LETTERS TO THE EDITOR

Carbamazepine in Reiter’s syndrome

Editor,—A psoriatic spectrum with Reiter’s syndrome and carbamazepine in Reiter’s syndrome occurs with greater frequency in HIV infected individuals. New erythematous plaques developed on the chest before treatment with carbamazepine, and a rapid clearing of erythema, secondary to raised levels of neuropeptides, with carbamazepine may have been mediated through inhibition of these neuropeptides and by inhibition of uptake of noradrenaline. The exacerbation is consistent resolution of lesions on withdrawal and reinstitution of carbamazepine respectively proves its efficacy in our patient. Also, the clinical remission maintained for 1 year after stopping carbamazepine therapy. The therapeutic response seen in our patient conforms to that seen in the HIV-1 positive patient of Smith et al. This apparent success adds carbamazepine to the armamentarium against Reiter’s syndrome 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 JERAJANI
Department of Dermatology, LTM Medical College and LTM General Hospital, Sion, Mumbai - 400066, India

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

madhunil@hotmail.com


Accepted for publication 20 March 2000

Condoms and warts

Editor,—Wen et al 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 (SSHIC) 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 SSHIC [in 1997].” However, many of these patients had been previously diagnosed with genital warts elsewhere while others had recurrent lesions. In Australia, most genital warts are managed by general practitioners. 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 the study subjects.

The SSHIC database does document whether a person has previously been diagnosed with HPV infection. To me, the study would have had more validity if patients with a past history had been excluded. The diagnostic grouping for warts at SSHIC does not distinguish between genital and anal lesions. The readers of the journal need to know that many of these male “genital wart” cases would have been homosexually active men with anal warts. This is important as risk factors for penile and anal warts may differ, potentially confusing the results of the present study.

Finally, the referent group in the table describing condom use deemed as “Not applicable, no sex” should have been more accurately described as “No vaginal or anal sex in the previous 3 months.” Many of these people would have practised oral sex or other sexual acts during those 3 months. Others may have ceased practising vaginal or anal intercourse up to 3 months earlier because of their persistent or recurrent warts.

Large relational quality assured clinical databases can be powerful tools for health service evaluation, surveillance, and the generation of research questions. It may be prudent for researchers to engage the people responsible for designing and maintaining those databases to minimise errors of interpretation.

LINDA DAYAN
Sydney Sexual Health Centre and Sexual Health Services, Northern Sydney Health, Sydney, Australia
LDayan@doh.health.nsw.gov.au


Accepted for publication 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...
of prevalent and recurrent cases as well inci-
dent cases. However, our concern with this pos-
able bias at the outset of the study led us to ex-
clude all patients with a history of previ-
ous genital warts. This included those previ-
ously diagnosed at SSHC, and those who gave a history of having their warts managed 
elsewhere. Consequently, when we state a 
new diagnosis of genital warts, this is 
precisely what we mean.

With regard to the conduct of the study, 
this was performed with the assistance of the 
current data manager responsible for the 
SSHC data base, whose help and assistance 
were duly acknowledged.

ADRIAN MINDEL 
12 MINDEL 
CLAUDIA E. ESTCOURT 
Academic Unit of Sexual Health Medicine, 
Sydney Hospital, GPO Box 1614, 
Sydney NSW 2001, Australia

JUDY M SIMPSON 
Department of Public Health and 
Community Medicine, University of Sydney NSW 2006, Australia

Photosensitivity reaction to efavirenz

EDITOR,—The non-nucleoside reverse tran-
scriptase inhibitor (NNRTI) efavirenz is a re-
cent addition to the armamentarium avail-
able to physicians in the treatment of HIV 
infection. However, at present the known side 
effects 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 efavirenz 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 
forth 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 pre-
scribed antihistamines and asked to continue 
with his medication. One week later the rash 
had subsided. Then having spent a day 
outside in the sun he had a florid recurrence 
of a rash affecting exposed areas (arms, back 
of neck, face, and ears). The rash was signifi-
cantly worse over his elbows where there was 
obvious blistersing and oedema. His medi-
cation was stopped and 3 weeks later the rash 
completely resolved. Hepatitis C anti-
bodg and porphyria screening were negative. 
This man had been diagnosed as HIV 
positive in June 1997. In March 1998 his viral load was 356 790 copies/ml 
(Roche PCR) and his CD 4 count was 512 
(0.4% CD 4 count) at the time of his viral 
load test. This was treated with lamivudine 
and stavudine. His viral load dropped to 
39 copies/ml in February 1999 and his CD 4 
count was 512 copies/ml. 

