Comparing guidelines for the management of anogenital warts

What is the purpose of guidelines for management of clinical conditions? Implicit in the term guidelines is that they should provide a guide to diagnosis, treatment, and related management issues of a specific condition without being unduly prescriptive as that may alienate their use by those who do not always want to follow the "mantra." Successful guidelines based on sound evidence should be seen to improve outcomes for patients and be adapted across the spectrum of services to which the particular condition presents. Two recently published evidence based guidelines—the national guidelines for the management of anogenital warts (AGW) and the European course on the HPV associated pathology guidelines for the diagnosis and management of AGW—are efforts to accomplish these aims. Comparing these two, the most striking differences are ones of style and scope. The national guidelines is the work of a single author written to a brief which imposed a "house" style and concision to conform with the 22 other national guidelines on sexually transmitted infections jointly commissioned by the UK professional bodies, the Medical Society for the Study of Venereal Diseases, and the Association of Genitourinary Medicine. The European guidelines is the product of a multinational group of clinicians, pathologists, and virologists dedicated to teaching important principles for practice and management of HPV disease to physicians, gynaecologists, and other disciplines. As such, the European guidelines adopt a more didactic style with an expanded text which allows, among other things, for direction on how to perform procedures such as meatoscopy, the acetic acid test, differential diagnosis, and details of mechanism of action and outcomes of therapies. Both use the same guidelines to grading of evidence supporting treatment recommendations developed by the agency of Health Care Policy and Research. Of the treatments covered in both texts it is reassuring that identical conclusions as to the level of evidence available was reached. What is, of course, evident is that much yet remains to be done to provide a sound evidence base for all available treatments. The most striking difference on treatment is the exclusion for consideration by the European guidelines of the use of podophyllin and 5-fluorouracil, both being dismissed as no longer recommendable—a view which others would hold. In the United Kingdom podophyllin is still a widely used clinic based treatment and as such it would not have been possible to omit from the national guidelines. Certainly the days of indiscriminate application of podophyllin to all AGW should be over, but judicious use may still have its place for small numbers of soft poorly keratinised warts—for example, subpreputially.

There are still no studies comparing different modalities depending on morphology, although differing responses are much quoted. With the wider use of home based therapies, podophyllin and imiquimod, it may well be time to consign podophyllin and 5-FU to the archives. Neither guideline attempts to tackle the problem of interpreting combination therapies. One omission from the national guidelines is that monopolar electrosurgery should not be used in pregnancy because of the risk of transmission of current to the uterine contents.

Guidance as to the frequency of cervical cytology specimens for women with AGW is not given in the European guidelines, which may be because there are different national guidelines across Europe. Certainly as far as the United Kingdom is concerned, many women have cytology taken at too young an age, and too frequently if they have AGW. This is a hangover from the evolution of our understanding of the natural history of human papillomavirus infection of the cervix which needs correcting.

Included in the national guidelines are reference to the use of the guidelines against which to audit practice. This is of particular importance with respect to clinical governance which is certainly to the forefront in United Kingdom medicine today. Also, treatments are costed in the national guidelines although, with different pricing structures, it would not have been possible to give figures for the European guidelines. Overall, the encouraging feature of these two guidelines is their concordance in almost all aspects of practice, with the greater detail making the European guidelines perhaps more of a teaching aid. Both help to highlight areas of deficiency in our practice and as such should be useful in pointing the way for areas of research.

The greatest challenge as far as these and other guidelines are concerned is how they are going to be disseminated outside a relatively small group of specialists to many other practitioners who encounter these conditions in daily practice.
Comparing guidelines for the management of anogenital warts

Raymond Maw

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/content/76/4/325.full.pdf

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LETTERS TO THE EDITOR

Lymphatic filariasis—lest we forget

EDITOR,—Lymphatic filariasis is characterised by a wide range of clinical manifestations. In a non-endemic area the diagnosis may be missed unless the index of suspicion is high. An 18 year old sexually active male presented with a progressively increasing painless nodular swelling in the right inguinal region of 4 months’ duration. The patient had an unprotected vaginal contact with a commercial sex worker 6 months earlier. There was no history of genital ulcer or urethral discharge. The general health of the patient was preserved. Examination revealed an enlarged right inguinal and external iliac lymph node, 1–3 cm in size, firm, mobile, non-tender, and matted with normal overlying skin. Examination of genital, anal, and buccal mucosa was normal. There was no other lymphadenopathy. A differential diagnosis of lymphogranuloma venereum (LGV) and tuberculous lymphadenitis was considered. Complete blood count revealed mild leucocytosis and eosinophilia. Renal and hepatic functions, urinalysis, and chest x ray were normal. A complement fixation test for chlamydia group specific antibody was negative. Fine needle aspiration cytology from the nodes revealed reactive hyperplasia with occasional giant cells and microfilariae of Wuchereria bancrofti. Nocturnal blood samples for microfilariae were negative.

