LETTERS TO THE EDITOR

Carbamazepine in Reiter’s syndrome

Editor,—A psoriatic spectrum with Reiter’s syndrome
dermatitis, and psoriasis. The patient was
to raised levels of neuropeptides, with
to raised levels of neuropeptides, with

A 30 year old married man presented with
erythematous papules and plaques of 2 months’ duration covered with hard limpet-
ike scales on face, body, and both extremi-
ties (fig 1). Palms and soles showed kerato-
derma blennorrhagicae and sub ungual hyperkeratosis with distal onycholysis. Both
two knees and wrists had painful swelling with restriction of movements. With this presentation Reiter’s syndrome was inferred. All routine investigations were normal except a raised erythrocyte sedimentation rate of 100 mm in the first hour. x Rays of the affected joints were normal. ELISA for HIV-1 and HIV-2 was positive with two kits (Immunocomb, Tri-dot) and confirmed with western blotting technique (Speciality Ran-

Carbamazepine therapy.

The rapid clearing of erythema, secondary to raised levels of neuro peptides, with carbamazepine may have been mediated through inhibition of these neuro peptides and by inhibition of uptake of noradrenaline. The exacerbation of symptoms with resolution of lesions on withdrawal and reinstatement of carbamazepine respectively proves its effi-
cacy in our patient. Also, the clinical remission maintained for 1 year after stop-
ing carbamazepine therapy was attributed to the biological effect of the drug. The therapeutic response seen in our patient conforms to that seen in the HIV-1 positive patient of Smith et al.1

This apparent success adds carbamazepine to the armamentarium against Reiter’s syn-
drome in an HIV infected patient. This is the first reported case and an evaluation of long term carbamazepine therapy is warranted.

N N GOYAL R S DHURAT H R JERAJAN
Department of Dermatology, LTM Medical College
and LTM General Hospital, Sion, Mumbai - 400063,
India

Correspondence to: Dr N N Goyal, 14 Vinay,
Prayas Sadan, Chiheda nagar, Chembur, Mumbai -
400089, India

1 Davic M, Crane M, Conant M, et al. Zidovu-
dine improves psoriasis in human immuno-
deficiency virus-positive males. Arch Dermatol
1994;130:447–51.
2 Johnson T, Davic M, Rapini R. Acquired immuno-
5 Parer E, Nickelhoff B, Recht B. Stress, symme-

Accepted for publication 20 March 2000

Condoms and warts

Editor,—Ween et al1 should be applauded for their attempt to address the key question of whether or not condoms protect people from genital warts. However, some of the major study variables need clarification, as they did not match up with my knowledge of the Sydney Sexual Health Centre (SSHC) database.

The article discussed the issue of “acquisition of genital warts” and was presented as an incidence study. Cases were defined as: “All patients with a new diagnosis of macroscopic genital warts who attended SSHC [in 1997].” However, many of these patients had been previously diagnosed with genital warts else-
where while others had recurrent lesions. In Australia, most genital warts are managed by general practitioners.2 Consequently, the experience of specialist services is biased towards recurrent and difficult cases. “New diagnosis” in this situation means new to the clinic but not necessarily new to the patient. This means that the main outcome measure was a mixture of incident, prevalent, and recurrent cases, with the possibility that the warts may have affected the behaviour of many of the study subjects.

The SSHC database does document whether a person has previously been diag-

3 Original J. Natural history of genital warts. Br J Vener Dis 1971;47:1–13. Accepted for publi-
cation 20 March 2000

Reply

Editor.—We are grateful to Dr Dayan for her helpful and constructive comments. The major criticism of our paper relates to the selection of cases, and the possible inclusion

Figure 1 Close view of erythematous annular papules and plaques on chest before carbamazepine therapy.
Photosensitivity reaction to efavirenz

EDITOR,—The non-nucleoside reverse transcriptase inhibitor (NNRTI) efavirenz is a recent addition to the armamentarium available to physicians in the treatment of HIV infection. However, at present the known side effect profile of this new agent is still in its infancy. We would like to report a case of photosensitivity associated with efavirenz.

