scope of the service, useful contacts, where to make contact with CSWs, and so on. Importantly, in the current climate there are sections on evaluation and monitoring of the service, the legal and political context of the work, and dealing with the media. It stresses the heterogeneous nature of commercial sex workers whether male, female, or transsex, and the spectrum of commercial sex venues. Peer educator programmes are covered in some detail. There are fascinating pieces of practical advice—for example, cooperate with police, but don’t be identified too closely with law enforcement. Advising police of your outreach vehicle’s registration number may pre-vent you being stopped for kerb crawling! You can set up a flawless screening service and find only a few CSWs attend. The book reminds us middle class, health aware profes-sionals that, for many, sexual health is not a priority. We are perplexed when faced with the "indifference, hostility and self destructive behaviour"; that her next fix, a roof over her head, or the desire to have a baby might be more important to the CSW than the nefarious risk of HIV. Address some of these needs and you have the carrot to attract attention to and confidence in your service. The spin off is that clients can then benefit from STD screening and safer sex advice. Simply providing toilets and somewhere safe to have a cup of tea may be enough for some.

I would have liked to see a further reading list, but this book fulfils its remit excellently.

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2150; email: europap[ci.ac.uk]. (Also available in nine other European languages (Danish, Finnish, Flemish, French, German, Greek, Italian, Portuguese, Spanish), and the full text (without illustrations) can be found online on the website (http://www.med. ic.ac.uk/df/dftm/euprope/hustling/press.htm).
The 13,000 bodies providing CAMHS service (sic) of public
money annually in England and Wales. The Commission’s team of seven have met with
external advisers with a view to shaping of the audit, its comments, and guidance.
The aim is to achieve economy with
efficiency and e-

Laboratory Diagnosis of Sexually
Transmitted Diseases. Pp 135 (available in
English, French, and Spanish); Sw fr 35/
$31.50, in developing countries Sw fr 24.50.

"Venerable diseases are like the fine arts—it is pointless to ask who invented them." (Vol-
taire, *Dictionnaire philosophique*).

Sexually transmitted diseases (STDs) now
rank among the top ten diseases for which
adults in developing countries seek health
care. The economic burden of STDs on both
developed and developing countries is enor-
mos. Infection with conventional STDs is a
risk factor for transmission of infection
with HIV, and therefore for the development
and spread of the AIDS.

It is important that laboratory services are
available to guide the clinician to the correct
diagnosis and treatment of these conditions,
and to give an accurate epidemiological
picture of their prevalence in a particular
community in terms of the passing of relevant
populations and ensure optimal and economic
use of available resources. Yet, the availability
of both funds and technology varies widely
between different settings.

This manual sets out to give comprehen-
sive guidance on tests available and applica-
table to the level of expertise and funding avail-
able.

Nine chapters cover the major STDs,
compassing bacterial and viral infections,
and under the umbrella of vaginitis in adults;
trichomoniasis, candidiasis, and bacterial
vaginosis. Each chapter begins with a brief
description of the microbiology of the infect-
tive agent and the clinical spectrum of
disease. The detail given is not consistent,
being comprehensive for chancroid and
granuloma inguinale, and surprisingly brief
for HIV and chlamydia by way of contrast.
Then follows a description of collection and
transport requirements, and of techniques for
diagnosis. The emphasis is on tests that are
possible in a reasonably well equipped
laboratory, with a list of reference facilities.
Tests that are suitable for use in the field are
highlighted. An evaluation of sensi-
tivity and specificity is also given. Other tests
available in central or reference laboratories
are mentioned in brief, usually with support-
ing references.

Two annexes cover media, reagents and
stains, and details of equipment required to
diagnose each condition. A third annex is an
interesting table of which tests should be
available at "peripheral," "intermediate," and
"central" laboratories.

Overall, this manual is to be welcomed as
an educational and reference source for
medical microbiologists, technologists,
and clinicians. However, I would recommend
that the authors “road test” the manual to
discover omissions in technical detail that
would prevent the sole use of the manual in
the field.

