LETTERS TO THE EDITOR

Carbamazepine in Reiter’s syndrome

Editor,—A psoriatic spectrum with Reiter’s syndrome as the most severe manifestation occurs with greater frequency in HIV infected individuals. Immunosuppressive therapies for RS are associated with poor response and increased morbidity.¹ We describe a case where carbamazepine showed an excellent response in an HIV infected patient with Reiter’s syndrome.

A 30 year old married man presented with erythematous papules and plaques of 2 months’ duration covered with hard limpet-like scales on face, body, and both extremities (fig 1). Palms and soles showed keratoderma blennorrhagicum and subungual hyperkeratosis with distal onycholysis. Both knees and wrists had painful swelling with restriction of movements. With this clinical 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 Ranbaxy Limited). The absolute helper T lymphocyte count was 435 cells x10^3/l. Human leucocyte antigen B27 and rheumatoid factor were negative. The patient was commenced on prednisolone by mouth 60 mg daily and indomethacin by mouth 25 mg twice daily with no relief of joint pain and swelling and joint pain and swelling and new lesions developed in the same dose. Drugs were reintroduced in the same dose. Erythema cleared again within 7 days followed by scaling and joint swelling and pain. New lesions stopped appearing.

In seeking an effective treatment, we serendipitously came across the efficacy of carbamazepine in an HIV infected patient with psoriatic erythroderma.² We started carbamazepine 200 mg daily in two divided doses in addition to above. The erythema cleared rapidly within 7 days. To confirm the effect of carbamazepine, it was stopped. New lesions similar to the old ones appeared within 3–4 days. Carbamazepine was then reintroduced in the same dose. Erythema cleared again within 7 days followed by scaling and joint swelling and pain. New lesions stopped appearing. Prednisolone was then tapered off rapidly and analgesics were stopped. Carbamazepine was continued in the same dose for 6 months. On follow up at 1 year, the patient showed no recurrence of skin lesions and synovitis, no change in liver and renal function tests, with no further deterioration in his overall health and no opportunistic infections.

It has been proposed that in genetically predisposed people, the release of neuropeptides like substance P, calcitonin gene related peptide, vasoactive intestinal peptide, and the inflammatory leucotriene B4 from cutaneous sensory nerves causes local inflammatory responses that trigger psoriasis.³ Stimulated mast cells secrete a number of proinflamma- tory cytokines and proteases that act similarly.⁴ Carbamazepine significantly inhibits the uptake of substance P, calcitonin gene related peptide, vasoactive intestinal peptide, and blocks a cyclic AMP mediated calcium influx that is associated with neuropeptide release and control of a slow potassium current.⁵

The 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 and subsequent resolution of lesions on withdrawal and reintroduction of carbamazepine respectively proves its efficacy in our patient. Also, the clinical remission maintained for 1 year after stopping carbamazepine confirms its therapeutic role in Reiter’s syndrome. The therapeutic response seen in our patient conforms to that seen in the HIV-1 positive patient of Smith et al.⁶

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.

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

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Condoms and warts

Editor,—Wen et al⁷ 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 clarifying, 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 1998].” 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.⁸ 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 diagnosed with HPV infection. To me, the study would have had more validity if patients with a history had been included.

The diagnostic grouping for warts at SSHC 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 homosexu- ally 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.

Originally developed as an HIV risk measure, the condom use variable at SSHC only refers to the previous 3 months or since the last registration/disease episode. Wen et al’s article failed to mention that this variable was time limited. As 3 months is the median duration before the appearance of exophytic warts,⁹ up to half of the relevant sexual behaviour may have been overlooked.

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.

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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

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of prevalent and recurrent cases as well inci- 
dent cases. However, our concern with this 
possible bias at the outset of the study led us 
to include 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 
SSH data base, whose help and assistance 
were duly acknowledged.

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221 
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Photosensitivity reaction to efavirenz

EDITOR,—The non-nucleoside reverse tran-
scriptase inhibitor (NNRTI) efavirenz is a recent 
addition to the armamentarium available 
to physicians in the treatment of HIV in-
fection. 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 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 fur-
ther into his treatment he represented 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 the rash affecting his entire body, especially 
his trunk and arms, associated with enlarged 
lymph nodes and constitutional symptoms. 
fever, and lethargy. In view of the constitu-
tional symptoms it was decided to stop this 
present combination. One month later, the 
rash had settled, he then commenced combi-
vir and efavirenz.