A 27 year old white homosexual man was commenced on combivir (zidovudine/lamivudine) and nevirapine in March of 1999. One month later he reported that he was well and had no major side effects associated with his new combination. However, 4 weeks further into treatment he presented with an itchy rash affecting his arms and hands. On examination there was a maculopapular rash over the affected area but there was no oral ulceration, conjunctivitis, or fever. A drug reaction was diagnosed and he was prescribed antihistamines and asked to continue his new combination. However, 4 weeks further into treatment he presented with an itchy rash affecting his arms and hands. On examination there was a maculopapular rash over the affected area but there was no oral ulceration, conjunctivitis, or fever. A drug reaction was diagnosed and he was prescribed antihistamines and asked to continue his new combination. However, 1 week later he developed a rash over his elbows where there was no exposure to sunlight, but who had been diagnosed as HIV infected patients receiving prophylaxis against CMV retinitis. We conducted a retrospective review of all HIV infected patients diagnosed with CMV retinitis at Fairfield Hospital and the Alfred Hospital between 1984 and 1996, aiming to review of human immunodeficiency virus (HIV) associated cytomegalovirus (CMV) retinitis in Melbourne, Australia. T he presence of visual symptoms at diagnosis of CMV retinitis was predictive of the development of moderate visual loss (relative risk 2.1, 95% confidence interval 1.1–4.2). Fifty eight of 138 patients (42%) with visual symptoms at diagnosis developed moderate visual loss, compared with 16 of 64 patients (25%) who were asymptomatic at diagnosis (p=0.02). The presence of visual symptoms at diagnosis was not predictive of the development of severe visual loss, or early death (p=0.2). Other factors measured in the diagnosis of CMV retinitis included the patients’ age, CD4 count, weight, visual acuity, and the presence of any previous AIDS defining condition. None of these was associated with the development of visual loss or early death (p>0.1).

The advent of highly active antiretroviral therapy (HAART) has resulted in a reduction in the incidence of new diagnoses of opportunistic infections. Prolonged survival times with CMV retinitis have been demonstrated in patients who achieve immunological recovery with HAART.1 The ability to predict those patients who are at highest risk of visual loss may assist in advising those who may reasonably cease maintenance therapy for CMV retinitis following immune restoration. An understanding of the natural history of CMV retinitis in the pre-HAART years remains important in managing patients who are failing therapy. The only factor measurable at diagnosis of CMV retinitis that was predictive of outcome was the presence of visual symptoms. The use of routine ophthalmological screening for CMV retinitis in HIV infected individuals with low CD4 counts aims to detect CMV retinitis before visual symptoms occur. It is possible that visual loss may be prevented by detecting disease before retinal damage occurs. A prospective evaluation is needed to confirm this finding.
Azithromycin v oxytetracycline for the treatment of non-specific urethritis

EDITOR,—Single dose azithromycin 1 g rather than multidose tetracyclines or erythromycin over several days for the treatment of chlamydial urethritis is becoming more widespread as patient acceptability and improved compliance outweigh cost considerations. However, in men, treatment is often initiated on the basis of evidence of urethritis before the chlamydia result is available. Relatively few studies report the efficacy of azithromycin in the treatment of non-gonococcal non-chlamydial urethritis (NSU), but recently published evidence based guidelines for the management of NSU recommend either doxycycline 100 mg twice daily for 7 days or azithromycin 1 g immediately.1

In this genitourinary medicine clinic azithromycin became first line treatment for all proved or suspected chlamydial infections from 1 April 1998. This retrospective study assessed the efficacy of azithromycin for the treatment of NSU compared with oxytetracycline 250 mg four times daily for 7 days, the previous first line treatment regimen for men with microscopic urethritis in whom no Gram negative diplococci were evident. The results of all men with NSU diagnosed between 1 April 1998 and 30 September 1999 (treated with azithromycin) was compared with those diagnosed between 1 April 1998 and 30 September 1997 (treated with oxytetracycline).

