A study on the possible association of dysfunctional uterine bleeding with bacterial vaginosis, mycoplasma, ureaplasma, and *Gardnerella vaginalis*

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Ethnicity and country of acquisition of HIV in the current Leicester genitourinary medicine clinic cohort

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Accepted for publication 14 June 2000

<table>
<thead>
<tr>
<th>Country of acquisition</th>
<th>Ethnicity</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Asian</td>
<td>African</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9%</td>
<td>31%</td>
</tr>
<tr>
<td>Asia</td>
<td>2 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Africa</td>
<td>2 (3%)</td>
<td>19 (23%)</td>
</tr>
<tr>
<td>UK</td>
<td>15 (35%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Total</td>
<td>9%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Note: *Thailand*

Table 1: Table of ethnicity in relation to country of acquisition of HIV as found in the Leicester genitourinary medicine clinic HIV cohort, and assessed in April 2000

www.sti.bmj.com
Detection of 14-3-3 brain protein in cerebrospinal fluid of HIV infected patients

Editor.—The 14-3-3 proteins are a group of highly conserved proteins involved in intracellular signalling. Loss of function of 14-3-3 brain protein has been described in cerebrospinal fluid (CSF) of patients with transmissible spongiform encephalopathies including both sporadic and variant Creutzfeld–Jakob disease.1, 2 False positive results have been reported in conditions producing (sub)acute neuronal destruction, including herpes simplex encephalitis, ischaemic stroke, multi-infarct dementia, and paraneoplastic syndromes.3, 4 We postulated that 14-3-3 brain protein may be detected in CSF from patients with HIV associated dementia complex (HADC) as this condition is characterised neuropathologically by a giant cell encephalitis, leukoencephalopathy, astroglia- sis and neuronal loss.

We prospectively studied 17 HIV antibody positive patients (14 men) aged 27–60 (median 37) years, with CD4 counts of 0–220 (median 20) cells x10⁹, who underwent lumbar puncture for investigation of HADC (six patients), staging of lymphoma (five patients), or investigation of other conditions (six patients): HBV (three patients), meningitis (two), ventricular shunting (three), and investigation of paraneoplastic syndromes.

CSF was routinely processed as described previously.5 Detection of 14-3-3 protein was done without knowledge of the patient’s diagnosis, using a technique described by Hisch et al,6 modified to use anti-14-3-3-γ polyclonal rabbit antibody. In 14 of 17 patients CSF was negative for 14-3-3 protein. Of the three with detectable 14-3-3 protein in CSF, all had lymphoma but only one had CNS disease, the other two had only extraneural disease (table 1). These data, although from a small study population, suggest that detection of 14-3-3 protein in CSF is not useful for diagnosis of HADC. Detectable 14-3-3 protein has previously been reported in a non-HIV infected patient with CNS lymphoma,7 so this observation in our patient is not unique, although brain necrosis from coexisting cerebral toxoplasmic encephalitis provides an alternative explanation. Of the two patients with extraneural lymphoma and detectable 14-3-3 protein in CSF, one had EBV DNA in CSF and so was at high risk of developing cerebral lymphoma. This possibility could not be confirmed as necropsy was not performed. In neither of the latter two patients was there a CSF pleocytosis, so contamination by peripheral blood leucocytes is unlikely. In the final case the absence of limbic encephalitis or cerebellar degeneration makes it difficult to ascribe the finding to a paraneoplastic process.