Indifferent colour reproduction detracts
from the quality of the text—for example,
blue reactions appearing as red in the figure.
For the next edition, a chapter on basic
microscopical techniques and another on the
general principles and interpretation of labo-
atory tests would provide useful introduc-
tions to an otherwise excellent publication.

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Department of Clinical Microbiology, UCH Accident
and Emergency Building, London WC1E 6DB

Facing HIV: A Resource for Primary
Healthcare. Contributors: Annalisa Rossi,
Margaret Allen, Sirrka-Lisa Nuttkala,
Begona Gros, Cristina Martinez-Bueno.
£29.38. East Lancashire Health Authority,
South Lancashire Health Authority,
University of Central Lancashire, The
Faculty of Health, and The Centre for
Learning Technologies at the University of
Central Lancashire

This is an interesting CD Rom which gives a
very personal guide to issues surrounding
HIV—covering the experience of the patient,
carer and healthcare professional.

Four main sections cover the following
areas: Living with HIV, Is HIV different?
Loss, grieving and bereavement, Supporting
people affected by HIV.

These areas are illustrated by short video clips
and backed up by further information.
Basic information is given about HIV treat-
ment, the impact of diagnosis and of ill
health, and other related topics. Unfortu-
nately the information about drug treatment
is already outdated and there is no search
facility.

The strength of this CD Rom is the view it
gives of the emotional responses to HIV and
the strategies for coping with the infection
from the viewpoint of those involved. The
academic content is limited but it is worth a
look for the patient perspectives.

SARAH EDWARDS
Department of GU Medicine, West Suffolk Hospital,
Bury St Edmunds, Suffolk, IP32 9QZ

This is a superb CD Rom covering various
aspects of HIV and AIDS by means of inter-
active tutorials. It is clear, concise, and up to
date and has tutorials under the following
headings: Overview, Biology of HIV, Natural
history, Infections and malignancies, Epide-
miology, Transmission and risk factors,
Prevention, Diagnosis and monitoring,
Women and children, Management, Social
and psychological issues.

Each tutorial is self contained (which does
lead to some duplication) and has self assess-
ment questions—usually with click and drag
matching of statements or true/false boxes.
The information itself is well illustrated and
contains animations and a video clip together
with further information/annotations in pop
up boxes. At the end of each section there is a
set of summary points, a reading list, and fur-
ther activities such as internet sites.

There is a searchable picture index which
allows you to search, view, and save sets of
images for reference and lectures (although
copyright does apply), and a glossary of terms.
Overall this is an excellent CD Rom
providing good information, presented in an
attractive and usable way, with a wealth of
illustrations. I would strongly recommend it.

SARAH EDWARDS
Department of GU Medicine, West Suffolk Hospital,
Bury St Edmunds, Suffolk, IP32 9QZ

CD-ROM REVIEWS

Topics in International Health. HIV/
AIDS. London: The Wellcome Trust, CAB
£120; individual licence £30

This is a valuable and stimulating CD Rom
covering all aspects of HIV, AIDS, and the
world of sexual health. It is a useful resource
for medical students or trainees, for
healthcare professionals, and for
universities. Whatever the need for the
CD—training, undergraduate teaching,
clinicians, planners, or others—it
provides excellent information.

The CD is easy to use and has several
sections: An introduction, World and
country data, a comprehensive guide to
the causes and extent of HIV and AIDS,
the impact of diagnosis and of ill
health, and other related topics.

There is a searchable picture index which
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Overall this is an excellent CD Rom
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SARAH EDWARDS
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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: isidbox@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: (086) 7422778; email: bozchod@amb.ac.bialystok.pl).

Joint meeting of the MSSVD and the ASTDV, 3–7 May 2000, Baltimore Marriot 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@bbam.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Advanced Course in Fetal Medicine, 22–24 May 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte's and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Advanced Course for Obstetricians and Gynaecologists, 19–23 June 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte's and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

Australasian Sexual Health Conference, Van 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).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Caring for Sexuality in Health and Illness (for healthcare professionals and nurses), jointly with Association of Psychosexual Nursing 27 June 2000
Further details: Kathy Taylor (tel: 01384 235207; email: palmtraining@tesco.net).