The patient was given diethylcarbamazine 100 mg thrice daily for 2 weeks. The lymph node regressed and no relapse was observed in 6 months of follow up.

The differential diagnosis of inguinal lymphadenopathy in a sexually active male includes syphilis, genital herpes, chancroid, LGV, pyogenic adenitis, tuberculosis, and lymphoma. In the present case a diagnosis of LGV was considered in view of a history of sexual contact, painless and non-suppurative lymphadenopathy not apparently preceded by a genital ulcer.

Demonstration of microfilariae was decisive in clinching the diagnosis of filariasis which was not considered in the differential diagnosis. Presentation with inguinal lymphadenopathy is a feature common to both LGV and filariasis. The most frequent manifestation of secondary stage of LGV in men is unilateral inguinal lymphadenopathy which does not suppurate in two thirds of cases. Iliac lymphadenopathy often develops in LGV as was observed in our patient. Painful enlargement of inguinal lymph nodes with fever is the usual presentation in lymphatic filariasis. Lymphangitis can accompany recurrent attacks. Other complications include orchitis, funiculitis, and epididymitis. These were, however, absent in our patient. It is suggested that lymphatic filariasis should be considered in differential diagnosis of inguinal lymphadenopathy even in areas which are not known to be endemic for it. It is otherwise likely to be missed.

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Canary to sparrow; what is in a name?

EDITOR,—The Contagious Diseases Act of 1864 allowed for the compulsory arrest, examination, and treatment of women considered (by an all male board) to be of loose morals. Women were detained in the so called “Canary” wards and their identity made clear by the bright yellow garments they were made to wear. In the year 2000, there is still perceived stigma and blame associated with the diagnosis of sexually transmitted infections (STIs) and this must be minimised if a screening programme for chlamydia is to be successful. It will help reduce stigma if people know and accept that it is not a disease of a few readily identifiable people that is common and easy to acquire. It has been estimated that one in 14 young people will acquire it at some time. In the NHS chlamydia pilot screening programme in Wirral and Portsmouth we are confirming that this infection is indeed endemic. Information material for the pilot study clearly states that it is a very common infection. To reduce the element of blame, we have included testing of men in some settings and have introduced instead of sexually transmitted, the term “sexually shared infection.” We hope that by measures such as these, young people will avoid stigmatisation as “canaries.” We do not, however, suggest that you change the name of your journal again!

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Acceptability of home screening for chlamydial infection: some remaining issues

EDITOR,—In the recent article by Stephenson et al1 the authors describe participation rates of 39% for women and 46% for men for home screening and comment that this might form a useful component of a community based chlamydial screening programme in which non-responders could be offered opportunistic screening at the general practice. However, certain crucial issues remain unanswered. This acceptability survey was done among women aged 18–25 years and men 18–30 years. What happens with people below the age of 18? We know that Chlamydia trachomatis prevalence is associated with young age, but can we also send home screening kits to 15 year olds? What about the paradigm of opportunistic screening—will it be likely to be associated with young age but also with ethnicity. Among young Surinam-Antillian women aged <25 years, prevalences ranged from 5% to 15% in the opportunistic survey up to 22.4% in the opportunistic survey.3 In the systematic survey an unexpectedly high Ch. trachomatis prevalence of 10% was found among very young Surinam-Antillian men. Among the 15–19 year olds visiting our health centre in Amsterdam which is located in a multiethnic neighbourhood, half of the population having a Surinam-Antillian background, C. trachomatis prevalence was 25%.4 Thus, the question is not whether a home screening and comment “that this programme is indeed effective. Information material for the pilot study clearly states that it is a very common infection. To reduce the element of blame, we have included testing of men in some settings and have introduced instead of sexually transmitted, the term “sexually shared infection.” We hope that by measures such as these, young people will avoid stigmatisation as “canaries.” We do not, however, suggest that you change the name of your journal again! 1 Stephenson J, Gardner C, Copas A, et al. Home screening for chlamydial infection: is it acceptable to young men and women? Sex Transm Inf 2000;76:25–7.


www.sextransinf.com
Nurse counselling for women with abnormal cervical cytology improves colposcopy and cytology follow up attendance rates

EDITOR,—A well organised cervical screening programme has considerable benefits; however, one negative aspect is anxiety associated with abnormal results. The NHSCSP guidelines state that an explanatory leaflet should be given to women with abnormal cytology and those being referred for colposcopy, with a verbal explanation wherever possible. We assessed if there is any additional benefit from a verbal explanation, following written information, when an abnormal smear result is given, in understanding and future attendance for colposcopy and cytology follow up.

