LETTERS TO THE EDITOR

Labial adhesions following severe primary genital herpes

Editor,—Labial adhesions following genital herpes infection have been described previously.1 To prevent their development various suggestions such as the use of early aciclovir,2 paraffin gauze,3 and saline bathing4 have been put forward. We believe nursing care is a significant factor in the prevention of this complication. Here we report two cases of severe genital herpes presenting at different sites, almost at the same time, both necessitating admission and developing labial adhesions.

CASE 1
A 25 year old woman was admitted to the medical ward with severe vulval ulceration, generalised skin rash, and difficulty in micturition of 4 days' duration. Clinical examination revealed target lesions, swollen labia, bilaterally enlarged tender inguinal lymphadenopathy with extensive vulval ulcerations. A clinical diagnosis of erythema multiforme enopathy with extensive vulval ulcerations. A presumptive diagnosis of cellulitis was made. The patient was catheterised and commenced on intramuscular lignocaine gel, subcutaneous morphine, intravenous metronidazole, and cefuroxime, and insulin by sliding scale. Two days later she developed perineal and vulval ulcerations and intravenous aciclovir was added. In view of failure of clinical response the gynecological department was asked to review the case. Examination revealed perineal and perianal ulcers. A diagnosis of primary HSV was made, intravenous antibiotics were stopped, and oral antivirals were started. The nursing staff were instructed to offer the patient a sitz bath twice daily in view of extensive discomfort and oedema. Swabs taken confirmed the diagnosis of HSV. The patient made a gradual recovery and she was allowed home after 1 week in hospital. Two weeks later when she presented to the gynecological medicine clinic, genital examination showed a thick band of adhesions between the middle halves of the labia minora, and new herpetic lesions (fig 1). She was prescribed oral valaciclovir, metronidazole, and lignocaine gel and advised to continue salt and water bathing at home. A follow up appointment was arranged for release of adhesions. Surprisingly, separation of adhesions was not needed.

COMMENT
These two cases illustrate that females with severe genital herpes can be admitted to different hospital departments other than gynecological medicine, where the nursing staff may not be familiar with the management and complications of this infection. Patients should be encouraged to separate the labial folds; this can be facilitated by the liberal use of local anaesthetic agents with the assistance of the nursing staff. Frequent saline bathing of the genitalia should be encouraged to facilitate the removal of the fibrinous exudate, which is responsible for the formation of these adhesions.

GUM nurses and physicians should play an active part in the education and nursing care of such cases and lead the management especially when admitted to other specialties.

Contributors: EH managed case 1, JD managed case 2, while both authors wrote the manuscript.

E HEBIEKA
Department of Genitourinary Medicine, Leicester Royal Infirmary

J DHAR
Department of Genitourinary Medicine, Derbyshire Royal Infirmary

Correspondence to: E Herieka, Department of GUM Leicester Royal Infirmary, Leicester LE1 5WW, UK


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CASE REPORT
A 19 year old man presented with 2 day history of extensive painful pustular eruptions of the hands, forearms, and chest. He also felt unwell and had fever. Fingers were stiff and could not be fully extended. He was seen in the local accident and emergency department and prescribed flucloxacillin. On direct questioning he admitted that his illness started with painful penile ulcers followed 2 days later by ulcerated crops of blisters, which then became infected. Ten days before this he had unprotected sexual intercourse with a casual female friend in Ibiza. He had extensive atopic eczema during childhood, which is well controlled now but has been getting hay fever for the past few years.

Examination revealed symmetrical pustular eruptions on the hands, wrists, forearms, lower legs and chest, and a few vesicular eruptions on the hands typical of herpes. He also had multiple superficial penile ulcers. Axillary and inguinal lymph nodes were enlarged. There was also evidence of generalised eczema.

Herpes simplex was isolated from the penile ulcers. Screening for other STIs and HIV was negative. He was treated with aciclovir 200 mg five times a day for 5 days after his local hospital were suspicious of a viral aetiology.