Photosensitivity in the context of HIV has 
been reported as a presenting sign of 
underlying HIV infection in a number of 
cases.1 In addition to this porphyria cutanea 
tarda (PCT) has been reported in the context 
of HIV infection and has been associated with 
comanitant hepatic dysfunction; however, 
screening for both these conditions was nega-
tive. Switching to nevirapine to efavirenz in 
this context may have been regarded as unwise; 
however, of 19 patients who have been 
 intolerant of nevirapine secondary to the 
 development of rash, who have switched to 
efavirenz only nine have developed a mild 
to moderate rash, of which only two needed to 
discontinue therapy.1 Photosensitivity in the 
context of HIV infection may not only be 
a presenting condition but also secondary to 
comanitant treatment.

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1 Pappert A, Grossman M, DeLeo V. Photosensi-
tivity as the presenting symptom in four patients 
with human immunodeficiency viral infection. 
Arch Dermatol 1994;130:618–23.

2 Schreckenberg C, Cocker D, Petiau P, et al. Photosensitivity as presenting sign of HIV 
infection. Control with triple antiretroviral 

3 Meola T, Sanchez M, Lim HW, et al. Chronic 
actinic dermatitis associated with human 
immunodeficiency virus Br J Dermatol 1997; 

4 O’Connor WJ, Murphy GM, Darby C, et al. 
Porphyria abnormalities in acquired immuno-
deficiency syndrome Arch Dermatol 1996:132: 
1445–7.

5 DuPont Pharmaceuticals Company Research 
Laboratories. Wilmington, DE. In-house data 
1980–95.

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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-
titals 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 × 10^9/l.

The study outcomes were visual loss and 
death. Moderate visual loss was defined as a 
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 
(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 
1.4–4.2). Fifty eight of 138 patients (42%) 
were failing HIV treatment. Other factors mea-
sured during the course of CMV retinitis 
were failing HIV treatment.

5 DuPont Pharmaceuticals Company Research 
Laboratories. Wilmington, DE. In-house data 
1980–95.

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Incidence and risk factors for developing CMV 
retinitis in HIV infected patients. Antiretro-

128

virovirus. Spanish CMV-AIDS 


2 Duan S, Cochereau I, Guervin KN, et al. 
Cytomegalovirus retinitis in HIV-infected 
patients with and without highly active anti-


2 Duan S, Cochereau I, Guervin KN, et al. 
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patients with and without highly active antiret-

Azithromycin in nongonococcal urethritis

Editor,—Single dose azithromycin 1 g rather than multidose tetracyclines or erythromycin over several days for the treatment of chlamydial uropathy is currently becoming more widespread as patient acceptability and improved compliance outweigh cost considerations. However, in men, treatment is often initiated on the basis of clinical evidence of urethritis before the chlamydial result is available. Relative few studies report the efficacy of azithromycin in the treatment of nongonococcal 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.

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 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. Of all men with NSU diagnosed between 1 April 1998 and 30 September 1998 (treated with azithromycin) was compared with those diagnosed between 1 April 1997 and 30 September 1997 (treated with tetracycline).

NSU was defined as the presence of at least five polymorphonuclear leukocytes (PMNL) in five or more fields on microscopy of a urethral smear, not supportive of Neisseria gonorrhoea after direct plating onto modified New York culture medium and negative chlamydial smear on ELISA testing (Stya) of a urethral swab.

"Cure" was defined as either resolution of symptoms or clearing of previously positive two glass urine. A repeat urethral smear was not examined routinely.

"Treatment failure" was defined as persistent PMNL on microscopy of a urethral smear taken because of ongoing symptoms or persistent positive two glass urine test, with possibility of reinfection denied.

The results (see table 1) demonstrate that azithromycin is as effective as tetracycline in curing NSU, and produces fewer treatment failures, possibly owing to better compliance with single dose therapy. Compliance with multidose regimens might be expected to be less good in asymptomatic patients, but with no satisfactory “test of cure” this was difficult to ascertain. Overall, there was a 25% non-attendance rate for follow-up, biased towards the asymptomatic patients and those treated with tetracycline.

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

<table>
<thead>
<tr>
<th></th>
<th>1997</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number treated</strong></td>
<td>76</td>
<td>52</td>
</tr>
<tr>
<td><strong>Number of patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Median age (range)</strong></td>
<td>28 (18–63)</td>
<td>25 (16–54)</td>
</tr>
<tr>
<td><strong>No with symptoms (%)</strong></td>
<td>35 (46)</td>
<td>25 (48)</td>
</tr>
<tr>
<td><strong>No cured (%)</strong></td>
<td>29 (38)</td>
<td>27 (52)</td>
</tr>
<tr>
<td><strong>No treatment failures (%)</strong></td>
<td>6 (8)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Outcome uncertain (%)</strong></td>
<td>41 (54)</td>
<td>25 (48)</td>
</tr>
</tbody>
</table>

Asymptomatic symptoms

<table>
<thead>
<tr>
<th></th>
<th>8/35 (23)</th>
<th>4/25 (16)</th>
</tr>
</thead>
</table>

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

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.