Between April and December 1998 we recruited 89 women with abnormal cytology. All women attending for results are given the NHSCSP leaflet "What your abnormal result means" if their smear shows borderline changes, mild, moderate, or severe dyskaryosis.

The study women completed a questionnaire after reading the leaflet. A nurse (BH) then gave a verbal explanation about the smear result. They then completed the questionnaire again. Attendance for colposcopy and cytology follow up was recorded, default being defined as non-attendance without cancellation. Default rates were compared with those in the control group comprised of 104 women. In the study group 65 required colposcopy; three (4.6%) defaulted, compared with seven of 38 (18.4%) women not receiving a verbal explanation; p=0.03 Fisher’s exact test; OR 0.21 (95% CI 0.03–1.03). Of the study group, 81 had should have attended for follow up colposcopy 6 months after colposcopy or smear showing borderline changes; 12 (15%) defaulted compared with 37 of 95 (38.8%) women not receiving verbal explanation; p=0.001 x2 test; OR 0.18 (95% CI 0.08–0.41). Eventually only one (1.5%) in the study group two (5.3%) of the 17 controls did not attend for colposcopy, and 11 (13.8%) and 24 (25.3%) of the controls defaulted and attended, respectively.

Despite the leaflet the women in our study still had misunderstandings and anxieties. The verbal explanation helped clarify these. Verbal information can be tailored to the individual, some requested detailed descriptions, others preferred a simpler explanation (as reported previously). This is not possible with written information. Marteau et al found that a brief, simple booklet increased knowledge and reduced anxiety whereas a more complex booklet increased knowledge but did not reduce anxiety.

The default rates were lower in those receiving the verbal explanation. Lerman et al found that women with abnormal cervical cytology who defaulted colposcopy appointments were more worried about cancer with impairment of mood and sleeping. Following the explanation our default rate for colposcopy was within the 15% recommended target, and follow up cytology was similar to the rates reported in primary care.

There are deficits in this study. The lack of randomisation means the improvement in default rates could be the result of baseline differences rather than the verbal explanation. However, it has shown benefit to the women by improving understanding. The department has also benefited; although extra nursing time has been required, the lower default rates for colposcopy and cytology has reduced the clerical, medical, and secretarial time normally required recalling non-attenders.

Table 1 The questionnaire results before and after the verbal explanation

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Before</th>
<th>After</th>
<th>χ2 test p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well do you understand the result you were given?</td>
<td>Not at all</td>
<td>26</td>
<td>1</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>29</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A lot</td>
<td>27</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Are you worried about the result of your smear test?</td>
<td>Yes</td>
<td>45</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>42</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
<td>16</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Will it worry you if you need to do further investigations?</td>
<td>Yes</td>
<td>36</td>
<td>23</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>40</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>13</td>
<td>14</td>
<td>0.0002</td>
</tr>
<tr>
<td>Are you worried that further investigations will be painful?</td>
<td>Yes</td>
<td>55</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>11</td>
<td>14</td>
<td>0.0002</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>23</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Do you think that any abnormality found can be treated?</td>
<td>Yes</td>
<td>61</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>25</td>
<td>4</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Do you think you have cancer?</td>
<td>Yes</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>34</td>
<td>9</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>50</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Do you think this smear result will affect your ability to have children?</td>
<td>Yes</td>
<td>15</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>34</td>
<td>10</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>40</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Do you think this result will change your attitude to sex with your partner?</td>
<td>Yes</td>
<td>18</td>
<td>13</td>
<td>0.004</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>30</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>41</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Do you think this result will affect the way your partner thinks of you?</td>
<td>Yes</td>
<td>8</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>13</td>
<td>10</td>
<td>0.36</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>68</td>
<td>75</td>
<td></td>
</tr>
</tbody>
</table>


Accepted for publication 19 June 2000

Phone sex: information technology (IT) and sexually transmitted infection in young people

EDITOR,—The recent article on the acceptability of home testing for chlamydia was noted.1 We would like to offer an alternative approach. Young people could be accessed via an internet clinic. Our experience during the chlamydia pilot study is that this population are more likely to use technology, in particular mobile phones. The presence of sex on the internet has been widely publicised. We propose that testing for sexually transmitted infection (STI) via the internet is the next step.