NSU was defined as the presence of at least five polymorphonuclear leucocytes (PMNL) in five or more fields on microscopy of a urethral smear.1,2 Gram positive diplococci were evident in five or more fields on microscopy of a urethral smear.1 Inclusion in the study was made on the basis of microscopic evidence of urethritis, pending the chlamydia result. Financial considerations preclude the use of azithromycin as first line treatment for NSU in many centres, but better compliance resulting in fewer treatment failures, and fewer wasted appointments from defaults may counter the economic argument.3

C THOMPSON
Fjö Acute Hospitals NHS Trust, Victoria Hospital, Kirkaldy, Fjö, KY2 5AH

Table 1 Comparative age, symptoms, and response to treatment of the two groups

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number treated</th>
<th>Median age (range)</th>
<th>Percentage with symptoms</th>
<th>Percentage with no cure</th>
<th>Percentage with no treatment failure</th>
<th>Percentage with persistent positive two glass urine test, with microscopy urethritis and no previous first line treatment regimen for men</th>
<th>Outcome uncertain</th>
<th>Sexually transmitted infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger</td>
<td>76</td>
<td>28 (18–63)</td>
<td>35 (46)</td>
<td>29 (39)</td>
<td>6 (8)</td>
<td>41 (54)</td>
<td>11 (14%)</td>
<td>6 (8%)</td>
</tr>
<tr>
<td>Older</td>
<td>52</td>
<td>25 (16–54)</td>
<td>25 (48)</td>
<td>27 (52)</td>
<td>0</td>
<td>4 (8%)</td>
<td>4 (8%)</td>
<td>0</td>
</tr>
</tbody>
</table>

*Originally asymptomatic with clear two glass urine, did not reattend (DNA), possibly reinfected.

Table 1 Diagnoses of older and younger clinic attendees

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Younger clinic</th>
<th>Older clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>STIs</td>
<td>7 (11%)</td>
<td>7 (13%)</td>
</tr>
<tr>
<td>Latent syphilis</td>
<td>3 (5%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Genital warts</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>1 (2%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>1 (2%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>HIV</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Other conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erectile dysfunction</td>
<td>15 (24%)</td>
<td>10 (20%)</td>
</tr>
<tr>
<td>Balanitis</td>
<td>9 (14%)</td>
<td>7 (14%)</td>
</tr>
<tr>
<td>Lichen sclerosus</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Zoon’s balanitis</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Genital psoriasis</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Genital eczematous</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Genital skin tag</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Genital sebaceous cyst</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Miscellaneous (hepatitis B vaccination)</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

Many elderly people maintain heterosexual and homosexual activity. Therefore this age group is at a risk of all sexually transmitted infections.1 In our study, a smaller percentage of older attendees had STIs compared with previous studies.3,4 However, the number of older patients who attended for non-STI management is comparable. The delay between symptom recognition and clinic attendance is a feature of STI related illness behaviour. The delay behaviour among individuals with suspected STIs is age specific, with longer latency periods experienced by people over the age of 50.5 This finding was seen in our study as well.

NELSON DAVID
SASIKALA RAJAMANOHARAN
ALAN TANG
Department of GU Medicine, Royal Berkshire Hospital, Reading RG1 5AH

Correspondence to: Dr Nelson David


Tertiary syphilis

EDITOR,—I read Dr Reed’s letter on tertiary syphilis6 with interest.

The regimen he describes for the treatment of early syphilis—arsenic, bismuth, and rough the clock aqueous penicillin, was used in our hospital from 1946–8 although daily penicillin in beeswax was also used. It was unclear how much inactive penicillin K was in the commercial product used. The penicillin injection used here was higher than in Lincoln (40 000–75 000 units 3–4 hourly). There were 10 treatment failures (reinfections) out of 275 patients described.6

Treponema pallidum remains viable in the CSF even after adequate clinical treatment.6

Accepted for publication 20 April 2000

STIs

<table>
<thead>
<tr>
<th>No of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSU</td>
</tr>
<tr>
<td>Latent syphilis</td>
</tr>
<tr>
<td>Genital herpes</td>
</tr>
<tr>
<td>Genital warts</td>
</tr>
<tr>
<td>Gonorrhoea</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
</tr>
<tr>
<td>HIV</td>
</tr>
</tbody>
</table>

Other conditions

<table>
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<tr>
<th>No of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erectile dysfunction</td>
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<tr>
<td>Genital psoriasis</td>
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</tr>
<tr>
<td>Miscellaneous (hepatitis B vaccination)</td>
</tr>
</tbody>
</table>

Accepted for publication 20 April 2000

The most striking first impression of these two volumes is the lavish production with marvellous illustrations, photographs, and tables. It has many excellent features. The text is well set out and easy on the eye. The experience of the authors in approaching various diseases and clinical syndromes comes through strongly. The sections comprehensively cover infectious disease from basic to advanced clinical management. The clinical microbiology section is an important anchor and could be a short textbook in itself. I very much enjoyed the numerous practice points, which are oriented towards clinicians faced with funding solutions to problems. These consist of short essays with tables or illustrations and tackle particular clinical problems such as “the diagnosis of HIV in newborns,” “what is the treatment of a positive toxoplasma titre in pregnancy?” or are in a debating style—for example, “how long should osteomyelitis be treated?”