C Thompson
Fife Acute Hospitals NHS Trust, Victoria Hospital, Kirkcaldy, Fife, KY2 5AH

Table 1

<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>5</td>
<td>1</td>
</tr>
<tr>
<td>Late syphilis</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Genital warts</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HIV</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erectile dysfunction</td>
<td>15</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 eczep 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. In our study, a smaller percentage of older attendees had STIs compared with previous studies.

However, the number of older patients who attended for non-STI management is 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. This finding was seen in our study as well.

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Accepted for publication 1 April 2000

Sexually transmitted infections in elderly people

Editor,—Jaleel et al recently presented the incidence of sexually transmitted infections and other conditions among elderly people attending a genitourinary medicine clinic.

We, in our genitourinary medicine department at Royal Berkshire Hospital, Reading, studied the reasons for attendance of elderly people and compared them with the younger age group. Data were collected from patients aged 60 and above who attended the clinic between January 1998 and December 1998. Randomly selected sex matched people aged 20–35 years are taken for comparison.

A total of 68 elderly people attended compared. The mean age was 66.5 years (range 60–83); 61 (90%) were male and seven (10%) were female. Forty one (60%) attended for STI screening and 27 (40%) attended for non-STI management.

In the younger age group 60 (98%) attended for STI screening and eight (12%) attended for non-STI management. Sixteen (24%) older attendees had an STI compared with 35 (51%) in the younger age group (see table 1). Of the 16 older attendees, 11 (68%) waited over 2 weeks between symptom recognition and clinic attendance. Of 31 symptomatic attendees in the younger age group 10 (32%) waited over 2 weeks for symptom recognition and clinic attendance (p<0.001).

Table 1

<table>
<thead>
<tr>
<th>Diagnosis of older and younger clinic attendees</th>
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<tbody>
<tr>
<td><strong>Older clinic</strong></td>
</tr>
<tr>
<td>STIs</td>
</tr>
<tr>
<td>NSU</td>
</tr>
<tr>
<td>Late syphilis</td>
</tr>
<tr>
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Many elderly people maintain heterosexual and homosexual activity. Therefore this age group is at a risk of all sexually transmitted infections. In our study, a smaller percentage of older attendees had STIs compared with previous studies.

However, the number of older patients who attended for non-STI management is 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. This finding was seen in our study as well.

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Accepted for publication 1 April 2000

Tertiary syphilis

Editor,—I read Dr Reed’s letter on tertiary syphilis with interest.

The regimen he describes for the treatment of early syphilis—arsenic, bismuth, and rouleau—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 given here was higher than that used in Lincoln (40 000–75 000 units 3–4 hourly).

There were 10 treatment failures (reinfections) out of 275 patients described.

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

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The old adage that we achieve clinical but not microbiological cure of syphilis with antibiotics is probably true.

It is likely that most people in developed countries nowadays who have untreated syphilis have received treponemal antibiotic 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. But, to answer Dr Reed’s question, we haven’t seen anyone treated since the second world war who has developed neurosyphilis in subsequent years.

DAVID GOLDMEIER

BOOK REVIEWS


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 science to 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 the date the book is. They must have been chased hard to get their contribution 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 unlikely that any of the useful tables have not been made 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 be one being designed 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 book 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 book 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 book 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 book 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 book and now they are all neatly packed together in this ABC”.

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 with confidence.

I had ended.

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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. IHRMF.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 Health Organization, regional office of the World Health Organization

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@tsp.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: 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; 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: sympreg@ac.uk).
Further details: Rebecca Mitchell (tel: 023 9286 6796; fax: 023 9286 6796).

6th ESC Congress on Contraception in the Third Millennium: a (R)Evolution in Reproductive and Sexual Health, Ljubljana, Slovenia, 28 June–1 July 2000
Further details: Organ-Med Congress Office, Mr Peter Erard, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.uunet.be).

