Secretary having difficulty keeping her head above water. Some major issues for the specialty were key strategic issues for the society for housing and lending of the MSSVD library books, and support for educational activities.

MSSVD

Report of the Honorary Secretary to the 79th annual meeting of MSSVD held at the Royal Society of Medicine, Friday 27 October 2000

My final year as Honorary Secretary to MSSVD is now drawing to a close. The final challenge I set myself is to have circulated a summary of the main activities of the society including accounts and financial report in advance of the annual general meeting. It has required the hard work of the officers of the society, the secretariat and finance department at the RSM, and Graham Tomlinson, charitable governance adviser. The annual report was printed in November and circulated to members.

There are now 657 UK members of the society, with 101 overseas members and 31 honorary life members, 21 of whom are resident in the United Kingdom. There were 62 new members last year, of which 34 were nurses and health advisers. There are a number of MSSVD members to whom we paid tribute. These included Dr Ratnatunga; Dr Seaman; Dr George Csonka; Dr Christine Bakshi; Dr T Reed; Dr Andrew Crooks. January 21 was a particularly sad occasion for the society when Maggie Godley sadly died following her two year illness. She will be remembered for all the work she put into running both MSSVD and AGUM and for her care and support as a fellow human being. Her husband has agreed to a memorial, which will be in the form of a prize given to the best presentation from a district general hospital consultant at MSSVD Spring meetings.

The past year has seen an even more rapid pace of change resulting in the Honorary Secretary having difficulty keeping her head above water. Some major issues for the society have been identified.

The first of these is a review and implementation of the changes to the charitable governance of MSSVD. As incoming treasurer, Simon Barton investigated the duties and role of the Honorary Treasurer and after discussion with the officers, it was agreed that expert assistance would be required to undertake a comprehensive review of the society's position. Mr Graham Tomlinson was appointed as an external consultant to support the officers, resulting in the clarification of the roles and responsibilities of the officers, council, and trustees of the charity. Clearer mechanisms for decision making, strategy, and development of business plans are in place for the future. The charitable garden will continue for the year with his support. The Honorary Secretary and treasurer together with Mr Tomlinson have been developing an appropriate contract with the RSM to provide infrastructure and support services for the running of the society and refinement of the membership database. The contract will include a specification for secretarial and financial services, lines of accountability, an arrangement with the society for housing and lending of the MSSVD library books, and support for educational activities.

MSSVD National Continuing Professional Development course in GU Medicine/HIV/AIDS This year the MSSVD took over the running of this course, previously known as BPMF, latterly the CPD course run by University College, London. The steering group is chaired by Dr Jackie Sherrard. This is a new and challenging venture for the society. The aim will be to offer a reduced price for MSSVD members on courses arranged by MSSVD. There has also been discussion about the need for a more basic course directed at primary care physicians, healthcare workers working in contraceptive services, and others providing sexual health services to complement the DFP/R run by the Faculty of Family Planning and Reproductive Health Care (FFPRHC). Over the next year a core curriculum will be developed and the course piloted. The intention is to deliver this on a regional basis.

Special interest groups

The six special interest groups have submitted business plans to the treasurer for their educational activities for 2000–1. A proposal for a further special interest group of “Adolescent sexual health” has been accepted by council and will be submitting a business plan.

Doctors in training meeting

Last year the meeting was held in the president’s home city of Sheffield. Although the standard of hotels fell short of expectations, the scientific programme was well received and the skill workshops of personal image and communication skills provided direction to the consultants of tomorrow. The local cabaret of Karen Rogstad, David Daniels, Mary Stevenson, and Stephen Green, infectious disease consultant at Sheffield, entertained us on Saturday evening. Piers kindly sponsored the event.

MSSVD undergraduate prize

This was awarded as follows: clinical prize to Dr Daniel Jary, “Why do young people still catch STDs?”