The chlamydia pilot study was funded by the Department of Health, to investigate the feasibility of screening 16–25 year old women (and some men), for chlamydia, using a urine specimen. Antibiotics were to be dispensed at home and were cheap and effective. The cost of complications to the individual is enormous, as is the cost to the NHS—£200 million per year.2 Screening reduced the prevalence of infection in Sweden and the United States.3 Computer modelling suggests that screening in this country would be cost effective.4

After screening for chlamydia, a means of contacting clients to give results was arranged—for example, letter or phone call. On the Wirral, 2651 patients were screened in the first 4 months—2322 women and 285 men (34, sex not recorded). Sixty eight (2.6%) gave a mobile phone number, half (35) using this as their only means of contact. Sixty five were female and two male (one patient not recorded). Thus, women (2.8%) were more likely to use mobile phones than men (0.7%) (p<0.05). The genitourinary medicine (GUM) clinic screened 358 patients. Only 68 (19%) gave an address. The results of a further 469 (17.7%) of the screened population went back to the screening site. These clients could be interested in contact via mobile phone if it was openly offered (data collected from the Public Health Laboratory Service (PHL) database and analysed on 1999/03). According to a survey by NOP Social and Political, confidentiality is important to people in the target age group (unpublished data). Patients consider their mobile phones to be a secure method of communication between themselves and us. The advent of DNA amplification in the detection of STIs has opened up new possibilities.5 There are 30 000 websites pertaining to chlamydia. An internet clinic would be aimed at mildly symptomatic or asymptomatic patients. The client would access the website and request swabs or urine pots through the post then return them the same way.

If the patients were positive, they would need to attend a GUM clinic or equivalent.

www.sextransinf.com
Other infections should not be overlooked. Partner notification is necessary. Contact slips could be supplied but the health adviser’s role should not be underestimated.

Security on the internet would have to be addressed. However, the anonymity and convenience of participating from home may increase testing for STIs. This may appeal to younger patients particularly, in view of their experience with IT.

In summary, it is rising in the younger population. Their utilisation of technology is demonstrated by mobile phone use in the chlamydia pilot study. Health providers should respond using media with which the target population is comfortable. We might just access chlamydia pilot study. Health providers should discussed on the factors behind the changing pattern is presented here. The incidence from the Mersey Region shows a steady decline until the mid 1990s followed by a recent increase and represents the trend in most areas. In spite of the advances in the diagnostic and therapeutic field, organised health advisory system, easy access walk-in clinics, complete confidentiality, and free treatments; the incidence of gonorrhoea is rising. From the broader analysis of the situation, it is possible to say that most of the factors behind this changing pattern are socio-economic. The factors may include advances in contraceptives, sexual liberalisation, increase in the mobility of population, and the changing economic environment. The cumulative result of all these factors is an increase in casual relationships. Casual sex is made riskier when it is performed unprotected and without much knowledge about the partner and is possibly the main reason behind the poor contact tracing of only 0.5 out of an average of 1.5 per patient. Some of these factors are part of the wider evolutionary process and are difficult issues to deal with, but preventive measures may be taken against the others. In spite of the recent advances and better understanding of the disease in the recent years, there is still a lack of awareness, in the general population, of the possible mental and physical effects of such infection. The significant fall in the incidence of gonorrhoea seen in the late 1980s, secondary to extensive media coverage of HIV infection, shows how effective such campaigns can be. The present rise in the incidence of gonorrhoea in the past few years shows clearly that our prevention campaigns are not effective.

The young teenagers who make up the pool of supply and the young females who form the pool of asymptomatic reservoirs of the infection, are the two core groups our campaigns should be targeting. At present there is no programme in the school curriculum about sexual health and no regular screening programme for sexually active young females.


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Cheilitis in association with indinavir

Editor,—There is increasing speculation that indinavir may cause side effects which have been previously associated with high concentrations of retinoids. In the presence of all-trans-retinoic acid (ATRA), indinavir, but not other protease inhibitors (PIs), alters stem cell differentiation in vitro, not seen in the presence of ATRA alone.1 Alopecia and cheilitis are two side effects associated with both retinoids and the protease inhibitor indinavir (but not with any of the other protease inhibitors). These side effects can be
reversed on changing from indinavir to an alternative PI. We report a case of cheilitis associated with indinavir which resolved rapidly on changing treatment.

A 35 year old African man developed cheilitis (fig 1A) 5 months after commencing HAART with stavudine, lamivudine, and indinavir. His CD4 lymphocyte count at that time was 238 cells x 10⁹/l, with an HIV viral load of 78 copies per ml (Chiron bDNA assay version 3). He had a medical history of granulomatous uveitis of undetermined cause, which developed before HAART. It responded to prolonged treatment with oral prednisolone 40 mg daily and has since remained quiescent. The oral corticosteroids were tailed off and finally discontinued a month before the cheilitis developed. Following the development of cheilitis, further investigations showed: positive IgG antinuclear antibodies with a homogeneous pattern and a titre of 1 in 320; rheumatoid factor positive 1 in 40; anti-Ro and anti ScI-70 both negative; serum angiotensin converting enzyme 75 U/l (normal range 20–95); chest x-ray normal; C reactive protein 1 mg/l; erythrocyte sedimentation rate 4 mm in the first hour. Biopsy of the lip showed acanthosis and parakeratosis without associated inflammation. It was initially considered that the cheilitis might be an autoimmune phenomenon, but topical treatment with Eumovate (clobetasone butyrate, GlaxoWellcome) failed to improve the condition, which persisted for 10 months until the indinavir was changed to efavirenz. At the time of changing therapy his CD4 count was 418 cells x 10⁹/l, with an HIV viral load below detection. Within a week of changing therapy the cheilitis resolved completely (fig 1B).

