Lympnatic filariasis—lest we forget

Editor,—Lymphatic filariasis is characterised by a wide range of clinical manifestations. In a non-endemic area the diagnosis may be missed unless the index of suspicion is high.

An 18 year old sexually active male presented with a progressively increasing painless nodular swelling in the right inguinal region of 4 months’ duration. The patient had an unprotected vaginal contact 3 weeks earlier. There was no history of genital ulcer or lymphatic filariasis. The general health of the patient was preserved. Examination revealed an enlarged right inguinal and external iliac lymph nodes, 1–3 cm in size, firm, mobile, non-tender, and matted with normal overlying skin. Examination of genital, anal, and buccal mucosae was normal. There was no other lymphadenopathy. A differential diagnosis of lymphogranuloma venereum (LGV) and tubercular lymphadenitis was considered. Complete blood count revealed mild leucocytosis and eosinophilia. Renal and hepatic functions, urinalysis, and chest x ray were normal. Mantoux test and VDRL were negative. A complement fixation test for chlamydia group specific antibody was negative. Fine needle aspiration cytology from the nodes revealed reactive hyperplasia with occasional giant cells and microfilare of *Wuchereria bancrofti*. Nocturnal blood samples for microfilare were negative.

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

The differential diagnosis of inguinal lymphadenopathy in a sexually active male includes syphilis, genital herpes, chancroid, LGV, pyogenic adenitis, tuberculosis, and lymphoma.1 In the present case a diagnosis of LGV was considered in view of a history of sexual contact, painless and non-suppurative lymphadenopathy not apparently preceded by a genital ulcer.

Demonstration of microfilare was decisive in clinching the diagnosis of filariasis which was not considered in the differential diagnosis. Presentation with inguinal lymphadenopathy is a feature common to both LGV and filariasis. The most frequent manifestation of secondary stage of LGV in men is unilateral inguinal lymphadenopathy which does not suppurate in two thirds of cases.1 Iliac lymphadenopathy often develops in LGV as was observed in our patient.2 Painful enlargement of inguinal lymph nodes with fever is the usual presentation in lymphatic filariasis. Lymphangitis can accompany recurrent attacks. Other complications include orchitis, funiculitis, and epididymitis.2,3 These were, however, absent in our patient. It is suggested that lymphatic filariasis should be considered in differential diagnosis of inguinal lymphadenopathy even in areas which are not known to be endemic for it. It is otherwise likely to be missed.

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Accepted for publication 15 May 2000

Canary to sparrow; what is in a name?

Editor,—The Contagious Diseases Act of 1864 allowed for the compulsory arrest, examination, and treatment of women considered (by an all male board) to be of loose morals. Women were detained in the so-called “Canary wards” and their identity made clear by the bright yellow garments they were made to wear.

In the year 2000, there is still perceived stigma and blame associated with the diagnosis of sexually transmitted infections (STIs) and this must be minimised if a screening programme for chlamydia is to be successful. It will help reduce stigma if people know and accept that it is not a disease of a few readily identifiable people that is common and easy to acquire. It has been estimated that in 14 young people will acquire it at some time. In the NHS chlamydia pilot screening programme in Wirral and Portsmouth we are confirming that this infection is indeed endemic. Information material for the pilot study clearly states that it is a very common infection. To reduce the element of blame, we have included teaching of safe sex home setting and have introduced instead of sexually transmitted infections (STIs) the term “sexually shared infection.”

We hope that by measures such as these, young people will avoid stigmatisation as “canaries.”

We do not, however, suggest that you change the name of your journal again!

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Accepted for publication 7 June 2000

Acceptability of home screening for chlamydial infection: some remaining issues

Editor,—In the recent article by Stephenson et al1 the authors describe participation rates of 39% for women and 46% for men for home screening and comment that this might form a useful component of a community based chlamydial screening programme in which non-responders could be offered opportunistic screening at the general practice.2 However, certain crucial issues remain unanswered. The acceptability survey was done among women aged 18–25 years and men 18–30 years. What happens with people below the age of 18? We know that *Chlamydia trachomatis* prevalence is associated with young age, but can we also send home screening kits to 15 year olds? What about the para-social opinions and local emotions—for example, for the partner of a *C trachomatis* positive youngster?