Table 1 Clinical features, results of CSF brain protein detection, and outcome in patients with lymphoma

<table>
<thead>
<tr>
<th>Patient</th>
<th>Type of lymphoma</th>
<th>No of lumbar puncture</th>
<th>Interval between lumbar puncture (weeks)</th>
<th>14-3-3 detection</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Primary CNS</td>
<td>1</td>
<td>11</td>
<td>No</td>
<td>Died 2 weeks after second lumbar puncture</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Necropsy showed also cerebral toxoplasmosis</td>
</tr>
<tr>
<td>2</td>
<td>Primary CNS</td>
<td>2</td>
<td>2</td>
<td>Yes</td>
<td>Died 2 weeks after second lumbar puncture</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Necropsy confirmed diagnosis</td>
</tr>
<tr>
<td>3</td>
<td>Primary CNS</td>
<td>2</td>
<td>3</td>
<td>No</td>
<td>Died 3 weeks later. No necropsy</td>
</tr>
<tr>
<td>4</td>
<td>Systemic, disseminated extraneural</td>
<td>1</td>
<td>NA</td>
<td>No</td>
<td>Died 6 weeks later. Cranial MR scan normal but EBV DNA detected in cell free CSF</td>
</tr>
<tr>
<td>5</td>
<td>Systemic, extra neural</td>
<td>1</td>
<td>NA</td>
<td>Yes</td>
<td>Alive. Cranial MR scan normal. Treated with local RT and HAART. No lymphoma recurrence after 39 months follow up</td>
</tr>
</tbody>
</table>

CNS = central nervous system. NA = not applicable. EBV = Epstein–Barr virus. CSF = cerebrospinal fluid. MR = magnetic resonance. RT = radiotherapy. HAART = highly active antiretroviral therapy.
time during oral and anal intercourse, respectively. Given that HBV transmission usually results from mucous membrane exposure to infectious body fluids, including semen, the failure to vaccinate this high-risk population is a missed opportunity to prevent disease.

Our findings suggest that MSM lack information about HBV risk and vaccination, and are engaging in behaviours that put them at risk for HBV infection. It is critical to develop innovative interventions that encourage condom use and increase knowledge of HBV vaccination among MSM.

This study was supported financially by the researchers themselves. We wish to thank the rollin@sp.h.harvard.edu

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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 organization, the International Herpes Management Forum (website: www.IHMFM.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, symposium on Maternal Mental Health and the Child, 12 October 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG, UK (tel: +44 (0) 20 8383 3904; fax: +44 (0) 20 8383 8555; email: sympreg@ic.ac.uk).

11th Regional Meeting of International Union against Sexually Transmitted Infections, South East Asian and Western Pacific Branch and 24th National Conference of Indian Association for the Study of Sexually Transmitted Diseases and AIDS, 13–15 October 2000, Chandigarh, India
Further details: Dr Bhushan Kumar, Organising Secretary, 11th Regional Meeting of IUSTI–Asia Pacific (SE Asia and W Pacific Branch), Department of Dermatology, Venereology and Leprosy, PGIMER, Chandigarh – 160 012, India; tel: +91 (0172) 745330; fax: +91 (0172) 744401/745078; email: kumarbhushan@hotmail.com.

New Zealand Venereological Society Conference, Centennial Convention Centre, Palmerston North, New Zealand, 18–20 October 2000
Ka Hikotia Ka Korerotia Mo Te Tau Rua Mano (Maori) “Walk the Talk 2000.” Further details: Sue Peck, Conference Organiser, SP Conference Management, PO Box 4400, Palmerston North, New Zealand (tel: 64 4 15 4466; fax 64 4 351 4806; email: suepeck@xtra.co.nz).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics and Gynaecology, symposium on Women and Children with HIV and AIDS, 20 October 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG, UK (tel: +44 (0) 20 8383 3904; fax: +44 (0) 20 8383 8555; email: sympreg@ic.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics and Gynaecology, symposium on key issues in the Care of Women and Gynaecological Gancers for nurses, 30 October 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG, UK (tel: +44 (0) 20 8383 3904; fax: +44 (0) 20 8383 8555; email: sympreg@ic.ac.uk).