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte's and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

Sexual Health and HIV Conference: Facing the Millennium, Portsmouth Marriott Hotel, Portsmouth, 28 June 2000
Further details: Rebecca Mitchell (tel: 023 9286 6796; fax: 023 9286 6769).

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, Essenerstraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 19; email: orgamed@village.uunet.be).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, New Horizons in Recurrent Pregnancy Loss, 29 June–1 July 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte's and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Bereavement, 5 July 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte's and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Advances in Obstetric Medicine: International Meeting of Obstetric Medicine Societies (satellite to ISSHP, Paris, 6–7 July 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte's and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

XIII International AIDS Conference, 9–14 July 2000, Durban, South Africa
Further details: Congrex Sweden AB, PO Box 5619, Linnegetan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 661 91 25; email: aids2000@congresx.se).

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

Corrections
An error occurred in an original article by Hughes et al that appeared in the February issue of the journal (2000;76:18–24). In the participants section under West Midlands, “Dr Wade, Coventry and Warwickshire Hospital” should read “Dr Wade and Dr Allan, Coventry and Warwickshire Hospital.”

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

- Gonorrhoea
- Chlamydia
- Candidiasis
- Bacterial vaginosis
- Trichomoniasis
- Pelvic inflammatory disease
- Syphilis and other treponematoses
- Hepatitis
- Herpes
- Human papillomavirus infection
- Cervical cytology and colposcopy
- Other sexually transmitted infections
- Public health and social aspects
- Microbiology and immunology
- Dermatology
- Miscellaneous
**Neisseria gonorrhoeae** infections in girls younger than 12 years of age evaluated for genital Chlamydia trachomatis in subfertile women. P Koskela, T Anttila, T Bjork et al. Int J Cancer 2000;85:35–9


**Immunogenic and protective ability of the two developmental forms of Chlamydia in a mouse model of infertility.** S Pale, J Rangel, EM Peterson, LM Delamaza. Vaccine 1999;18:752–63


**Screening for Chlamydia trachomatis** in subfertile women. S Macmellan, A Templeton. Hum Reprod 1999;14:3009–12


**Bacterial vaginosis**

**Direct or referral microscopy of vaginal wet smear for bacterial vaginosis: experience from an STD clinic.** CS Petersen, AG Danielsen, J Renneberg. Acta Dermato-Venereol 1999;79:473–4

**Trichomoniasis**

**Improved diagnosis of Trichomonas vaginalis** infection by PCR using vaginal swabs and urine specimens compared to diagnosis by wet mount microscopy, culture and fluorescent staining. C Vanderschae, A Vanbelkum, L Zwijsers et al. J Clin Microbiol 1999;37:4127–34


**Identification of Trichomonas vaginalis** α-actinin as the most common immunogen recognized by sera of women exposed to the parasite. MF Addos, P Rappelli, AMP Deandrade et al. Infect Dis 1999;180:1727–30

**Pelvic inflammatory disease**


**Syphilis and other treponematoses**


**Hepatitis**


**Herpes**


Persistent stress as a predictor of genital herpes recurrence.  

Rapid detection of HSV from cytologic specimens collected into ThinPrep fixative.  

Treatment of primary herpes simplex virus infection in guinea pigs by imiquimod.  

Protective immune correlates can segregate by vaccine type in a murine herpes model system.  

Cellulose acetate phthalate (CAP): an ‘inactive’ pharmaceutical excipient with antiviral activity in the mouse model of genital herpesvirus infection.  

Co-infection of acyclovir-resistant and acyclovir-sensitive herpes simplex type 2 virus strains in BS-C-1 cells.  
K KEYWAN, E KATZ. Intervirology 1999;42:247–51

Immune responses and protection against vaginal infection after nasal or vaginal immunization with attenuated herpes simplex virus type-2.  
EL PARR, MB PARR. Immunology 1999;98:639–45

Immunity induced by DNA immunization with herpes simplex virus type 2 glycoproteins B and C.  
JC MESTER, TA TOWMEY, ET TEPE, DI BERNSTEIN. Vaccine 1999;18:875–83

Persistence of infectious herpes simplex virus type 2 in the nervous system in mice after antiviral chemotherapy.  