Recurrent eczema herpeticum: an underrecognised condition

Editor,—We present a case of eczema herpeticum to highlight that herpes simplex can cause generalised infection in atopic individuals and should be considered in the differential diagnosis.

ECZEMA HERPETICUM IS CLASSICALLY A DISSEMINATED INFECTION of the skin occurring in patients with pre-existing active dermatitis. The rash results from reactivation of latent virus from memory to a fulminating fatal disorder involving the viscera. The severity appears to be unrelated to the extent of cutaneous lesions. Active dermatitis is not necessary for the development of recurrent eczema herpeticum.

Atopic dermatitis typically begins in early infancy, and individuals with this disease frequently develop other atopic manifestations later in life such as hay fever, allergic rhinitis, and bronchial asthma. Eczema herpeticum has also been associated with seborrhoeic dermatitis, neurodermatitis, Darier’s disease, and psoriasis. Eczema herpeticum is a rare condition of unknown aetiology.

Eczema herpeticum is now being seen with increasing frequency in adults and herpes simplex infection should be considered in the differential diagnosis of vesicular skin lesions occurring in atopic patients.

V Harindra
Department of Genitourinary Medicine, St Mary’s Hospital, Milton Road, Portsmouth PO3 6AD, UK

Correspondence to: Dr Harindra


Accepted for publication 1 November 2000

Pooling urine samples for PCR screening of C trachomatis urogenital infection in women

Editor,—Selective or universal screening for Chlamydia trachomatis infections has been suggested by the World Health Organization as a primary prevention strategy. The improved sensitivity of the nucleic acid amplification assays for the detection of C trachomatis allows the use of urine samples, suitable for screening programmes. However, these commercial assays are expensive, which make them disadvantageous for this purpose.

Therefore, some authors have recently evaluated the accuracy and cost saving of different urinary pooling strategies using polymerase chain reaction (PCR) and ligase chain reaction (LCR) tests for the screening for genital C trachomatis infections, reporting encouraging results. As the pooling strategies need individual retesting of each component of a positive pool, in order to identify the positive samples the cost saving inherent to these strategies will depend on the size and pool size dependent. For this reason, pooling may be particularly suitable when applied to low prevalence populations. On the other hand, a high number of urine samples per pool may yield a decreased sensitivity because of the dilution effect associated with pooling. Peeling et al and Kacena et al have put forward a mathematical formula to estimate the number of pools that are likely to be positive given a selected pool size and population disease prevalence. Thus, it is possible to estimate the reduction on the number of tests required for a pooling strategy compared with individual testing.

The objective of this study was to evaluate a pooling urine samples strategy for screening urogenital chlamydial infection by PCR testing.

In all, 330 processed first catch urine samples (FCU) from women attending general practice clinics in Lisbon (from August 1999 to February 2000) were pooled by five into 66 pools. Pools and individual specimens were simultaneously tested using the Amplicor PCR test, according to the manufacturer’s...
Table 1  Distribution of positive samples

<table>
<thead>
<tr>
<th>+/+ Pools</th>
<th>Equivocal Pools</th>
<th>−/− Pools</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 (17)</td>
<td>4 (5)</td>
<td>0</td>
</tr>
</tbody>
</table>

*Confirmed as positive pools.

instructions. Equivocal results analysis (≥0.2 OD, <0.8 OD) was resolved by reprocessing original samples and by retesting both pooled and individual specimens by Amplicor PCR assay.

The results are summarised in table 1. The calculated prevalence was 5.2% (17/329). The dilution effect associated with the pooling strategy did not have any effect on either the sensitivity or specificity of the Amplicor PCR test (both 100%) and also solved the problem of PCR inhibitory substances in urine specimens (0% compared with 3.6% of individual testing). One FCU specimen was repeatedly inhibited and was excluded.

The choice for a 5x size pool model was based on the highest potential cost saving for the estimated prevalence of the studied population, according to Peeling et al and Kacena et al. According to the number of tests realised using pooling and individual testing (166 and 346, respectively) the cost saving was 52% compared with the 56% obtained using the mathematical formula. The main reason for this minor difference is that the formula does not take into account the inhibited and equivocal results requiring further sample testing.