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

Royal Society of Medicine and National Institutes of Health International Conference, RSOM, London, 7–8 December 2000
The RSOM in London, UK, and the NIH in Bethesda, Maryland, US, are organising an international conference to be held at the RSOM on “New trends in HIV management and research.” Further details: Victoria Boswell, Academic Conference Assistant, Royal Society of Medicine (tel: +44 (0) 20 7290 2965; fax: +44 (0) 20 7290 2977; email: victoria.boswell@royalsocmed.ac.uk).

International Symposium on Disorders of the Prostate, 21–23 March 2001, Castres, France
Further details: Dr Mike Briley, Scientific Director, Pierre Fabre Medicament, Parc Industriel de la Chartreuse, F-81106 Castres Cedex, France (tel:+33 563 741 501; fax: +33 563 725; email: briley@pierre-fabre.imagenet.fr).

Call for papers—6th European Forum on Quality Improvement in Health Care, 29–31 March 2001, Bologna, Italy
Further details: BMA/BMJ Conference Unit, BMA House, Tavistock Square, London WC1H 9JP, UK (tel: +44 (0) 20 7383 6409; fax: +44 (0) 20 7383 6869; email: quality@bma.org.uk; website: www.quality.bmjg.com).

Further details: ECEAR ’2001 Conference Secretary, Division of Retrovirology, NIIBSC, Blanche Lane, South Mimms, Potters Bar, Hertfordshire, EN6 3QG, UK.
The paper by Hughes et al. “Comparison of risk factors for four sexually transmitted infections: results from a study of attenders at three genitourinary medicine clinics in England” published in the August issue of STI (2000;76:262–7) contained errors in tables 1 and 2. The correct versions of these tables are published here. The multivariable statistical analyses presented in tables 3 and 4, on which the paper focuses and on which the discussion and conclusions are based, are unaffected by the errors and remain unchanged.