In two surveys performed in general practice in Amsterdam, Netherland, a systematic and opportunistic screening, prevalence was strongly associated with young age but also with ethnicity. Among young Surinam-Antillian women aged <25 years, prevalences ranged from 5% to 15% in the opportunistic survey up to 22.4% in the opportunistic survey.3,4 In the systematic survey an unexpectedly high *C trachomatis* prevalence of 10% was found among young Surinam-Antillian men. Among the 15–19 year olds screening our health centre in Amsterdam which is located in a multicultural neighbourhood, half of the population having a Surinam-Antillian background, *C trachomatis* prevalence was 25%.5

Thus, the question is not whether a good acceptable home screening is for the youngest age group, who might be most at risk, but also how acceptable home testing is for people with different ethnic backgrounds and people living in low socioeconomic status and high risk environments.

We piloted a pharmacy assisted approach offering urine home testing to all sexually active women aged 15–30 years who came to our pharmacy to collect their contraceptives. Since the start 4 months ago 189 people received an information leaflet and home test package together with their contraceptives. Fifty nine participated and sent their urine; four were positive (6.7%).6 The participation rate was 31%, lower than the reported rate for women in the article of Stephenson et al.

The assumption by the authors that people who do not participate for home screening will turn up for opportunistic screening at the general practice is, however, merely a hypothesis, and not a strong one, especially not for boys and men.

Tackling issues like risk perception and risk environment and changing healthcare seeking behaviours is not an easy task. Moreover, a community based *C trachomatis* prevention programme will require not only second generation prevention by active case finding but also primary prevention. What is needed is an integrated set of strategies, which are mutually reinforcing and that are age, sex, culture, and context specific. Quite a challenge!

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5 Stephenson J, Gardner C, Copas A, et al. Programme will require not only second generation prevention by active case finding but also primary prevention. What is needed is an integrated set of strategies, which are mutually reinforcing and that are age, sex, culture, and context specific. Quite a challenge!
6 J E A M VAN BERGEN
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Nurse counselling for women with abnormal cervical cytology improves colposcopy and cytology follow up attendance rates

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

Between April and December 1998 we recruited 89 women with abnormal cytology. All women attending for results are given the NHSCSP leaflet “What your abnormal result means” if their smear shows borderline changes, mild, moderate, or severe dyskaryosis. The study women completed a questionnaire before reading the leaflet. A nurse (BH) then gave a verbal explanation about the smear result. They then completed the questionnaire again. Attendance for colposcopy and cytology follow up was recorded, default being defined as non-attendance without cancellation. Default rates were compared with other women with abnormal cytology during the same period. They were not included in the study as they attended when the specified nurse was not available. They had all received the leaflet but not a structured explanation.

The explanation for each woman took approximately 15 minutes. The results of the questionnaire before and after explanation are shown in table 1. There was a significant improvement in understanding and reduction in anxiety. The control group comprised 104 women. In the study group 65 required follow up cytology; three (4.6%) defaulted, compared with seven of 38 (18.4%) women not receiving a verbal explanation; p=0.03 Fisher’s exact test; OR 0.21 (95% CI 0.03–1.03). Of the study group, 81 should have attended for follow up cytology 6 months after colposcopy or smear showing borderline changes; 12 (15%) defaulted compared with 37 of 95 (38.8%) women not receiving a verbal explanation; p=0.001 χ² test; OR 0.18 (95% CI 0.08–0.41). Eventually only one (1.5%) in the study group and two (5.3%) of the controls did not attend for colposcopy, and 11 (13.8%) and 24 (25.3%) did not follow up cytology.