Despite the low number of studies concerning urine pooling strategies, the results obtained so far suggest that pooling FCU samples can be useful for epidemiological studies and for screening programmes.

This study was supported by the “Comissão de Fomento da Investigação em Cuidados de Saúde do Ministério da Saúde, Project 20/98” and by the “Instituto Nacional de Saúde”.

J P GOMES
M A A FERREIRA
Bacterology Department, National Institute of Health, Lisbon, Portugal
A BRITO DE SÁ
Institute of Preventive Medicine, Lisbon Medical School, Lisbon, Portugal
M A CATRY
Bacterology Department, National Institute of Health, Lisbon, Portugal

Correspondence to: João Paulo Gomes, Centro de Bacteriologia, Instituto Nacional de Saúde, Av Padre Cruz, 1649–016, Lisboa, Portugal

Emergence of high level ciprofloxacin resistant Neisseria gonorrhoeae strain in Buenos Aires, Argentina

Editor,—The surveillance programme of Neisseria gonorrhoeae (NG) antimicrobial susceptibility patterns was implemented in 1980 in the National Reference Centre for STI (NRC).

Twenty nine peripheral STI laboratories belonging to the National Network of Argentina, distributed throughout the country, routinely sent isolates to the NRC for typing, susceptibility testing, and plasmid characterisation.

The NRC was incorporated into the WHO Gonococcal Antimicrobial Susceptibility Profiling Programme in Buenos Aires city and was submitted to the NRC; no inhibition zone was observed with a 5 µg ciprofloxacin disc.

In May 2000 the first NG strain with high level quinolone resistance (QRNG) was isolated. The strain was isolated in a private medical centre in Buenos Aires city and was submitted to the NRC; no inhibition zone was observed with a 5 µg ciprofloxacin disc.

CASE REPORT

The patient was a heterosexual man, aged 34 years, married, not a drug user, and he hadn’t travelled abroad during the past year. However, he admitted to having had sexual intercourse with a commercial sex worker, 4 days before the onset of the symptoms. He presented with a purulent acute urethritis with dysuria and was treated with a parenteral dose of ceftriaxone 500 mg and a week’s course of doxycycline. The patient became asymptomatic 36 hours after the start of the treatment. Serological tests for VDRL, HIV, and hepatitis B and C were negative.

The strain was β lactamase negative and exhibited high level ciprofloxacin resistance (MIC 16 µg/ml) and low level tetracycline resistance (MIC 4 µg/ml) and was susceptible to the other antibiotics assayed. The MICs were penicillin 0.002 µg/ml, spectinomycin 32 µg/ml, ceftriaxone 0.004 µg/ml, and azithromycin 0.25 µg/ml. The auxotype-serogroup class was proline requiring WII-III.

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Dorsal perforation of prepuce due to locally erosive condylomata acuminata

EDITOR,—We recently reported five patients with sexually/non-sexually transmitted ulcerative diseases complicated by perforation on the dorsal surface of the prepuce. We could find reports of only three similar cases in the indexed literature. During screening of our STD clinic files we found record of another patient with dorsal perforation of the prepuce; however, it was not due to genital ulcer disease, but to condylomata acuminata. This patient, a 22 year old man had unprotected sexual intercourse with a commercial sex worker about 6 months before reporting to our STD clinic in January 1994. About 1 month after sexual contact, he
developed small papular lesions on the glans penis. Lesions enlarged rapidly and started eroding the undersurface of the prepuce. On retraction of the prepuce, lesions were also visible all around the prepuce: a common end point of severe ulcerative diseases involving genitalia. Maite and Hay⁶ earlier reported a patient with genital warts treated with topical podophyllin, who presented later with perforation of the dorsal surface of prepuce. They considered it as delayed podophyllin damage. Our patient had not been treated before with podophyllin. The identical presentation in our and the reported patient suggests that warts themselves and not podophyllin are responsible for perforation. Condylomas particularly in immunocompromised individuals may attain a very large size and rarely become locally invasive and destructive.¹ In our patient, however, condylomas were not very large and there was no evidence of immunosuppression.