Repression of viral transcription during herpes simplex virus latency.  

The major neutralizing antigenic site on herpes simplex virus glycoprotein D overlaps a receptor-binding domain.  

Herpes simplex virus type 2 glycoprotein G-negative clinical isolates are generated by single frame shift mutations.  

Potential role for human, the cellular homologue of herpes simplex virus VPA16 (a gene trans-inducing factor) in herpesvirus latency.  

Granzyme A, a noncytolytic component of CD8(+) cell granulues, restricts the spread of herpes simplex virus in the peripheral nervous systems of experimentally infected mice.  

Intracellular localization of the UL31 protein of herpes simplex virus type 2.  

Human papillomavirus infection

Pernicious papillomavirus infection.  

Type-specific persistence of human papillomavirus DNA before the development of invasive cervical cancer.  

Epidemiology of acquisition and clearance of human papillomavirus infection in women from a high-risk area for cervical cancer.  

HPV transmission—still feeling the way.  
A MINDEL, R TIDEMAN. Lancet 1999;354:2097

HPV DNA testing of self-collected vaginal samples compared with cytologic screening to detect cervical cancer.  

HPV DNA testing in cervical cancer screening: results from women in a high-risk province of Costa Rica.  
M SCHIFFMAN, R HERRERO, A HILDESHEIM et al. JAMA 2000;283:87–93

Human papillomavirus testing for primary cervical cancer screening.  

HPV-based cervical cancer screening in a population at high risk for HIV infection.  
SD WOERNER, TQ ALESSI et al. Int J Cancer 2000;85:206–10

Screening for cervical neoplasia by self-assessment for human papillomavirus DNA.  

Spontaneous evolution of human papillomavirus infection in the uterine cervix—a prospective observational study.  

Seroactivity to human papillomavirus type 16, 18, 31 and 45 virus-like particles in a case-control study of cervical squamous intraepithelial lesions.  

Anal intraepithelial neoplasia.  

A randomized, controlled, safety study using imiquimod for the topical treatment of anogenital warts in HIV-infected patients.  

Human papillomavirus type 16 E6 variants in cervical carcinoma: relationship to host genetic factors and clinical parameters.  
CS BRADY, MF DUGGANKEEN, JA DAVIDSON et al. J Gen Virol 1999;80:3253–60

Favorable clinical outcome of cervical cancers infected with human papilloma virus type 58 and related types.  
HL LAI, CA SUN, MH YU et al. Int J Cancer 1999;84:553–7


Improved amplification of genital human papillomaviruses.  

Additional human papillomavirus types detected by the hybrid capture tube test among samples from women with cytological and colposcopical atypia.  

PCR-RFLP-detected human papilloma virus infection in a group of Senegalese women attending an STD clinic and identification of a new HPV-68 subtype.  

Detection of human papilloma virus genomes by the primed in situ (PRINS) labelling technique.  

DNA vaccination of mice with plasmid expressing human papillomavirus 6 major capsid protein L1 elicits type-specific antibodies neutralizing pseudovirions constructed in vitro.  

Capture ELISA and in vitro cell binding assay for the detection of antibodies to human papillomavirus type 6b virus-like particles in patients with anogenital warts.  
SW PENG, YM QI, N CHRISTENSEN et al. Pathology 1999;31:418–24

Detection of high-risk cervical intraepithelial neoplasia and cervical cancer by amplification of transcription derived from integrated papillomavirus oncogenes.  
Antibodies against oncoproteins E6 and E7 of human papillomavirus types 16 and 18 in cervical-carcinoma patients from Russia.

HPV 16 E6 blocks TNF‐mediated apoptosis in mouse fibroblasts LM cells.
PJ DUEKSENHUGHES, J YANG, SB SCHWARTZ. Virology 1999;264:55–65

CD4(+) tumor‐infiltrating lymphocytes in cervical cancer recognize HLA‐DR‐restricted peptides provided by human papillomavirus E7.