A 25 year old white homosexual man was 
commenced on combivir (zidovudine/ 
lamivudine) and efavirenz 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 
forth 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 pre-
scribed antihistamines and asked to continue 
with his medication. One week later the rash 
had subsided. Then having spent a day 
outside in the sun he had a florid recurrence 
of a rash affecting exposed areas (arms, back 
of neck, face, and ears). The rash was signifi-
cantly worse over his elbows where there was 
obvious blistersing and oedema. His medi-
cation was stopped and 3 weeks later the rash 
completely resolved. Hepatitis C anti-
bodg and porphyria screening were negative. 
This man had been diagnosed as HIV 
positive in June 1997. In March 1998 his viral load was 356 790 copies/ml 
(Roche PCR) and his CD 4 count was 512 
(0.4% CD 4 count) at the time of his viral 
load test. This was treated with lamivudine 
and stavudine. His viral load dropped to 
39 copies/ml in February 1999 and his CD 4 
count was 512 copies/ml.

HIV associated cytomegalovirus retinitis in Melbourne, Australia

EDITOR,—We report the results of a 12 year 
review of human immunodeficiency virus (HIV) 
associated cytomegalovirus (CMV) retinitis in Melbourne, Australia.

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 
identify factors at diagnosis of CMV retinitis 
which were predictive of outcome. Both hos-
pitals had the same protocol for the treatment 
of CMV retinitis and employed 3 monthly 
ophthalmological screening of all HIV in-
fected patients with CD4 counts of less than 
50 ×10⁹/l.

The study outcomes were visual loss and 
death. Moderate visual loss was defined as 
visual acuity of less than 6/12 in the better 
eye, and severe visual loss as visual acuity of 
less than 6/60 in the better eye (this is legal 
blindness in Australia).

CMV retinitis was diagnosed in 212 of 
1281 patients (16.5%) with AIDS over the 
study period. As of June 1998, 193 (93%) 
had died, at a median time of 36 weeks 
(range 192) from CMV diagnosis. Seventy four 
patients (35%) developed moderate visual 
loss at a median time of 23 weeks (range 
0–163) and 30 patients (14%) developed 
severe visual loss at a median time of 35 
weeks (range 0–120) from diagnosis of CMV retinitis.

The 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 
1.4–2.2). 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 at 
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 associ-
ated 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 oppor-
tunistic infections. Prolonged survival times 
with CMV retinitis have been demonstrated 
in patients who achieve immunological recov-
er 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 rem-
ains important in managing patients who are 
failure 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 
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 pro-
spective evaluation is needed to confirm this 
finding.

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 rem-
ains important in managing patients who are 
failure therapy.

C L CHERRY 
A M MIJCH 
M BRYANT 
M HELLARD 
C K FAIRLEY 
A J H HALL 
The Alfred Hospital, Victoria, Australia

The Alfred Hospital, Victoria, Australia 
The Alfred Hospital, Victoria, Australia 
The Alfred Hospital, Victoria, Australia 
The Alfred Hospital, Victoria, Australia 
The Alfred Hospital, Victoria, Australia

retinitis in HIV infected patients receiving a protease 
inhibitor therapy. Spanish CMV-AIDS 

2 Doan S, Cochereau I, Guvenisi KN, et al. 
Cytomegalovirus retinitis in HIV-infected patients with and without 
an antiretroviral therapy. Am J Ophthalmol 1999;128: 
250–1.

Accepted for publication 20 April 2000
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 and gonococcal non-chlamydial urethritis (NGU), 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.2

NSU was defined as the presence of at least five polymorphonuclear leucocytes (PMNL) in five or more fields on microscopy of a urethral smear.3

Oxytetracycline 250 mg four times daily for 7 days, the commercial product used. The penicillin in beeswax was also used. It was a potent antibiotic with good local tissue penetration and was used in many cases of early syphilis—arsenic, bismuth, and mercury. It was used to treat primary and secondary syphilis and occasionally tertiary syphilis.4

Azithromycin was as effective as oxytetracycline in curing NSU, and produces fewer persistent positive two glass urine test, with ent PMNL on microscopy of a urethral smear.

The results (see table 1) demonstrate that azithromycin is as effective as oxytetracycline in curing NSU, and produces fewer persistent positive-two glass urine test, with ent PMNL on microscopy of a urethral smear. The median age of the two groups was 28 (18–63) 25 (16–54) (p<0.001).