Our patient had condylomas all over the glans, but perforation took place only on the dorsum of the prepuce, confirming that this site is more susceptible to this complication. Incidentally, two more patients with perforation on the dorsal surface of the prepuce as a complication of chancreoid and genital herpes have been depicted in A colour atlas of AIDS in the tropics.¹ Both patients were HIV seropositive. This suggests that this complication is not uncommon (though underreported), more so in tropics. HIV infection by altering the course and severity of genital lesions of sexually transmitted diseases probably makes this complication more frequent. Out of the 10 patients reported/published, half were HIV seropositive.

SOMESH GUPTA
BHUSHAN KUMAR
Department of Dermatology, Venereology and Leprosy, Postgraduate Institute of Medical Education and Research, Chandigarh 160 012, India


Urine proves a poor specimen for culture of Trichomonas vaginalis in women

Editor,—Trichomonas vaginalis infection occurs worldwide with an incidence of over 200 million infections per year. Clinical disease in women ranges from asymptomatic to severe vaginitis, and has been associated with preterm delivery¹ and an increased rate of HIV-1 transmission.²

The magenta colour of T vaginalis associated morbidity, including risk of HIV-1 transmission, makes simple accurate diagnosis important especially in at-risk populations. Microscopic examination of a wet mount vaginal fluid is a quick and easy to perform but identifying 40–60%⁷ of infections in comparison to culture is more effective. The In-pouch culture system (Biomed Inc, San Jose, CA, USA) is reported to be equally sensitive yet more practical than traditional culture methods. Condylomas particularly in immunocompromised individuals may attain a very large size and rarely become locally invasive and destructive.¹ In this particular study we obtained specimens from participants in two study sites. Participants were instructed by one of the study nurses how to obtain a self collected vaginal swab and at the same time collect urine. Women were asked not to clean the genit area before providing both specimens. Immediately after collection the vaginal swab was inoculated into the In-pouch and urine was spun at 2000 g for 10 minutes. After the supernatant was discarded, the sediment was agitated and pipetted directly into the In-pouch. Specimens were shipped at room temperature to the University of Nairobi and incubated at 37°C for up to 5 days according to manufacturer’s instructions. Daily microscopic examination was performed for identification of T vaginalis. Random specimen coding ensured that laboratory staff remained blind to specimen source and pairing.

We recruited subjects from a randomised community study that investigated the prevalence of sexually transmitted infections in women with and without access to female condoms.³ In this particular study we obtained specimens from participants in two study sites. Participants were instructed by one of the study nurses how to obtain a self collected vaginal swab and at the same time collect urine. Women were asked not to clean the genit area before providing both specimens. Immediately after collection the vaginal swab was inoculated into the In-pouch and urine was spun at 2000 g for 10 minutes. After the supernatant was discarded, the sediment was agitated and pipetted directly into the In-pouch. Specimens were shipped at room temperature to the University of Nairobi and incubated at 37°C for up to 5 days according to manufacturer’s instructions. Daily microscopic examination was performed for identification of T vaginalis. Random specimen coding ensured that laboratory staff remained blind to specimen source and pairing.

We recruited 675 women for this substudy. T vaginalis was detected by culture in 121 (17.9%) women per self collected swab and 23 (3.4%) women per centrifuged urine. In comparison with culture of self collected swab, culture of centrifuged urine yielded a sensitivity of only 17% and a specificity of 99.6% (table 1). We originally intended to recruit over 2000 women into the study, but discontinued recruitment when preliminary results clearly demonstrated the inadequacy of urine for culturing T vaginalis in women. In this large scale community study we found culture of centrifuged urine very insensitive for identification of trichomonads in women. Since only 5–10 organisms in a sample are necessary for a positive culture,⁴ these findings were unexpected. We cannot fully explain why culture of urine for T vaginalis in women proved so poor. Because of contamination of the external genitalia with vaginal fluid, a first void urine specimen might have proved a better sample.

Supported by the United States Agency for International Development, Family Health International and a grant from the National Institutes of Health (AI11418). Biomed Inc donated the In-pouch for this investigation.