**Table 1** Characteristics of patients attending three GUM clinics in England, April 1994 to September 1997

<table>
<thead>
<tr>
<th></th>
<th>Royal Hallamshire, Sheffield (%)</th>
<th>St Thomas’s, London (%)</th>
<th>Mortimer Market Centre (MMC), London (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total attenders</td>
<td>20 334</td>
<td>15 155</td>
<td>15 882</td>
</tr>
<tr>
<td>Sex:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>9 992 (49)</td>
<td>7 969 (53)</td>
<td>8 143 (51)</td>
</tr>
<tr>
<td>Females</td>
<td>10 314 (51)</td>
<td>7 186 (47)</td>
<td>7 659 (48)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>28 (&lt;1)</td>
<td>–</td>
<td>80 (1)</td>
</tr>
<tr>
<td>Age group:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13–15</td>
<td>189 (1)</td>
<td>64 (&lt;1)</td>
<td>20 (&lt;1)</td>
</tr>
<tr>
<td>16–19</td>
<td>2 319 (11)</td>
<td>977 (6)</td>
<td>671 (4)</td>
</tr>
<tr>
<td>20–24</td>
<td>5 672 (28)</td>
<td>3 199 (21)</td>
<td>3 390 (21)</td>
</tr>
<tr>
<td>25–34</td>
<td>7 809 (38)</td>
<td>7 425 (49)</td>
<td>7 658 (48)</td>
</tr>
<tr>
<td>35+</td>
<td>4 254 (21)</td>
<td>3 485 (23)</td>
<td>4 135 (26)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>91 (&lt;1)</td>
<td>5 (&lt;1)</td>
<td>8 (&lt;1)</td>
</tr>
<tr>
<td>Male sexual orientation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>heterosexual</td>
<td>9 181 (92)</td>
<td>6 744 (85)</td>
<td>2 176 (27)</td>
</tr>
<tr>
<td>homosexual/bisexual</td>
<td>800 (8)</td>
<td>1 174 (15)</td>
<td>1 751 (22)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>11 (&lt;1)</td>
<td>51 (1)</td>
<td>4 216 (52)</td>
</tr>
<tr>
<td>Female sexual orientation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>heterosexual</td>
<td>10 145 (98)</td>
<td>7 057 (98)</td>
<td>4 001 (52)</td>
</tr>
<tr>
<td>homosexual/bisexual</td>
<td>165 (2)</td>
<td>89 (1)</td>
<td>96 (1)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>4 (&lt;1)</td>
<td>40 (1)</td>
<td>3562 (47)</td>
</tr>
<tr>
<td>Ethnic group:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>18 014 (89)</td>
<td>8 383 (55)</td>
<td>8 629 (54)</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1 038 (5)</td>
<td>4 308 (28)</td>
<td>433 (3)</td>
</tr>
<tr>
<td>Black African</td>
<td>140 (1)</td>
<td>1 611 (11)</td>
<td>435 (3)</td>
</tr>
<tr>
<td>Asian</td>
<td>483 (2)</td>
<td>246 (1)</td>
<td>506 (3)</td>
</tr>
<tr>
<td>Other/mixed</td>
<td>297 (1)</td>
<td>357 (2)</td>
<td>499 (3)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>362 (2)</td>
<td>5381 (34)</td>
<td></td>
</tr>
<tr>
<td>Presenting diagnosis:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital warts</td>
<td>1 976 (10)</td>
<td>963 (6)</td>
<td>619 (4)</td>
</tr>
<tr>
<td>Genital HSV</td>
<td>548 (3)</td>
<td>433 (3)</td>
<td>265 (2)</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>389 (2)</td>
<td>559 (4)</td>
<td>285 (2)</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>2 175 (11)</td>
<td>752 (5)</td>
<td>633 (4)</td>
</tr>
<tr>
<td>Number of partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(heterosexuals):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–1</td>
<td>10 353 (53)</td>
<td>7 299 (53)</td>
<td>2 897 (47)</td>
</tr>
<tr>
<td>2</td>
<td>5 027 (26)</td>
<td>3 541 (26)</td>
<td>1 669 (27)</td>
</tr>
<tr>
<td>3</td>
<td>2 802 (20)</td>
<td>1 611 (11)</td>
<td></td>
</tr>
<tr>
<td>Not recorded</td>
<td>13 (&lt;1)</td>
<td>159 (1)</td>
<td></td>
</tr>
<tr>
<td>Previous STI:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5 791 (28)</td>
<td>5 807 (38)</td>
<td>3 483 (22)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>–</td>
<td>3 (&lt;1)</td>
<td>7 533 (47)</td>
</tr>
<tr>
<td>Ever injected drugs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>361 (2)</td>
<td>228 (2)</td>
<td>145 (1)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>–</td>
<td>2 (&lt;1)</td>
<td>7 486 (47)</td>
</tr>
<tr>
<td>Commercial sex work (ever):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>543 (3)</td>
<td>181 (1)</td>
<td></td>
</tr>
<tr>
<td>Not recorded</td>
<td>–</td>
<td>15 155 (100)</td>
<td>7 641 (48)</td>
</tr>
</tbody>
</table>

1 Data for 1 April 1994 to 30 September 1997.
2 Data for 1 April 1994 to 31 December 1996.
3 Data for 1996 only.
4 Includes “black other.”
5 First episode.
6 Uncomplicated infection.
7 Number of partners in past 12 months for Sheffield and St Thomas’s clinics and in past 3 months for MMC (see methods for details).

**Table 2** Numbers of attenders diagnosed with first episode genital warts, first episode genital HSV, uncomplicated gonorrhoea and uncomplicated chlamydia, showing concurrent infections, in attenders at three GUM clinics in England, April 1994 to September 1997 (+ = present, − = absent)