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BOOK REVIEW


This book is a must for anyone interested in how this fascinating organism causes damage. The first part reviews the knowledge on the molecular phylogeny, genomic autobiography, developmental biology, and metabolism of chlamydiae. It shows how far our knowledge of the organism has broadened in the past few years, particularly as gene sequencing has changed our view of chlamydiae. Until this was made available, metabolic studies on chlamydiae were hampered by its intracellular obligate nature, lack of knowledge of the enzyme pathways, and the relatively small genome which suggested very limited metabolic activity. It now becomes apparent that the organism, which we believed to be biologically crippled, has quite sophisticated biosynthetic capabilities. This opens the way to creating a non-cell dependent culture system in the future.

A chapter by Ted Hackstadt on the cell biology shows a whole spectrum of novel interactions with the host cell that contribute to the success of the genus as pathogens. This is followed by an excellent chapter by Julius Schachter on infection and disease epidemiology. He makes the interesting point that given that some individuals lose antibody over time it is possible that almost all humans have met the organism at some time in their lives. This may be quite important in understanding some of the longer term consequences of chlamydial infections, where the organism may not be isolated and antibody tests may be negative. These sequelae are covered in subsequent chapters by Michael Ward, Robert Brunum, and Roger Rank. Since all three concentrate on novel immunological response to chlamydia there is bound to be some overlap, but also some differences and interesting emphasis. For example Ward plays down the current obsession with cross reactions between chlamydia and human heat shock proteins.

A lot of our information, particularly on the immunology, comes from animal studies and their relevance to human pathology remains to be established. In an excellent final chapter Penelope Hitchcock points to the future directions of research. In particular, she laments that little research has been done in men with chlamydia. Certainly the book is rather short on discussion of the male. There is also a need to find a male model for pathogenesis. Non-gonococcal urethritis maybe a suitable, and easily accessible, marker of chlamydial infection in men and deserves more in-depth study. Much more research also needs to be done, particularly on clinically inapparent infections in the human.

There is also a need to find a male model for pathogenesis. Non-gonococcal urethritis maybe a suitable, and easily accessible, marker of chlamydial infection in men and deserves more in-depth study. Much more research also needs to be done, particularly on clinically inapparent infections in the human.

National NCCG Update Meeting, Bromsgrove Stakis Hotel, 23–24 September 2000
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11th Regional Meeting of International Union against Sexually Transmitted Infections, South East Asian and Western Pacific Branch and 24th National Conference of Indian Association for the Study of Sexually Transmitted Diseases and AIDS, 13–15 October 2000, Chandigarh, India
Further details: Dr Bhushan Kumar, Organising Secretary, 11th Regional Meeting, of IUSTI–Asia Pacific (SE Asia and W Pacific Branch), Department of Dermatology, Venereology and Leprosy, PGIMER, Chandigarh – 160 012, India (tel: +91 (0172) 745330; fax: +91 (0172) 74401745078; email: kumarbhushan@hotmail.com).
New Zealand Venerological Society Conference, Centennial Convention Centre, Palmerston North, New Zealand, 18–20 October 2000

Ka Hikotia Ka Koreroa Mo Te Tau Rua Mano (Maoi) “Walk the Talk 2000.” Further details: Sue Peck, Conference Organiser, SP Conference Management, PO Box 4400, Palmerston North, New Zealand (tel: 64 6 357 1466; fax 64 6 357 1426; email suepeck@xtra.co.nz).

Corporation 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, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cverapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanhid Panalanej, Bangkok Hospita, 189 Sathorn Road, Bangkok 10120, Thailand (fax: (66-2) 286 3013; email: pthanit@email.ksc.net).

Corporation 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: Hat Yai Secretariat, Dr Verapol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cverapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanhid Panalanej, Bangkok Hospita, 189 Sathorn Road, Bangkok 10120, Thailand (fax: (66-2) 286 3013; email: pthanit@email.ksc.net).