Each section is colour coded and although the American numbering system takes a few minutes to get used to one can easily navigate around the book. The contributors are all internationally famous in their fields and, with so many of them, I am quite impressed by how up to date the book is. They must have been chased hard to get their contributions in on time. One of the few criticisms would be that there could have been more on hepatitis C and its interaction with HIV.

However, if you can’t find what you want in this book, there is a comprehensive list of websites, which are of interest to infectious disease and other physicians. There is a free CD ROM which creates a direct internet link to these sites. The other important resource is a slide library, which comes on the same CD ROM. In all, 1500 tables and clinical and other photographs are stored and can be made up into personalised presentations; these can then be used as a teaching resource via computer generated images. The high quality of these images will impress anyone involved in producing material for teaching. However, it is regrettable that some of the useful tables have not made it from the text to the CD ROM.

Although this book is expensive, I would recommend it to anyone interested in infectious diseases especially those who have to teach at any level, undergraduate or postgraduate.

With the rise of the internet the big textbook might well be heading for extinction. Thankfully this book delays the time when I will be downloading information from the super highway rather than turning over the pages of a well produced book. If I need to use my computer there is always that free CD ROM....

ANTON POZNIAK
St Stephen’s Centre, Chelsea and Westminster Health Care Trust, Chelsea and Westminster Hospital, London SW10 9TH


I was delighted when the editor sent me this book and asked me to review it. I had looked forward with anticipation to the original series that were published in the BMJ. I had thought then that each article was just superb and now they are all neatly packed together in this ABC, I am of the opinion that this is an excellent book which achieves its aim completely. On the cover, it says "It is an ideal reference for doctors, nurses, students and all those not involved in the area of sexual health," and Professor Adler adds in the foreword that this book will put the profession in touch with the real world, real people, with real problems, and fill a large gap in our knowledge.

John Tomlinson, the editor, has pulled together an excellent group of experts who have practical experience in the field and have managed to condense that experience into a series of short articles, all of which make informative, yet entertaining reading. In my opinion, no specific background is required to gain information from these articles and I have recommended specific sections of this book for individual patients who need to read about their problem.

Those of us who work in sexual medicine were amused that the BMJ had to carry a warning about the sexually explicit material inside and, indeed, John Tomlinson refers to this in the preface and admits that a very small number of readers were offended. However, given the general reticence in society about sexual matters, this is not surprising.

Sexual health is an essential part of having a happy and fulfilling life, and everyone who works in a caring profession should be comfortable when the conversation drifts into areas of sexuality. Patients, who often broach the topic with trepidation, need to be assured of a sensitive hearing. In my opinion, this excellent book will give anyone in the caring profession a good grounding in sexual matters, so that they can explore these areas with patients when appropriate, and without embarrassment and have some idea of likely strategies of management.

COLUM O’MAHONY
Countess of Chester Hospital NHS Trust, Chester CH2 1UL

NOTICES

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Herpes Alliance, Regional Office of the World Health Organisation

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@csp.sheridan.com).

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: symfreq@ic.ac.uk).

Australasian Sexual Health Conference, Ven Troppo, Carlton Hotel, Darwin, Northern Territory, 21–24 June 2000