The E6 protein of human papillomavirus type 16 binds to and inhibits co‐activation by CBP and p300.
D PATEL, SM HUANG, LA BAGLIA, DJ MCCANCE. EMBO J 1999;18:5061–72

The human papillomavirus type 16 E5 protein modulates phospholipase C‐γ1 activity and phospatidylinositol turnover in mouse fibroblasts.
K CRUSSOS, M KASGIN, V KINZEL, A ALONSO. Oncogene 1999;18:6714–8

Interaction between the HPV‐16 E2 transcriptional activator and p53.
P MASSMI, D PIM, C BERTOLI et al. Oncogene 1999;18:7748–54

The E8/E2C protein, a negative regulator of viral transcription and replication, is required for extrachromosomal maintenance of human papillomavirus type 31 in keratinocytes.

The differentiation‐specific factor CDP/Cut represses transcription and replication of human papillomaviruses through a conserved silencing element.

Cervical cytology and colposcopy

Cervical cytology after 2000: where to go?

Comparative evaluation of seven cell collection devices for cervical smears.

Efficacy of cervical smear collection devices: a systemic review and meta‐analysis.
P MARTSINSH, R LIFORD, G JARVIS, HC KITCHENER. Lancet 1999;354:1763–70

Detection of false‐negative Papanicolaou smears by rapid rescreening in a large routine cervical cytology laboratory.
B G WRIGHT, J A HAFORD, DJ DITCHMAN. Pathology 1999;31:379–81

Determining the cost‐effectiveness of mass screening for cervical cancer using common analytic models.

A prototype computer image‐based Papanicolaou smear proficiency test.

The diagnostic value of computer‐assisted primary cervical smear screening: a longitudinal cohort study.
H DOORNFWAARD, YT VANDERSCOHOUW, Y VANDERGRAAF et al. Mod Pathol 1999;12:995–1000

Detection of human herpesvirus 8 in cervical cells of Chinese women with abnormal Papanicolaou smears.

A study of the follow up patterns of women treated for CIN 2 and 3 before and after the introduction of the 1992 guidelines.
CH MAANN, S SEIDOR, A BROWN, CM LUESCH. Br J Obstet Gynaecol 1999;106:1126–9

Cidofovir, a new approach for the treatment of cervix intraepithelial neoplasia grade III (CIN III).

Effects of chemotherapy and tamoxifen on cervical and vaginal smears in bone marrow transplant recipients.

Serum carotenoids and vitamins and risk of cervical dysplasia from a case‐control study in Japan.

Vaginal 5‐fluorouracil for high‐grade cervical dysplasia in human immunodeficiency virus infection: a randomized trial.

Preclinical feasibility study of NMP179, a nuclear matrix protein marker for cervical dysplasia.

Fhit alterations in cancerous and non‐cancerous cervical epithelium.

Cytotoxic distending toxin of Haemophilus ducreyi induces apoptotic death of Jurkat T cells.

Public health and social aspects

Encouraging use of coupons to stimulate condom purchase.

Microbiology and immunology

Human herpesvirus 8 cellular immune responses in homosexual men.

Correlation of behaviours with microbiological changes in vaginal flora.
JR SCHWERSKE, CM RIHEY, HL WEISS. J Infect Dis 1999;180:1632–6

The identification of vaginal Lactobacillus species and the demographic and microbiological characteristics of women colonized by these species.
MAD ANTONIO, SE HARMS, ML HILLIER. J Infect Dis 1999;180:1950–6

Common mucosal immunity: a novel hypothesis.
FA MOORE. Ann Surg 2000;231:9–10

Immunoglobulin concentrations and antigen‐specific antibody levels in cervico‐covaginal lavages of rhesus macaques are influenced by the stage of the menstrual cycle.

Evaluation of the bacterial flora of the prostate using a 16s rRNA gene based polymerase chain reaction.

Dermatology

Incidence of preputial lichen sclerosus in adults: histologic study of circumcision specimens.

Penile cancer among patients with genital lichen sclerosus.
Vulvar lichen sclerosus: an immunologic study.