Other MSSVD activities

The changes in provision of medical care driven by government have made a significant impact on the day to day activities of all healthcare workers. Key issues that have been discussed at council have included charitable registrants recorded. Consequently, the VAT bill is larger than usual and the term “success” was confined to educational and social rather than financial! The debate trio of Drs Simon Barton, Colm O’Mahony, and Do lore Hooker provided eye opening entertainment for our more reserved colleagues in other infection disciplines.

MSSVD continues to provide meetings in conjunction with other societies. These have included the SSSTD/JUSTI meeting held in London City, South Africa, and the joint BHIVA/MSSVD held on 8 October 1999. The MSSVD/ASTDA inaugural meeting was a resounding success. The society has been asked by the Section of Dermatology at the RSM to develop a joint meeting, which will take place on 8 June 2001.

NCCG meeting

The MSSVD NCCG meeting organised by Dr Jonathan Ross took place in September and was well received.

www.sextransinf.com
Papulonecrotic tuberculids of the glans penis

EDITOR,—A 27 year old promiscuous, married man presented with recurrent episodes of ulceration of the penis of 12 years' duration. Each episode began with a painful, small raised lesion which got ulcerated and finally healed spontaneously in 2–3 months.

The possibility of tuberculosis of the penis may manifest as primary, secondary, or papulonecrotic tuberculosis. Clinically, it may present as superficial ulcers of the penis or tuberculous cavernositis. Papulonecrotic tuberculids, a form of cutaneous tuberculosis, represents an allergic reaction to bursts of antigens reaching highly immune skin following haematogenous spread from an internal focus. The tuberculous focus is often not clinically active but forewarn colleagues of the potential for at-risk population to come to us. This requires a critical look at the way services are provided at present and opportunities for providing them in a more efficient way. Our strength, particularly with regard to health promotion, partner notification, accessibility and skills in communicating with young people, need to be increased and marketed. We are fortunate to have at the helm of MSSVD an extremely proactive president with strategic vision and a grip on operational aspects of running sexual health services. I am delighted that the work which has been undertaken over the 4 years since I have been Honorary Secretary will continue, be refined, and changed according to political imperatives and the needs of people accessing our services. I wish Keith Radcliffe as my successor good fortune and thank him and the treasurer and president for all the help and encouragement that they have proffered over the last year.

Finally, my thanks to all fellows and members for their continuing support to the MSSVD and to me personally over these past 4 years.

ANGELA J ROBINSON
Honorary Secretary

Table 1 Mean total and subscale scores for Attitudes to Lesbian and Gay Men (ATLG) Questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Male (<em>n</em>=86)</th>
<th>Female (<em>n</em>=123)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATLG mean (range)</td>
<td>69.0 (20–176)</td>
<td>56.0 (20–142)</td>
<td>0.003</td>
</tr>
<tr>
<td>ATG mean (range)</td>
<td>40.9 (10–90)</td>
<td>31.8 (10–62)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ATL mean (range)</td>
<td>28.4 (10–90)</td>
<td>24.2 (10–80)</td>
<td>0.03</td>
</tr>
</tbody>
</table>

*ATG = Attitudes to Gay Men.
†ATL = Attitudes to Lesbians.
Figure 1 A theoretical model of how response rate may perform according to questionnaire length

interest because of the length of the questionnaire. Conversely, if a questionnaire is too short, it may be deemed “unimportant” and not worth completing.

The real question is, is there any real difference in the size of the length of questionnaires used in this study? In comparison, a four or 10 page questionnaire they are still long. Studies are lacking which high the threshold or optimal length of questionnaires.

Figure 1 shows a theoretical model of how response rate may perform according to questionnaire length. Part A represents low response rates due to questionnaires of short length; part B is the optimal questionnaire length giving the best response rate; and part C shows the poor response rate due to questionnaires of excessive length.

The presentation of the questionnaires will also influence the response rates to postal surveys. Questionnaires that are professionally printed and designed are more likely to be taken seriously by participants compared with two pages stapled together.