Subjects: 100 women from the study were selected at random and observed for 14 days according to manufacturer’s instructions. Specimens were shipped at room temperature to the University of Nairobi, Nairobi, Kenya and Department of Obstetrics and Gynecology, University of Washington, Seattle, Washington, USA

OMARI A MOHAMED
Department of Medical Microbiology, University of Nairobi, Nairobi, Kenya and Family Health International, Nairobi, Kenya

CRAIG R COHEN
Department of Medical Microbiology, University of Nairobi, Nairobi, Kenya and Department of Obstetrics and Gynecology, University of Washington, Seattle, Washington, USA

MAUREEN A KUYOH
Family Health International, Nairobi, Kenya

JAMES A ONYANGO
JOB J BWAYO
Department of Medical Microbiology, University of Nairobi, Nairobi, Kenya

PAUL J FELDBLUM
Research Triangle Park, North Carolina, USA

Correspondence to: Craig R Cohen, MD, MPH, Department of Obstetrics and Gynecology, University of Washington, Box 356460, Seattle, WA 98195, USA
crcohen@u.washington.edu

3 Laga MA, Manohla A, Kivuvu M, et al. Non-ulcerative sexually transmitted diseases as

Table 1 Comparison of culture of T vaginalis from centrifuged urine and self collected vaginal swab in 675 women

<table>
<thead>
<tr>
<th>T vaginalis urine culture</th>
<th>Negative</th>
<th>Positive</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>T vaginalis self administered vaginal swab</td>
<td>552</td>
<td>2</td>
<td>554</td>
</tr>
<tr>
<td>Positive</td>
<td>100</td>
<td>21</td>
<td>121</td>
</tr>
<tr>
<td>Total</td>
<td>652</td>
<td>23</td>
<td>675</td>
</tr>
</tbody>
</table>

Kappa = 0.256.
BOOK REVIEWS


It is 6 years since the first edition of this book and the expansion in knowledge about lower genital tract precancer affected in the addition of an assistant and a contributing author, as well as an increase in the number of pages (from 254 in the first edition to 323 in the present one).

The extra input and space has been used to maximal effect with the book losing none of its attractions of appearance, content, and even texture by its use of high quality paper.

The addition of a chapter on the role of human papilloma virus in lower genital tract neoplasia makes the book more rounded. This chapter is comprehensive as well as excellently presented and very up to date. I appreciated the section on the role of oncogenic HPV detection in the prevention of lower genital tract precancer, although this naturally concerned CIN rather than VIN or VaIN.

I would have preferred chapter 5 (Cytology and screening for cervical precancer) to follow chapter 2 (HPV in the pathogenesis of lower genital tract neoplasia) and then the more practical aspects of colposcopy itself would not be introduced until chapter 8. This is a small criticism of an otherwise comprehensive and logical content.

The chapter on the management of cervical precancer is a delight to read and see, with the section devoted to HIV positive women reflecting most shades of reliable opinion in this developing field. HIV is again included in the chapter on VIN.

GU colposcopy will be particularly interested in the final chapters on infective conditions causing confusion in diagnosis of lower genital tract precancer. It is easy to quibble with some of the statements of management of the infections noted (cervical warts do not even merit a mention of treatment) but that is not the remit of the book.

The illustrations are generous thorough and the line photography used to very good effect. The overabundant book critic might mention the data left on some colposcopic photographs, the venerable laser machine showed on page 171 and whether the specular is correctly placed on page 36, but not me.

This is a “must buy.” It's a big book (in size, content, and price) which should form the nucleus of the colposcopist’s library.

D A HICKS
Royal Hallamshire Hospital, Department of Gynaecological Medicine, Glossop Road, Sheffield S10 2ZP


Considering we inquire about or promote the use of condoms with each and every patient we see in GU/HIV clinics, it’s extraordinary how little we know about them. “Penis protectors” have come a long way since they were used in battle, cast to size, and made from goat bladder, although “natural” condoms can still be obtained today from the caeca of New Zealand lambs. Thanks to Charles Goodyear, the birth control movement, and the HIV epidemic the condom has enjoyed a renaissance and with more strin-

Letters, Book reviews, CD-Rom review, Notices

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gent quality control and legal standards, has become a life saving device. The chapter on latex condom manufacture was fascinating and gives almost enough detail to allow you to try it at home!