In conclusion, although the numbers are small, it would appear that azithromycin is an effective treatment for NSU, and can be given at the time of clinical diagnosis, pending the chlamydial 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.4

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

Table 1 Diagnoses of older and younger clinic attendees

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Older clinic</th>
<th>Younger clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>STIs</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>NSU</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital warts</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>HIV</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other conditions</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Erectile dysfunction</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Balanitis</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Lichen sclerosus</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Zoon’s balanitis</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital psoriasis</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital eczematous sebaceous glands</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital skin tag</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital sebaceous cyst</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Miscellaneous (hepatin B vaccination)</td>
<td>1</td>
<td>1</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.5 In our study, a smaller percentage of older attendees had STIs compared with previous studies.6 However, the number of older patients who attended for non-STI management was comparable. The delay between symptom recognition and healthcare presentation 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 50.7 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


Many elderly people maintain heterosexual and homosexual activity. Therefore this age group is at a risk of all sexually transmitted infections.5 In our study, a smaller percentage of older attendees had STIs compared with previous studies.6 However, the number of older patients who attended for non-STI management was comparable. The delay between symptom recognition and healthcare presentation 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 50.7 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


Accepted for publication 30 April 2000

Tertiary syphilis

EDITOR,—I read Dr Reed’s letter on tertiary syphilis8 with interest.

The regimen he describes for the treatment of early syphilis—arsenic, bismuth, and round the clock aqueous penicillin, was used in our hospital from 1946–8 although daily penicillin in beewax was also used. It was unclear how much inactive penicillin K was in the commercial product used. The penicillin 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.9 Treponema pallidum remains viable in the CSF even after adequate clinical treatment.4

Letters, Book reviews, Notices, Correction, Current publications
The old adage that we achieve clinical but not microbiological cure of syphilis with antibiot-
ics is probably true.
It is likely that most people in developed
countries nowadays who have untreated
syphilis have received treponemical antibi-
otics for other intercurrent infections, so that
any neurosyphilis that developed would
either be modified with few physical signs or
would be completely treated and clinically
cured. However, others disagree with this.
To answer Dr Reid’s question, we have
haven’t seen anyone treated since the second
world war who has developed neurosyphilis
in subsequent years.

DAVID GOLDMEIER

BOOK REVIEWS

Infectious Diseases. By Donald Armstrong
and Jonathan Cohen. Pp 2000; £250 (two
0723 423288.

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 com-
prehensively 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 posi-
tive toxoplasma titre in pregnancy?” or are in
a debating style—for example, “how long
should osteomyelitis titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-
tive toxoplasma titre in pregnancy?” or are in
newborns,” “what is the treatment of a posi-


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 com-
pletely. On the cover, it says “it is an ideal ref-
erence for doctors, nurses, patients and all
those not involved in the area of sexual
health,” and Professor Adler adds in the fore-
word 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 soci-
ety about sexual matters, this is not surpris-
ing.

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 with confidence, without
embarrassment and have some idea of likely
strategies of management.

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

NOTICES

International Herpes Alliance and Inter-
national Herpes Management Forum
The International Herpes Alliance has intro-
duced a website (www.herpesalliance.org)
from which can be downloaded patient infor-
mation 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 Inter-
national Congress on Infectious Disease
(ICID) in Buenos Aires.

Pan-American Health Organization, re-
gional office of the World Health Organiza-
tion
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: pubahc@usp.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 Char-
lotte’s and Chelsea Hospital, Goldhawk Road,
London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: symprog@ac.uk).

Australasian Sexual Health Conference,
Ven Troppo, Carlton Hotel, Darwin,
Northern Territory, 21–24 June 2000
Further details: Shirley Corley, Conference
manager, Dart Associates, PO Box 781, Lane
Cove, 2066 NSW, Australia (tel: 02 9418 9396/9397; fax: 02 9418 9398; email:
dartcov@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 Char-
lotte’s and Chelsea Hospital, Goldhawk Road,
London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: symprog@ac.uk).
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 9286 6796; fax: 023 9286 6769).

Further details: Rebecca Mitchell (tel: 023 9286 6796; fax: 023 9286 6769).

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, Linneegatan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 661 91 25; email: aids2000@congrex.se).


Ethical Issues in International Health Research, Durban, South Africa, 16–21 July 2000 (immediately following XIII International AIDS Conference)

Further details: Marie-Christine Ryckaert, Program director, Ethical Issues in International Health Research, Harvard University, John F Kennedy School of Government, Cambridge, MA 02138, USA (tel: (617) 496-0484 ex 7474; fax: (617) 495-3090; email: Marie-Christine.Ryckaert@harvard.edu).