Royal Society of Medicine and National Institutes of Health International Conference, RSM London, 7–9 December 2000

The RSM in London, UK, and the NIH in Bethesda, Maryland, US, are organising an international conference to be held at the RSM on “New trends in HIV management and research.” Further details: Victoria Boswell, Academic Conference Assistant, Royal Society of Medicine, tel: (44) (020) 7290 2965; fax: +44 (0)20 7290 2977; email: victoria.boswell@roycemed.ac.uk).

Call for papers—6th European Forum on Quality Improvement in Health Care, 29–31 March 2001, Bologna, Italy

Further details: BMA/BMJ Conference Unit, BMA House, Tavistock Square, London WC1H 9JR, tel: +44 (0) 20 7383 6409; fax: +44 (0) 20 7383 6869; email: quality@bma.org.uk; website: www.quality.bmj.org).

CORRECTION

An error occurred in the editorial by R D Maw which was published in the June issue (STI 2000;76:155). In the second column, lines 3–6, podophyllin should be replaced by podophyllotoxin in each case.

CURRENT PUBLICATIONS

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

**Gonorrhoea**

**Chlamydia**

**Hepatitis**

**Pelvic inflammatory disease**

**Bacterial vaginosis**

**Hepatitis**

**Fungal infections**

**Miscellaneous**

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

Gonorrhoea, chlamydia and the sexual network—pushing the envelope (Editorial).


Gonorrhoea in male adolescents and young adults in Newark, New Jersey—implications of risk factors and patient preferences for prevention strategies.


Comparative epidemiology of heterosexual gonococcal and chlamydial networks—implications for transmission patterns.


Unique gonococcal phenotype associated with asymptomatic infection in men and with erroneous diagnosis of nongonococcal urethritis.

W H WHITTINGTON, KK HOLMES. J Infect Dis 2000;1044:8

Asymptomatic infections have been associated with strains of Neisseria gonorrhoeae belonging to certain phenotypes; arginine, hypoxanthine, and uracil requiring (AHU) and proline, citrulline, and uracil requiring (PCU).

This study describes an outbreak caused by a new phenotype, citrulline and uracil requiring, which has unique clinical presentation. The authors report an increase in the prevalence of gonococci belonging to the CU auxotype from 1.6% in 1987 to 16.5% in 1997 in King County, Washington, USA. The characteristics of these strains were that they belonged to one of two closely related serovars, IB-1 and IB-3 that differ only by reactivity with a single antibody, they were all susceptible to penicillin, tetracycline, and erythromycin and were highly susceptible to broad spectrum cephalosporins and fluoroquinolones. The number of cases rose from 57 to 75 per year in the 1980s to 125 and 115 in 1996 and 1997 respectively despite a fall in the total number of cases of gonorrhoea seen. The CU auxotype was also isolated more frequently than other types from healthcare facilities other than GU clinics.

The demographic and behavioural data showed that men infected with the CU auxotype were more often black, heterosexual, younger, less likely to seek care for symptoms and to be co-infected with Chlamydia trachomatis than were men infected with other auxotypes. Among heterosexual men, infection with the CU auxotype produced symptoms of urethral discharge or dysuria or signs of moderate or profuse urethral discharge less often than in men infected with other auxotypes. Symptoms of dysuria and discharge were also of longer duration and urethral smears showing intracellular Gram negative diplococci were found in only 67% of patients with the CU auxotype compared with 95% of men with other types.

The characteristics of the CU auxotype may enable these strains to evade detection and hence confer a selective advantage for survival. This is of particular importance given that total numbers have fallen and the pressure for screening asymptomatic populations has decreased.

Concurrent gonococcal and chlamydial infection—how best to treat.

AJ ROBINSON, GL RIDGWAY. Drugs 2000;59:801–14

Neisseria gonorrhoeae M11 mKop opacity protein expression in vitro and during human volunteer infectivity studies.


Gonococcal lipo-oligosaccharide is a ligand for the asialoglycoprotein receptor on human sperm.


Reexamining the prevalence of Chlamydia trachomatis infection among gay men with urethritis—implications for STD policy and HIV prevention activities.

EL CEMENS, J FLOOD, CK KENT et al. Sex Transm Dis 2000;27:249–51

Pooling of urine specimens for detection of asymptomatic Chlamydia trachomatis infections by PCR in a low-prevalence population: cost-saving strategy for epidemiological studies and screening programs.


Multiple drug-resistant Chlamydia trachomatis associated with clinical treatment failure.