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

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

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

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Table 1 The questionnaire results before and after the verbal explanation

<table>
<thead>
<tr>
<th>Question</th>
<th>Response (n=89)</th>
<th>Before</th>
<th>After</th>
<th>χ² test p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well do you understand the result you have been given?</td>
<td>Not at all</td>
<td>26</td>
<td>1</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>36</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A lot</td>
<td>27</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Are you worried about the result of your smear test?</td>
<td>Yes</td>
<td>45</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>42</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
<td>16</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Will it worry you if we need to do further investigations?</td>
<td>Yes</td>
<td>36</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>40</td>
<td>46</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>7</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Are you worried that further investigations will be painful?</td>
<td>Yes</td>
<td>55</td>
<td>28</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>11</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>23</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Do you think that any abnormality found can be treated?</td>
<td>Yes</td>
<td>61</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>25</td>
<td>4</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Do you think you have cancer?</td>
<td>Yes</td>
<td>30</td>
<td>79</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>34</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>50</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Do you think this smear result will affect your ability to have children?</td>
<td>Yes</td>
<td>15</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>34</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>40</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Do you think this result will change your attitude to sex with your partner?</td>
<td>Yes</td>
<td>18</td>
<td>13</td>
<td>0.004</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>30</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>41</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Do you think this result will affect the way your partner thinks of you?</td>
<td>Yes</td>
<td>8</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>13</td>
<td>10</td>
<td>0.36</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>68</td>
<td>75</td>
<td></td>
</tr>
</tbody>
</table>


Accepted for publication 19 June 2000

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

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

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

After screening for chlamydia, a means of contacting clients to give results was arranged—for example, letter or phone call. On the Wirral, 2651 patients were screened in the first 4 months—2323 women and 285 men (34, sex not recorded). Sixty eight (2.6%) gave a mobile phone number, half (35) using this as their only means of contact. Fifty five were female and two male (one patient not recorded). Thus, women (2.8%) were more likely to use mobile phones than men (0.7%) (p = 0.03). The genitourinary medicine (GUM) clinic screened 358 patients. Only 68 (19%) gave an address. The results of a further 469 (17.7%) of the screened population went back to the screening site. These clients could be interested in contact via mobile phone if it was openly offered (data collected from the Public Health Laboratory Service (PHLS) database and analysed on SPSS-INFO 6).

According to a survey by NOP Social and Political, confidentiality is important to people in the target age group (unpublished data). Patients consider their mobile phones to be a secure method of communication between themselves and us. The advent of DNA amplification in the detection of STIs has opened up new possibilities.5 6 There are 30 000 websites pertaining to chlamydia. An internet clinic would be aimed at mildly symptomatic or asymptomatic patients. The client would access the website and request swabs or urine pots through the post then return them the same way.

If the patients were positive, they would need to attend a GUM clinic or equivalent.
Other infections should not be overlooked. Partner notification is necessary. Contact slips could be supplied but the health adviser’s role should not be underestimated.

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

In summary, it is rising in the younger population. Their utilisation of technology is demonstrated by mobile phone use in the chlamydia pilot study. Health providers should respond using media with which the target population is comfortable. We might just access a whole generation. The future’s bright... Conflict of interest: None.

Funding of chlamydia pilot study: Department of Health.

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Gonorrhoea: an incidence graph of Mersey region data for the 1990s and discussion on the factors behind the changing pattern of incidence

Editor.—Gonorrhoea is one of the oldest and a highly infectious sexually transmitted infection. Its prevalence is dynamic and fluctuates over time and is influenced by a number of factors. The incidence of this infection has changed from a trend of steady decline to a recent increase in many parts of the world.\(^1\)\(^2\)

The pattern of incidence is closely related to socioeconomic conditions.\(^3\)\(^4\)

An incidence graph of Mersey Region figures (fig 1) for the 1990s and a discussion on the possible factors associated with the changing pattern is presented here. The incidence from the Mersey Region shows a steady decline until the mid 1990s followed by a recent increase and represents the trend in most areas. In spite of the advances in the diagnostic and therapeutic field, organised health advisory system, easy access walk-in clinics, complete confidentiality, and free treatments; the incidence of gonorrhoea is rising. From the broader analysis of the situation, it is possible to say that most of the factors behind this changing pattern are socioeconomic. The factors may include advances in contraceptives, sexual liberalisation, increase in the mobility of population, and the changing economic environment. The cumulative result of all these factors is an increase in casual relationships. Casual sex is made riskier when it is performed unprotected and without much knowledge about the partner and is possibly the main reason behind the poor contact tracing of only 0.5 out of an average of 1.5 per patient.\(^5\)

Some of these factors are part of the wider evolutionary process and are difficult issues to deal with, but preventive measures may be taken against them. In spite of the recent advances and better understanding of the disease in the recent years, there is still a lack of awareness, in the general population, of the possible mental and physical effects of such infection. The significant fall in the incidence of gonorrhoea seen in the late 1980s, secondary to extensive media coverage of HIV infection, shows how effective such campaigns can be. The present rise in the incidence of gonorrhoea in the past few years shows clearly that our prevention campaigns are not effective.