Each year 8–10 billion condoms are used worldwide, although an estimated 15 billion are required to protect adequately against HIV/STDs. The chapter outlining the effectiveness of condoms in preventing STIs was cleanly set out with an excellent summary table outlining data and references. There was a fascinating chapter on how the commercial sector has risen to the challenge of global condom distribution through social marketing. By using pre-existing infrastructure, supplies to Africa have increased from 45.8 million in 1987 to 264.5 million in 1990. In Thailand by targeting commercial sex workers through the “100% condom programme” usage rates have increased from 14% in 1982–9 to 93% in 1993 with STI cases in government clinics dropping from 237 000 to 39 000. In the chapter on condoms and commercial sex there was a fabulous table summarising different condom usage rates by CSWs in developing countries.

The condom should probably receive more credit as a contraceptive device. Failure rates diminish with increasing experience and it may be a sensible long term option for some women when combined with knowledge of fertile days and progesterone only emergency contraception. There were interesting discussions on the use of condoms for anal sex, the pros and cons of non-latex condoms, female condoms (becoming increasingly popular, especially in Zimbabwe), and recent developments in spermicides and virucides.

In summary, condoms are highly effective, cheap, and largely free of side effects. This book left me with a renewed belief that they should be promoted at every opportunity and not be so condescendingly sneered at. I would highly recommend this book to anyone working in the field of sexual health.

GILL DEAN
The Lawson Unit, Royal Sussex County Hospital, Eastern Road, Brighton BN2 5BE

CD-ROM REVIEW

**NOTICES**

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpessalliance.org) from which can be downloaded patient information leaflets. Its sister organisation 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@spсли.org). The 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:+33 563 714 501; fax: +33 563 725; email: briley@pierre-fabre.imaginet.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 7833 6868; email: quality@bma.org.uk; website: www.quality.bmjg.com).

Joachim Kuhlmann AIDS award 2001

The Joachim Kuhlmann AIDS Foundation, Essen, Germany, is awarding the above mentioned prize to investigators in the field of clinical and scientific HIV work. The prize is valued at 50 000 DM.

Further details: Joachim Kuhlmann AIDS Foundation, Kraemarkstrasse 55, 45128 Essen, Germany.

Each of the submitted papers should contain a running title and may not indicate the names of the authors. An additional envelope should contain the running title on the outside and information in the inside as follows: first name, last name, date of birth, address, professional position, as well as the running title and the complete title of the submitted paper.


Further details: ECEAR 2001 Conference Secretary, Division of Retrovirology, NIBSC, Blanche Lane, South Mimms, Potters Bar, Herts, EN6 3QG, UK.

International Congress of Sexually Transmitted Infections, 24–27 June 2001, Berlin, Germany

Further details: Congress Partner GmbH, Kraumenstrasse 63, D-10117, Berlin, Germany (tel: +49-30-204 500 41; fax: +49-30-204 500 42; email: berlin@cpb.de).

10th International Congress on Behçet's Disease will be held in Berlin 27–29 June 2002

Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de).

20th World Congress of Dermatology, Paris, 1–5 July 2002

Further details: P Fourrier, Colloquium, 12 rue de la Croix St Faubin, 75011 Paris, France (tel: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fourrier@colloquium.fr; website: www.derm-wcd-2002.com).

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Letters, Book reviews, CD-Rom reviews, Notices
Urine proves a poor specimen for culture of *Trichomonas vaginalis* in women

Omari A Mohamed, Craig R Cohen, Dorcas Kungu, Maureen A Kuyoh, James A Onyango, Job J Bwayo, Mike Welsh and Paul J Feldblum

*Sex Transm Infect* 2001 77: 78-79
doi: 10.1136/sti.77.1.78

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