Further details: PACIFICO, SA, E Granados, 44, 08008 Barcelona, Spain (tel: +34.93.454.46.00; fax: +34.93.451.74.38; email: gp@pacifico-meetings.com).

MSSVD Clinical Developments Fund

The MSSVD Clinical Developments Fund is asking for applications for funding to support projects that advance the understanding and practice of genitourinary medicine. An amount of £10 000 is available to one or more successful applicant(s). Closing date for application is 25 August 2000. Further details: Dr Keith Radcliffe, Honorary Assistant Secretary MSSVD, Whitall Street Clinic, Whitall Street, Birmingham B4 6DH (tel: 0121 237 5719; fax: 0121 237 5729; email: keith.radcliffe@bscht.wmids.nhs.uk).

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, 76–76, Riga, LV-1013, Latvia (tel: +(371) 7370395; fax: +(371) 7361615; email: arubins@apollo.lv).

National NCCG Update Meeting, Bromsgrove Stakis Hotel, 23–24 September 2000

Further details: Kathy Taylor (tel: 01384 235207; email: palmtraining@tesco.net).
CURRENT PUBLICATIONS

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
Human papillomavirus infection
Herpes
Hepatitis
Trichomoniasis
Gonorrhoea
published worldwide are arranged in the following sections:

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.
IMC MARTIN, CA ISON. Lancet 2000;355:623

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.

EL CIEMINS, CK KENT, J FLOOD, JD KLAUSNER. Sex Transm Dis 2000;27:165–7

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 CT/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.

Candidiasis

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

Evaluation of the Oricul-N dipslide for laboratory diagnosis of vaginal candidiasis. 
P CARLSON, M RICHADTSON, J PAWONEN. J Clin Microbiol 2000;38:1063–76

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.
B NIEVES. Anaerobe 1999;5:343–6

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

Pre-term labor associated with bacterial vaginosis.
H CALDERAS, B NIEVES, 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 treponematoses

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.


Herpes

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 lipopeptides induce CCR5 on human monocytes and enhance their susceptibility to infection by human immunodeficiency virus type 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.


Herpes simplex virus DNA in amniotic fluid without neonatal infection.


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 type 2 infection of the uterine cervix—relationship with a cervical factor?


The herpesviruses 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, Y Li, KC Yeh, DM Knipe. *Virology* 2000;267:326–34
Human papillomavirus infection

Gynecological infections as risk determinants of subsequent cervical neoplasia.

Papillomavirus detection: demographic and behavioral characteristics influencing the identification of cervical disease.

Evaluation of a human papillomavirus assay in cervical screening in Zimbabwe.

Determinants of low-risk and high-risk cervical human papillomavirus infections in Montreal university students.
H Richardson, E Franco, J Pintos et al. Sex Transm Dis 2000;27:79–86

Population-based study of human papillomavirus infection and cervical neoplasia in rural Costa Rica.

Epidemiological aspects of human papillomavirus infection and cervical cancer in Brazil.

Human papillomavirus-associated carcinomas in Hawaii and the mainland US.


A novel and rapid PCR-based method for genotyping human papillomaviruses in clinical samples.

Seroreponses to human papillomavirus types 16, 18, 31, 33 and 45 virus-like particles in South African women with cervical cancer and cervical intraepithelial neoplasia.

Seroreponses to virus-like particles of human papillomavirus types 16, 18, 31, 33 and 45 in San people of southern Africa.

Type specificity and significance of different isotopes of serum antibodies to human papillomavirus capsids.

Specific serum IgG, IgM and IgA antibodies to human papillomavirus types 6, 11, 16, 18 and 31 virus-like particles in human immunodeficiency virus-seropositive women.

HPV16 E6 oncoregents in women with cervical intraepithelial neoplasia.

Human papillomavirus types 16 E6 and E7 contribute differently to carcinogenesis.
S Song, A Liem, JA Miller, PF Lambert. Virology 2000;267:141–50

The effects of interferon on the expression of human papillomavirus oncoproteins.

Human papillomaviruses and DNA ploidy in anal condylomata acuminata.
S RiHet, P Bellach, M Lowenzato et al. Histopathol 2000;15:79–84

HPV11 mutant virus-like particles elicit immune responses that neutralize virus and delineate a novel neutralizing domain.


Telomerase, p53 and human papillomavirus infection in the uterine cervix.