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

A programme of long term measures, such as education on sexual health and sexually transmitted infections in schools, and a programme of regular screening programme for gonorrhoea (and chlamydia) for all sexually active young females, may be useful and this can be, to start with, combined with the cervical smear screening programme at very little additional cost. Short term programmes, like vigorous media campaigns nationally and poster and leaflet campaigns locally in high risk recreational areas like pubs and clubs, may have an educational value and help reduce the incidence.

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Accepted for publication 19 June 2000

Russian STI


We hope for further collaboration. We shall inform you about our future plans.

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Alopecia and cheilitis in association with indinavir

Editor.—There is increasing speculation that indinavir may cause side effects which have been previously associated with high concentrations of retinoids. In the presence of all-trans-retinoic acid (ATRA), indinavir, but not other protease inhibitors (PIs), alters stem cell differentiation in vitro, not seen in the presence of ATRA alone.\(^6\) Alopecia and cheilitis are two side effects associated with both retinoids and the protease inhibitor indinavir (but not with any of the other protease inhibitors). These side effects can be

Figure 1 Total incidence of gonorrhoea in the Mersey Region in 1990–9 (in absolute numbers).
reversed on changing from indinavir to an alternative PI. We report a case of cheilitis associated with indinavir which resolved rapidly on changing treatment.

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

**Figure 1** (A) Shows the indinavir related cheilitis and (B) after discontinuation of indinavir.

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**BOOK REVIEW**


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

A chapter by Ted Hackstadt on the cell biology shows a whole spectrum of novel interactions with the host cell that contribute to the success of the genus as pathogens. This is followed by an excellent chapter by Julius Schachter on infection and disease epidemiology. He makes the interesting point that given that some individuals lose antibody over time it is possible that almost all humans have met the organism at sometimes in their lives. This may be quite important in understanding some of the longer term consequences of chlamydial infections, where the organism may not be isolated and antibody tests may be negative. These sequelae are covered in subsequent chapters by Michael Ward, Robert Brunum, and Roger Rank.

Since all three concentrate on immunological response to chlamydia there is bound to be some overlap, but also some differences and interesting emphasis. For example Ward plays down the current obsession with cross reactions between chlamydia and human heat shock proteins.

A lot of our information, particularly on the immunology, comes from animal studies and their relevance to human pathology remains to be established. In an excellent final chapter Penelope Hitchcock points to the future directions of research. In particular, she laments that little research has been done in men with chlamydia. Certainly the book is rather short on discussion of the male. There is also a need to find a male model for pathogenesis. Non-gonococcal urethritis maybe a suitable, and easily accessible, marker of chlamydial infection in men and deserves more in-depth study. Much more research also needs to be done, particularly, on clinically inapparent infections in the human. This book is a must for all those interested in this fascinating organism. Perhaps while not losing site of the “why” and the “how” of sexual transmission we should also divert some resources into the “how” of its damage.

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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.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American 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).

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 Stakis 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) 74401/745078; fax: +91 (0172) 74401/745078; email: kumarbhushan@hotmail.com).

www.stxtransinf.com
Podophyllotoxin in each case. Lines 3–6, podophyllin should be replaced by STI Maw which was published in the June issue.

An error occurred in the editorial by R D Maw which was published in the June issue (STI 2000;76:153). In the second column, lines 3–6, podophyllin should be replaced by podophyllotoxin in each case.

**CURRENT PUBLICATIONS**

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

**Gonorrhoea**

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

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

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


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

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

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

Multiple drug-resistant Chlamydia trachomatis associated with clinical treatment failure.
Prevalence of *Chlamydia trachomatis* in urine of male patients with ankylosing spondylitis is not increased.

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