Bacterial vaginosis


Trichomoniasis


Pelvic inflammatory disease


Syphilis and other treponematoses


Hepatitis

Natural history of hepatitis C: its impact on clinical management. AM DeBreceny. Hepatology 2000;31:1014–9
Seroprevalence and risk factors of hepatitis B, hepatitis C and human cytomegalovirus among HIV-infected and high-risk uninfected adolescents—findings of the REACH study. CA Holland, Y Ma, AB Mosco et al. Sex Transm Dis 2000;27:296–302

Herpes

Seroprevalence of herpes simplex virus type 2 infection among attendees of a sexually transmitted disease clinic in Italy. M Cusini, M Cusan, C Parolin et al. Sex Transm Dis 2000;27:292–5
Herpes simplex virus-type 2 seropositivity in a Danish adult population denying previous episodes of genital herpes. CS Petersen, FG Larsen, Z Zachariae, M Heidenhein. Acta Dermato-Venereol 2000;80:158


Candidiasis

Cytokine modulation of specific and nonspecific immunity to Candida albicans. L Roman. Mycoses 2000;42:45–8

www.sextransinf.com
Seroprevalence of herpes simplex virus type 1 and type 2 in selected German populations—relevance for the incidence of genital herpes.


Valaciclovir—a review of its long term utility in the management of genital herpes simplex virus and cytomegalovirus infections.


Characterization of an acyclovir-resistant herpes simplex virus type 2 strain isolated from a premature neonate.


HSV.com: Maneuvering the internet-works of viral neuropathogenesis and evasion of the host defense.

SL Tan, MG Katze. Proc Natl Acad Sci USA 2000;97:5684–6

Molecular epidemiology of herpes simplex virus type 1 genital infection in association with clinical manifestations.


Evaluation of an enzyme-linked viral inducible system for the rapid detection of herpes simplex virus.


Premarket evaluation of the POCkit HSV-2 type-specific serologic test in culture–documented cases of genital herpes simplex virus type 2.

RL Ashley, A Walde, M Eagleton. Sex Transm Dis 2000;27:266–9

Immunisation with phase displaying peptides representing single epitopes of the glycoprotein G can give rise to partial protective immunity to HSV-2.


Use of herpes simplex virus type 1 ISCOMS 703 vaccine for prophylactic and therapeutic treatment of primary and recurrent HSV-2 infection in guinea pigs.


Antibody responses, cytokine levels and protection of mice immunized with HSV-2 antigens formulated into NISV or ISCOM delivery systems.


Interferon-γ up-regulates intercellular adhesion molecule-1 and vascular cell adhesion molecule-1 and recruits lymphocytes into the vagina of immune mice challenged with herpes simplex virus-2.


Evaluation of the inactivation of infectious herpes simplex virus by host-defense peptides.


Hydrogels containing monocapocrin prevent intravaginal and intracutaneous infections with HSV-2 in mice: impact on the search for vaginal microbicides.


1,3-dihydroxyacridone derivatives as inhibitors of herpes virus replication.

PAKantapatch, CT Lowdin, KF Bastow. Antiviral Res 2000;45:123–34

Human papillomavirus infection

Papillomaviruses causing cancer: evasion from host-cell control in early events in carcinogenesis.


Contemporary theories of cervical carcinogenesis: the virus, the host and the stem cell.


A simplified and reliable HPV testing of archival Papanicolaou-stained cervical smears: application to cervical smears from cancer patients starting with cytological normal smears.


High prevalence of human papillomavirus type 16 infection among children.


Human papillomaviruses and vulvar vestibulitis.


Human papillomavirus DNA in penile carcinomas in Argentina: analysis of primary tumors and lymph nodes.


Comparison of human papillomavirus genotypes in archival cervical cancer specimens from Alaska natives, Greenland natives and Danish Caucasians.


Warty (condylomatous) squamous cell carcinoma of the penis—a report of 11 cases and proposed classification of ‘verruciform’ penile tumors.


Type of human papillomavirus and expression of p53 in elderly women with cervical cancer.


High prevalence of serum antibodies to Ras and type 16 E4 proteins of human papillomavirus in patients with precancerous lesions of the uterine cervix.


Boosting with recombinant vaccinia increases HPV-16 E7-specific T cell precursor frequencies of HPV-16 E7-expressing DNA vaccines.


Human tumor growth is inhibited by a vaccinia virus carrying the E2 gene of bovine papillomavirus.


Human papillomavirus type 16 E7 oncoprotein represses transcription of human fibronectin.


Interleukin-10 increases Th1 cytokine production and cytotoxic potential in human papillomavirus-specific CD8(+) cytotoxic T lymphocytes.


Cytokine profile of draining lymph node lymphocytes in mice grafted with syngeneic keratinocytes expressing human papillomavirus type 16 E7 protein.


Cervical cytology and colposcopy

Advances in cervical screening technology.

MH Stoler. Mod Pathol 2000;13:275–84

Clinical significance of the qualification of atypical squamous cells of undetermined significance: an analysis on the basis of histologic diagnoses.