Further details: Shirley Corley, Conference manager, Dart Associates, PO Box 781, Lane Cove, 2066 NSW, Australia (tel: 02 9418 9355; fax: 02 9418 9398; email: dartcon@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: 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: symfreq@ac.ac.uk).
Further details: Orga-Med Congress O
Ljubljana, Slovenia, 28 June–1 July 2000
Reproductive and Sexual Health,
the Third Millennium: a (R)Evolution in
6th ESC Congress on Contraception in
2000
Marriott Hotel, Portsmouth, 28 June
Sexual Health and HIV Conference:
91 25; email: aids2000@congrex.se).
Sweden (tel: +46 8 459 6600; fax: +46 8 661
XIII International AIDS Conference,
2000, Riga, Latvia
Further details: Professor Andris Y Rubins,
Department of Dermatovenereology, Medical
Academy of Latvia, K Valdemara Street,
76–75, Riga, LV-1013, Latvia (tel: +(371)
7370395; fax: +(371) 7361615; email:
arubins@apollo.lv).
3rd Congress of the Baltic Association of
Dermatovenereology, 7–9 September
2000, Riga, Latvia
Further details: Professor Andris Y Rubins,
Department of Dermatovenereology, Medical
Academy of Latvia, K Valdemara Street,
76–75, Riga, LV-1013, Latvia (tel: +(371)
7370395; fax: +(371) 7361615; email:
arubins@apollo.lv).
National NCCG Update Meeting,
Bromsgrove Stakis Hotel, 23–24 Septem-
ber 2000
Further details: Kathy Taylor (tel: 01384
235207; email: palmtraining@tesco.net).


correction

An error occurred in the February issue of
571. The author of the editorial “The COPE
Report 1999” (2000;76:68) is Alexander (not
Alexandra) McMillan.
CURRENT PUBLICATIONS

Selected titles from 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

Susceptibility to gonococcal infection during the menstrual cycle.
S Nowicki, A Hartvantassell, B Nowicki. JAMA 2000;283:1291

‘Broken windows’ and the risk of gonorrhoea.

LV Torian, HA Makki, IB Menzies et al. AIDS 2000;14:189–96

Rise in gonorrhoea in London, UK.

Urine screening for gonococcal and chlamydial infections at community-based organizations in a high-morbidity area.
CA Jones, RC Knaup, M Hayes, BP Stoner. Sex Transm Dis 2000;27:146–51

Evaluation of four commercial transport media for the survival of Neisseria gonorrhoeae.


Prevalence and tetM subtype of tetracycline-resistant Neisseria gonorrhoeae in Ohio, 1994.

GM Li, Q Chen, SC Wang. Sex Transm Dis 2000;27:115–8

Effects of the immunoglobulin A1 protease on Neisseria gonorrhoeae trafficking across polarized T84 epithelial monolayers.

Charged tmRNA but not tmRNA-mediated proteolysis is essential for Neisseria gonorrhoeae viability.
CH Huang, WC Wolfgang, J Withey et al. EMBO J 2000;19:1098–1107

Chlamydia

Acute primary Chlamydia trachomatis infection in male adolescents after their first sexual contact.

Evaluation of patient-administered tampon specimens for Chlamydia trachomatis and Neisseria gonorrhoeae.


Impact of switching laboratory tests on reported trends in Chlamydia trachomatis infections.

Detection of Chlamydia trachomatis in pregnant women by the Papanicolaou technique, enzyme immunoassay and polymerase chain reaction.

Multicenter evaluation of the AMPLICOR and automated COBAS AMPLICOR GT/NG tests for detection of Chlamydia trachomatis.

Chlamydial development is adversely affected by minor changes in amino acid supply, blood plasma amino acid levels and glucose deprivation.

Differential regulation of CD4 lymphocyte recruitment between the upper and lower regions of the genital tract during Chlamydia trachomatis infection.

T-cell epitopes in variable segments of Chlamydia trachomatis major outer membrane protein elicit serovarspecific immune responses in infected humans.

Candidiasis

Vaginal colonization by Candida in asymptomatic women with and without a history of recurrent vulvovaginal candidiasis.

Effects of reproductive hormones on experimental vaginal candidiasis.

Evaluation of the Oricul-N dipslide for laboratory diagnosis of vaginal candidiasis.

Clonal and spontaneous origins of fluconazole resistance in Candida albicans.

Mechanisms of the proinflammatory response of endothelial cells to Candida albicans infection.

Bacterial vaginosis

Bacterial vaginosis.

Metronidazole to prevent preterm delivery in pregnant women with asymptomatic bacterial vaginosis.

Pre-term labor associated with bacterial vaginosis.
H Calderas, B Nieser, A Quintana. Anaerobe 1999;5:403–4
Trichomoniasis

Resistance of *Trichomonas vaginalis* to metronidazole: report of the first three cases from Finland and optimization of in vitro susceptibility testing under various oxygen concentrations.