The human papillomavirus type 16 E5 protein modulates ERK1/2 and p38 MAP kinase activation by an EGFR-independent process in stressed human keratinocytes.

Footnotes

A role 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.
GC Pereng, C Jones, JC 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.

Effect of route of vaccination with vaccinia virus expressing HSV-2 glycoprotein D on protection from genital HSV-2 infection.

DNA immunization utilizing a herpes simplex virus type-2 myogenic DNA vaccine protects mice from mortality and prevents genital herpes.

Evidence for a bidirectional element located downstream from the herpes simplex virus type-1 latency-associated promoter that increases its activity during latency.

Human papillomavirus infection

Smoking, diet, pregnancy and oral contraceptive use as risk factors for cervical intra-epithelial neoplasia in relation to human papillomavirus infection.
Nuclear matrix attachment regions of human papillomavirus type 16 repress or activate the E6 promoter, depending on the physical state of the viral DNA.


Repression of the integrated papillomavirus E6/E7 promoter is required for growth suppression of cervical cancer cells.


Recombinant adeno-associated virus expressing human papillomavirus type 16 E7 peptide DNA fused with heat shock protein DNA as a potential vaccine for cervical cancer.


Adeno-associated virus major Rep78 protein disrupts binding of TATA-binding protein to the P97 promoter of human papillomavirus type 16.


Correlation of TGβ1 overexpression with down-regulation of proliferation-inducing molecules in HPV-11 transformed human tissue xenografts.


Human papillomavirus E7 proteins stimulate proliferation independently of their ability to associate with retinoblastoma protein.


The hinge of the human papillomavirus type 11 E2 protein contains major determinants for nuclear localization and nuclear matrix association.


The E7 oncogene of human papillomavirus type 16 interacts with F-actin in vitro and in vivo.


The human papillomavirus type 11 E1E4 protein is phosphorylated in genital epithelium.


Cervical cytology and colposcopy

Is it feasible for women to perform their own Pap smears? A research question in progress.


Human papillomavirus testing for triage of women with cytologic evidence of low-grade squamous intraepithelial lesions: baseline data from a randomized trial.


Revisiting age effect of the Pap test on cervical cancer.


MK Kog, ME Boon, RH SchreinerRok, LG Koss. Hum Pathol 2000;31:23–8

Comparison of immediate and deferred colposcopy in a cervical screening program.


Quality control of cervical cytology in high-risk women: PAPNET system compared with manual rescreening.


Incidence of cervical squamous intraepithelial lesions in HIV-infected women.

TV Ellebroek, MA Chasson, TJ Bush et al. JAMA 2000;283:1031–7

Vaginal intraepithelial neoplasia and the Pap smear.


Effects of tamoxifen on cervicovaginal smears from patients with breast cancer.


A comparison of the side effects of prilocaine with felypressin and lignocaine with adrenaline in large loop excision of the transformation zone of the cervix: results of a randomized trial.


Completeness of excision and follow cytology in patients treated with loop excision biopsy.


Expression of MNCA9 protein in Pan-panicolaou smears containing atypical glandular cells of undetermined significance is a diagnostic biomarker of cervical dysplasia and neoplasia.


Other sexually transmitted infections

Scabies and pediculosis.


Risk factors for human herpesvirus 8 seropositivity and seroconversion in a cohort of homosexual men.


Invited commentary: Determining specific sexual practices associated with human herpesvirus 8 transmission.


Dukers et al respond to “Sexual practices associated with HH8V infection”.


Antibodies to human herpes virus type 8 (HHV8) in general population and in individuals at risk for sexually transmitted diseases in Western Sicily.


Prevalence and risk factors for human herpesvirus 8 infection in northern Cameroon.

A Reza, O Tchamgona, M Andreoni et al. Sex Transm Dis 2000;27:168–74

Localization of Haemophilus ducreyi at the pustular stage of disease in the human model of infection.


Public health and social aspects

Evidence of declining STD prevalence in a South African mining community following a core-group intervention.

STD prevention: effectively reaching the core and a bridge population with a four-component intervention.
CJ VANDAM, KK HOLMES. Sex Transm Dis 2000;27:9–11

A pragmatic intervention to promote condom use by female sex workers in Thailand.
N FORD, S KOETSAWANG. Bull WHO 1999;77:888–94

Factors associated with condom use for oral sex among female brothel-based sex workers in Singapore.
ML WONG, BKEW CHAN, D KOH, S WEE. Sex Transm Dis 2000;27:39–45

Effectiveness of an intervention promoting the female condom to patients at sexually transmitted disease clinics.