Qualitative analysis of value judgments in interpreting cervicovaginal smears using the Bethesda System.


Papanicolaou smear history and diagnosis of invasive cervical carcinoma among members of a large prepaid health plan.

HY Jung, KA Kearney, M Miller et al. Cancer 2000;88:2283–9

Cytologic and histologic diagnosis and significance of controversial squamous lesions of the uterine cervix.


Photodetection of cervical intraepithelial neoplasia using 5-aminolevulinic acid-induced porphyrin fluorescence.

Glandular lesions of the uterine cervix, RJ ZAINO. Med Pathol 2000;13:261–74

The effects of loop excision of the transformation zone on cervical length: implications for pregnancy.

Treatment of vaginal dysplasia: just a simple loop electrosurgical excision procedure?

AL SADER. Am J Obstet Gynecol 2000;182:866–71

Other sexually transmitted infections

Mycoplasma genitalium in males with nongonococcal urethritis—prevalence and clinical efficacy of eradication.

Development of a serological test for Haemophilus ducreyi for seroprevalence studies.

An isogenic hemoglobin receptor-deficient mutant of Haemophilus ducreyi is attenuated in the human model of experimental infection.

Public health and social aspects

A prospective study on condom slippage and breakage among female brothel-based sex workers in Singapore.
ML WONG, RKW CHAN, D KOH, S WEI. Sex Transm Dis 2000;27:208–14

Condom acceptance is higher among travelers in Uganda.
M MARRS, MJ WAXER, F MAKUMBI et al. AIDS 2000; 14:733–42

Microbiology and immunology

Pathogenesis of abnormal vaginal bacterial flora.

Wet mount microscopy reflects functional vaginal lactobacillary flora better than gram stain.

Induction of mucosal immune responses in the human genital tract.

Surface characteristics of lactobacilli isolated from human vagina.
VS OCANA, E BRU, AAPD HOLGADO, ME NADERMACIAS. J Gen Appl Microbiol Tokyo 1999;45:203–12

Cytokine profile in genital tract secretions from female adolescents: impact of human immunodeficiency virus, human papillomavirus and other sexually transmitted pathogens.

Evidence that anoreceptive intercourse with ejaculate exposure is associated with rapid CD4 cell loss.
DJ WILEY, BR VISSCHER, S GROSSER et al. AIDS 2000;14:707–16

Dermatology

Recurrent squamous cell carcinoma of the vulva—clinopathologic determinants identifying low risk patients.
M PRETI, G RONCO, B GREENGIELLO, L MICHELETTI. Cancer 2000;88:1869–76

Anaerobic blanoposthitis: two cases and review of the literature.
S TAVAKOLITABASI, RI HAMIL, SB GREENBERG. Am J Surg 2000;26:11–4

Proliferative epidermal lesions associated with anogenital Paget’s disease.

Caruncles at the external urethral meatus.

Cutaneous metastatic carcinoma of the penis: suspected metastasis implantation from a bladder tumor.
T MIYAMOTO, A REHARA, M ARAKI et al. J Urol 2000;163:1519

Miscellaneous

When is a sexually transmitted disease not an ‘STD’?

Notify or not to notify—STD patients’ perspectives of partner notification in Seattle.

Treatment of sexually transmitted bacterial diseases in pregnant women.
GOG DONDERS. Drugs 2000;59:377–86

Traditional intravaginal practices and the heterosexual transmission of diseases—a review.
JE BROWN, RC BROWN. Sex Transm Dis 2000;27:183–7

Extent of regretted sexual intercourse among young teenagers in Scotland: a cross sectional survey.
D WIGHT, M HENDERSON, G RAAB et al. BMJ 2000;320:1243–4

Sexually transmitted infections in European HIV-infected women: incidence in relation to time from infection.
BHR VANBRETHEM, M PRINS, C LARSEN et al. AIDS 2000;14:595–604

Prevalence and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls.
K RINGARD, K ORNSTAD. Acta Paediatr 2000;89:310–9

Antibiotics for bacterial prostatitis.
JC NICKEL. J Urol 2000;163:1407

Saw palmetto for the treatment of men with lower urinary tract symptoms.
GS GEBRE. J Urol 2000;163:1408–12

Cost utility analysis of sildenafil compared with papaverine-phonotolamine injections.
EA STOLK, JJV BUSSCHBACH, M CAFFA et al. BMJ 2000;320:1165–7

Non-Hodgkin’s lymphoma involving the vagina—a clinopathologic analysis of 14 patients.

S HAN, RE FISCHER. Cancer 2000;88:2319–25

Finger-length ratios and sexual orientation.
TJ WILLIAMS, ME PEPTONE, SE CHRISTENSEN et al. Nature 2000;404–455

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