Antigenicity of *Trichomonas vaginalis* heat-shock proteins in human infections.


Pelvic inflammatory disease

Pelvic inflammatory disease—an evidence-based approach to diagnosis.


Influence of human immunodeficiency virus infection on pelvic inflammatory disease.


Direct medical cost of pelvic inflammatory disease and its sequelae: decreasing but still substantial.


Syphilis and other treponematosis

Unraveling the Tuskegee Study for untreated syphilis.


Nodular tertiary syphilis mimicking granuloma annulare.


Social network method for endemic foci of syphilis: a pilot project.

R Rothenberg, L Kenbrough, R Lewishardy et al. *Sex Transm Dis* 2000;27:12–8

Geographic variation of HIV infection in childbearing women with syphilis in the United States.


HIV prevalence in patients with syphilis, United States.


From the CDC—syphilis elimination: history in the making—opening remarks.


From the CDC—syphilis elimination: history in the making—closing remarks.


Primary and secondary syphilis in the metropolitan area of Nashville and Davidson County, Tennessee—1996 to 1998 epidemic described.


Virulent *Treponema pallidum* lipoprotein and synthetic lipopptides induce CCR5 on human monocytes and enhance their susceptibility to infection by human immunodeficiency virus type 1.


Hepatitis

International congress on viral hepatitis A and B: experience in education and prevention.

*Vaccine* 2000;18:Suppl 1 (whole issue)

The seroprevalence of hepatitis A and B in people testing positive for hepatitis C.

*Can Med Assoc J* 2000;162:207–8

‘Silent killer’ or benign disease? The dilemma of hepatitis C virus outcomes.


Hepatitis C epidemiology: injecting new tools in the field.


45-Year follow-up of hepatitis C virus infection in healthy young adults.


Prevalence of hepatitis G virus in patients with hemophilia and their steady female sexual partners.


Are booster immunizations needed for lifelong hepatitis B immunity?


Cellular and humoral immune responses induced by intradermal or intramuscular vaccination with the major hepatitis B surface antigen.


Herpes

Herpes simplex type 2 infection in the developing world: is it time to address this disease?

L Corey. *Sex Transm Dis* 2000;27:30–1

Genital herpes and public health: addressing a global problem.

L Corey, HH Handsfield. *JAMA* 2000;283:791–4

Reactivation of genital herpes simplex virus type 2 infection in asymptomatic seropositive persons.


Herpes simplex virus type 2 shedding in human immunodeficiency virus-negative men who have sex with men: frequency, patterns and risk factors.


Editorial response: Asymptomatic herpes simplex virus shedding and Russian roulette.


Human immunodeficiency virus infection and genital ulcer disease in South Africa: the herpetic connection.


Medical care expenditures for genital herpes in the United States.


Herpes simplex virus DNA in amniotic fluid without neonatal infection.


Herpes simplex virus infection of the uterine cervix—relationship with a cervical factor?


The herpesvirus proteases as targets for antiviral chemotherapy.


Monoclonal antibodies suitable for type-specific identification of herpes simplex viruses by a rapid culture assay.


Establishment of latent herpes simplex virus type 1 infection in resistant, sensitive and immunodeficient mouse strains.


Herpes simplex virus infection blocks events in the G1 phase of the cell cycle.

B Song, J Li, Kc Yeh, DM Knipe. *Virology* 2000;267:326–34
A rule for MHC class 1 down-regulation in NK cell lysis virus-infected cells.


Virus-induced neuronal apoptosis blocked by the herpes simplex virus latency-associated transcript.

OC PERNG, C JONES, J CIACCIANELLA et al. Science 2000;287:1500–2

Herpes simplex virus type-1 and -2 pathogenesis is restricted by the epidermal basement membrane.


Mitochondrial distribution and function in herpes simplex virus-infected cells.


Antegrade transport of herpes simplex virus type 1 in cultured, dissociated human and rat dorsal root ganglion neurons.


The latency-associated transcript gene enhances establishment of herpes simplex virus type 1 latency in rabbits.


Limited antibody-dependent cellular cytotoxicity antibody response induced by a herpes simplex virus type 2 subunit vaccine.

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