Comparisons of sexual behaviors, unprotected sex and substance use between two independent cohorts of gay and bisexual men.
KJP CRAB, AC WEBER, PPA CORNELISSE et al. AIDS 2000;14:303–12

High prevalence of asymptomatic STDs in incarcerated minority male youth—a case for screening.
RP PACK, RJ DOLEMENTE, IW HOOK, MK OH. Sex Transm Dis 2000;27:175–7

Microbiology and immunology

Effects of contraceptive method on the vaginal microbial flora: a prospective evaluation.

Intravaginal practices, vaginal flora disturbances and acquisition of sexually transmitted diseases in Zimbabwean women.

Effect of chlorhexidine on genital microflora, Neisseria gonorrhoeae and Trichomonas vaginalis in vitro.
LR RARE, SL HILLIER. Sex Transm Dis 2000;27:74–8

Molecular epidemiologic approaches to urinary tract infection gene discovery in uropathogenic Escherichia coli.

Dermatology

Circumcision and genital dermatoses.

Vulvar intraepithelial neoplasia of the simplex (differentiated type): a clinicopathologic study including analysis of HPV and p53 expression.

Vulvovaginal soft tissue tumours: update and review.
MR NUCCI, CDM FLETCHER. Histopathol 2000;36:97–108

Protocol for the examination of specimens from patients with carcinomas and malignant melanomas of the vulva: a basis for checklists.
EJ WELKINSON. Arch Pathol Lab Med 2000;124:51–6

Mucoepidermoid carcinoma arising in the glans penis.

Penile Kaposi's sarcoma preceded by chronic penile lymphoedema.

Pathergy reaction in Behçet's disease: lack of correlation with mucocutaneous manifestations and systemic disease expression.
IJ KRAUSE, Y MOLAD, M MITRANI, A WEINBERGER. Clin Exp Rheumatol 2000;18:71–4

Case report: Artificial nodules of the penis—case report of an Indonesian man.

An unusual case of a metastatic lesion to the penis.
SS RAZI, JR GOTTINGER, RL GARCIA, KW LUI. Urol 2000;163:908–9

Miscellaneous

Vaccines against sexually transmitted infections: promise and problems of the magic bullets for prevention and control.
GD ZIMET, KM MANN, JD FORTENBERRY. Sex Transm Dis 2000;27:49–52

Is there a case for school-based screening for sexually transmitted diseases?
D HICKS. Lancet 2000;355:864

EL CHERINS, CK KENT, J Flood, J KLAUSNER. Sex Transm Dis 2000;27:154–8

Epidemiologic trends of sexually transmitted diseases in China.
KX CHEN, XD GONG, GJ KIANG, GZ ZHANG. Sex Transm Dis 2000;27:138–42

Editorial—sexually transmitted diseases in the People's Republic of China in 2K.
MS COHEN, G OING, K FOX, GE HENDERSON. Sex Transm Dis 2000;27:143–5

Preventative intervention to reduce sexually transmitted infections: a field trial in the Royal Thai Army.

Etiology of sexually transmitted infections among street-based female sex workers in Dhaka, Bangladesh.

Prevalence of serum antibodies against bloodborne and sexually transmitted agents in selected groups in Somalia.
YA NUR, J GROEN, AM ELMI et al. Epidemiol Infect 2000;124:137–42

Recurrent urinary tract infections in postmenopausal women.

Women's sexual health after childbirth.

New policy on circumcision—cause for concern.

Acceptability of formulations and application methods for vaginal microbicides among drug-involved women—results of product trials in three cities.

Implications of asymptomatic endocervical leukocytosis in infertility.
MC OGU, CS ME. Gynecol Obstet Invest 2000;49:124–6
Interleukin 1 receptor antagonist gene polymorphism in women with vulvar vestibulitis.

Sexual behaviour, STDs and risks for prostate cancer.

Incidence of erectile dysfunction in men 40 to 69 years old: longitudinal results from the Massachusetts male aging study.

Recurrent epididymo-orchitis in patients with Behçet's disease.

Hypertrophy of labia minora: experience with 163 reductions.

Would women trust their partners to use a male pill?
Melbourne, Australia

HIV associated cytomegalovirus retinitis in
C L Cherry, A M Mijch, J F Hoy, A J H Hall, M E Hellard, M Bryant, B
DeGraaff and C K Fairley

Sex Transm Infect 2000 76: 221
doi: 10.1136/sti.76.3.221-a