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 OXG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, New Horizons in Recurrent Pregnancy Loss, 29 June–1 July 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 OXG (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, Linnegatan 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 93.454.54.00; 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 Dermatovenerology, 7–9 September 2000, Riga, Latvia
Further details: Professor Andris Y Rubins, Department of Dermatovenerology, 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 Stanis Hotel, 23–24 September 2000
Further details: Kathy Taylor (tel: 01384 235207; email: palmtraining@tesco.net).

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) 7455330; fax: +91 (0172) 744401/745078; email: kumarbhushan@hotmail.com).

Consortium of Thai Training Institutes for STDs and AIDS—10th STDs/AIDS diploma course, Bangkok Hospital, Bangkok (30 Oct–12 Nov) and Prince of Songkla University, Hat Yai, Thailand (13–23 Nov) 30 October–23 November 2000
Further details: Dr Hat Yai Secretariat, Dr Ve- rapol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cvverapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bang- kok 10120, Thailand (fax: (66-2) 286 3013; email: pthanit@email.ksc.net).

Consortium of Thai Training Institutes for STDs and AIDS—International Re- union and Refresher Course on Sexual Health, Lee Garden Plaza Hotel, Hat Yai, Thailand 24–26 November 2000
Further details: Dr Hat Yai Secretariat, Dr Ve- rapol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cvverapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bang- kok 10120, Thailand (fax: (66-2) 286 3013; email: pthanit@email.ksc.net).

CORRECTION
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
 Gonorrhoea
 Pelvic inflammatory disease

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

Urine screening for gonococcal and chlamydial infections at community-based organizations in a high-morbidity area.
CA JONES, RC KAUSA, 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.
DL TREES, Y FAKILE, SW NEAL, JS KNAPP. Sex Transm Dis 2000; 27:46–8

GM LJJ, 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.

E INTIMINS, 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.
IW DICKER, DJ MOUSRE, WC LEVINES, CM BLACK, SM BERNAN. J Epidemiol 2000; 151:430–5

Detection of Chlamydia trachomatis in pregnant women by the Papanicolau 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.

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 Orlicut-N dipslide for laboratory diagnosis of vaginal candidiasis.
P CARLSON, M RICHATDSON, J PAVONEN. 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 Kinbrough, R Lewishard 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 lipopeptides 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.


‘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.


Hepatitis

Hepatitis simplex virus 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.


Hepatitis 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.


Hepatitis simplex virus DNA in amniotic fluid without neonatal infection.


Hepatitis 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.

R 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.

Herpes simplex virus type-1 and -2 pathogenesis is restricted by the epidermal basal 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 neuros.

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

Limited antibody-dependent cellular cytopotoxicity 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.

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 papilloma-virus 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 isoforms 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 oncogene variants 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 onco-genes.

Human papillomaviruses and DNA ploidy in anal condylomata acuminata.
SRHiet, P Belliaich, 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.

Human papillomavirus infection

Smoking, diet, pregnancy and oral contraceptives 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 TGβI 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 ElIE4 protein is phosphorylated in genital epithelium.

JT Bryan, A Han, KH Fife, DB Brown. Virology 2000;268:430–9

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.


MR Kok, ME Boon, RH SchreinerKoss, 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 Ellebrekke, 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 prolocaine 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-ncicoloua 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 HHV8 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.

G Rezza, OB Tchangomena, 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, RKF 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 CRABB, AC WEBER, P OA CORNELISSE et al. AIDS 2000;14:303–12

High prevalence of asymptomatic STDs in incarcerated minority male youth—a case for screening.

RP PACE, BJ DUCLEMENTE, FW HOOK, MK OH. Sex Transm Dis 2000;27:175–7

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.

BJ WILKINSON. Arch Pathol Lab Med 2000;124:51–6

Mucopidermoid 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.


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


An unusual case of a metastatic lesion to the penis.

SS RAZZ, EE GOTTENGER, RL GARCIA, KW LUI. J Urol 2000;163:908–9

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.


Vaccines against sexually transmitted infections: promise and problems of the magic bullets for prevention and control.

GD ZIMMET, RM MAYS, JD PORTENBERY. Sex Transm Dis 2000;27:49–52

Miscellaneous

Is there a case for school-based screening for sexually transmitted diseases?

D HICKS. Lancet 2000;355:864


EL CHEN, CR KENT, J FLOOD, JD KLAUSNER. Sex Transm Dis 2000;27:154–8

Epidemiologic trends of sexually transmitted diseases in China.

XX CHEN, XD GONG, GJ KANG, GC 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.

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?
Sexually transmitted infections in elderly people

Nelson David, Sasikala Rajamanoharan and Alan Tang

Sex Transm Infect 2000 76: 222
doi: 10.1136/sti.76.3.222

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