Guidelines for management of Bowen’s disease.
NH COX, DJ EEDY, CA MORTON. Br J Dermatol 1999;141:633–41

Vulvar melanoma, biologically different from other cutaneous melanomas.
CJ DUNTON, D BERD. Lancet 1999;354:2013

Cytomegalovirus balanitis in a renal transplant recipient.
A RODRIGUEZ, B HILL, R GOPOLAN, GN SKLAR. J Urol 1999;162:2086

The imidazooxinolines, imiquimod and R-485 induce functional but not phenotypic systemic vasculitides.

Miscellaneous

The staying power of sexually transmitted diseases.
W CATES, G DALLABETTA. Lancet 1999;354:62

Breaking the silence surrounding rape.
S RAMSAY. Lancet 1999;354:2018

Seasonal variations in sexual activity and their implications for sexual health promotion.

Future change in sexual behaviour?

Symptoms of reproductive-tract infection—not all that they seem to be.
K TROLLPEKUMAR. Lancet 1999;354:1745

Reproductive-tract infections in women in low-income, low prevalence situations: assessment of syndromic management in Matlab, Bangladesh.

High prevalence and incidence of sexually transmitted diseases in urban adolescent females despite moderate risk behaviors.

Sexual and reproductive health: what about boys and men? Education and service provision are the keys to increasing involvement.
G VAMEY. BMJ 1999;319:1315

Male adolescents and physician sex preference.
CJ VANNES, DA LYNCH. Arch Pediat Adolesc Med 2000;154:49–54

Repeated school-based screening for sexually transmitted diseases: a feasible strategy for reaching adolescents.
DA COHEN, M NSUAMI, DH MARTIN, TA FARLEY. Pediatrics 1999;104:1281–5

Lesbians’ sexual history with men: implications for a sexual history.
AL DIAMANT, MA SCHUSTER, K MCGUFFIN, J LEVER. Arch Intern Med 1999;159:2730–8

Hysterectomy and sexual function.
JC RHODES, KH KJERULFF, WW LANGENBERG, GM GUZINSKI. JAMA 1999;282:1934–41

Perineal anatomy and urine-voiding characteristics of young women with and without recurrent urinary tract infections.

Prophylactic antibiotics for intrauterine device insertion: a metaanalysis of the randomized controlled trials.
DA GRIMES, RF SCHULZ. Contraception 1999;60:57–64

Genital pain without urogenital pathology: the koro-like syndrome.

Neurochemical characterization of the vestibular nerves in women with vulvar vestibulitis syndrome.
N BODSTEBARKE, M HILLEGES, C FALCONE, E RYBLANDER. Gynecol Obstet Invest 1999;48:270–5

Acupuncture for vulvodynia.

Pudendal nerve injury associated with avid bicycling.
VS RICCHIUTI, CA HAAS, AD SEFTEL et al. J Urol 1999;162:2099

Prostate histopathology and the chronic prostatitis/chronic pelvic pain syndrome: a prospective biopsy study.

Asthma and epidydimitis: the calm before the storm.

Male impotence.
A MORGENTALER. Lancet 1999;354:1713–8

Lack of diagnostic tools to prove erectile dysfunction: consequences for reimbursement?
K LEHMANN, B EICHLEISBERGER, TC GASSER. J Urol 2000;163:91–4

Treatment of intracorporeal injection nonresponse with sildenafil alone or in combination with triple agent intracorporeal injection therapy.

Tamoxifen versus placebo in the treatment of Peyronie’s disease.

Iontophoresis for treatment of Peyronie’s disease.

Behçet’s syndrome: a multidisciplinary approach to clinical care.

Is there a place for large vessel disease in the diagnostic criteria of Behçet’s disease?
M SCHIRMER, ET CALAMA, JD ODOFFY. J Rheumatol 1999;26:2511–2

Secondary inflammation of the appendix via the vagina.

Two forms of reactive arthritis?
P TOVANEN, A TOVANEN. Ann Rheum Dis 1999;58:737–41

Reactive or infectious arthritis.
JG KULPERS, L KOHLER, H ZEIDLER. Ann Rheum Dis 1999;58:661–4

Beaver fever—a rare cause of reactive arthritis.
M TUPCHONG, A SIMOR, C DEWAR. J Rheumatol 1999;26:2701–2