<table>
<thead>
<tr>
<th>No of attenders (%)</th>
<th>Warts</th>
<th>HSV</th>
<th>Gonorrhoea</th>
<th>Chlamydia</th>
</tr>
</thead>
<tbody>
<tr>
<td>3320</td>
<td>(6.46)</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>3101</td>
<td>(6.04)</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>1184</td>
<td>(2.30)</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>957</td>
<td>(1.86)</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>233</td>
<td>(0.45)</td>
<td>−</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>187</td>
<td>(0.36)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>28</td>
<td>(0.05)</td>
<td>−</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>21</td>
<td>(0.04)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>21</td>
<td>(0.04)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>11</td>
<td>(0.02)</td>
<td>−</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>9</td>
<td>(0.02)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>2</td>
<td>(0.00)</td>
<td>−</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>42 297 (82.34)</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Total 51 371 (100)</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

Gonorrhoea

Sexually transmitted disease clinic clients at risk for subsequent gonorrhoea and chlamydia infections—possible ‘core’ transmitters.

BA GUNN, S FITZGERALD, SO ALAR. Sex Transm Dis 2000;27:543–9

Gonorrhoea among men who have sex with men: outbreak caused by a single genotype of erythromycin-resistant Neisseria gonorrhoeae with a single-base deletion in mtrR promoter region.

MS XIA, WLG WHITTINGTON, WM SHAPER, KK HOLMES. J Infect Dis 2000;181:2080–208

Amultiplex polymerase chain reaction to differentiate β-lactamase plasmids of Neisseria gonorrhoeae.


A typing system for Neisseria gonorrhoeae based on biotinylated oligonucleotide probes to PIB gene variable regions.


Expression of AnA, the major anaerobically induced outer membrane protein of Neisseria gonorrhoeae, provides protection against killing by normal human sera.

Chlamydia

Duration of untreated genital infections with Chlamydia trachomatis—a review of the literature. MB Golden, JA Schilling, L Markowitz, MSTDUS. Sex Transm Dis 2000;27:329–37


Relationship of hormonal contraception and cervical ectopy as measured by computerized planimetry to chlamydial infection in adolescents. DL Jacobson, L Peralta, M Farmer et al. Sex Transm Dis 2000;27:313–9


Priming with Chlamydia trachomatis major outer membrane protein (MOMP) DNA followed by MOMP ISCOM boosting enhances protection and is associated with increased immunoglobulin A and Th1 cellular immune responses. DJ Zhang, X Yang, CX Shen et al. Infect Immun 2000;68:3074–8


Bacterial vaginosis


Trichomoniasis


Host and tissue specificity of Trichomonas vaginalis is not mediated by its known adhesion proteins. MP Addis, P Raffelli, PL Fiore. Infect Immun 2000;68:4358–60


Syphilis and other treponematoses


Hepatitis


The natural history of hepatitis C virus infection—host, viral and environmental factors. DL Thomas, IA Semborski, RM Raj et al. JAMA 2000;284:450–6

Herpes


Further evidence from a murine infection model that famciclovir interferes with the establishment of HSV-1 latent infections. AM Thackeray, CJ Field. J Antimicrob Chemother 2000;45:825–34


Immune protection against HSV-2 in B-cell-deficient mice.
KL DUDLEY, N BOURNE, RN MILGANG. Virolology 2000;270:454–63

Decreased vaginal disease in J-chain-deficient mice following herpes simplex type 2 genital infection.

The role of the UL41 gene of herpes simplex virus type 1 in evasion of non-specific host defence mechanisms during primary infection.

Difference in incidence of spontaneous mutations between herpes simplex virus types 1 and 2.

Human papillomavirus infection

Quantitative tests for human papillomavirus.
C JOHNSTON. Lancet 2000;355:2179

Viral load of human papillomavirus 16 as determinant for development of cervical carcinoma in situ: a nested case-control study.

Consistent high viral load of human papillomavirus 16 and risk of cervical carcinoma in situ: a nested case-control study.

Mathematical model for the natural history of human papillomavirus infection and cervical carcinogenesis.

Human papillomavirus DNA testing for cervical cancer screening in low-resource settings.

Human papillomavirus testing in women with mild cytologic atypia.

Mucosal human papillomavirus types in squamous cell carcinomas of the uterine cervix and subsequently on fingers.

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