Other reasons for an increased response rate include the importance of assuring participants of their confidentiality and this can improve even further if the steps taken to keep subject data confidential is explained. Respondents may want or expect their answers to be treated strictly in confidence, especially if the topic area is threatening or sensitive. Data processors may have access to the information.

Ethics of repeated follow ups is of concern. Some individuals do not like receiving multiple mailouts and this can be a problem if they complain. The respondents’ privacy and dignity should be respected. A dilemma may sometimes arise when the need for the researcher to obtain the “informed” consent of respondents conflicts with the need for respondents not to know so much that the results are biased.

One thing is certain; the greater the number of follow up completed the higher the response rate will be. There can be problems associated with undertaking multiple follow ups, particularly when individuals complain about the number of letters and/or questionnaires they receive. However, this can easily be solved by stating on the initial cover letter if they do not wish to be contacted further to contact the researcher and tell them so they can be removed from the mailing list. By using some of these techniques researchers should be able to obtain increased response rates and higher quality questionnaire data.
EDITOR,—Those who have spent some time in genitourinary medicine will surely agree that the specialty has gone through vast changes over the years. Not only the nomenclature of our clinics from VD clinics or sexually transmitted infections (STI) clinics to psychosexual health departments, but also the language of our clinics from VD clinics or sexually transmitted infections (STI) clinics to psychosexual health departments, but the more open we are about infections the better it will be for our patients. Sharing an STI to me sounds a bit awkward. In my opinion people transmit the infections knowingly or unknowingly because of their high risk sexual behaviour. It does not matter if we try to play this down and make it acceptable. There will always be some stigma attached to STIs but we should ensure awareness, patient education, and partner notification. I believe this should be done by professionals in a confidential setting in a genitourinary medicine clinic. Changing the terminology about the mode of transmission will not eliminate the stigma attached to STIs but the more open we are about infections the better it will be for our patients.

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Accepted for publication 12 January 2001

Sexually shared infections

EDITOR,—Those who have spent some time in genitourinary medicine will surely agree that the specialty has gone through vast changes over the years. Not only the nomenclature of our clinics from VD clinics to special clinics to psychosocial health departments but also the language of our specialty itself has gone through a metamorphosis.

I was therefore interested to note the term “sexually shared infections” suggested by Hopwood et al and wondered what message it would project to our patients, sorry our “clients.” Hence, I decided to test this new term in my clinic and would like to share the results with the readers of STI.

Firstly, I saw a young girl who had primary presentation of genital warts. I suggested that she might have “shared” this infection with her partner to which she replied, “Look doctor, I know HE gave it to me because he is the one who was sleeping around.” The next one was a young man who presented with acute gonorrhoea. When I said he might have shared this infection with the one night stand he had in Manchester he replied, “Look doctor, I am no fool. I was so drunk that night that I couldn’t perform but she went ahead anyway this then happened.” The third one was a chlamydia re-infection. The young girl was found to be positive and received a single dose regimen. Her boyfriend was referred to a GUM clinic but by the time he attended they had protected sex but the condom split and the girl was re-infected. When I mentioned the “shared” element she fumed, “It was him who gave me this in the first place and he wouldn’t get treatment himself because he felt OK.”

English is not my first language but I always thought that you “share” something that is nice. Like sharing the tender moments, sharing your cake, British Airways share offer when it floated on stock market, etc.

Sharing an STI to me sounds a bit awkward.

In my opinion people transmit the infections knowingly or unknowingly because of their high risk sexual behaviour. It does not matter if we try to play this down and make it acceptable. There will always be some stigma attached to STIs but we should ensure awareness, patient education, and partner notification. I believe this should be done by professionals in a confidential setting in a genitourinary medicine clinic. Changing the terminology about the mode of transmission will not eliminate the stigma attached to STIs but the more open we are about infections the better it will be for our patients.

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Deterioration of disseminated cutaneous Mycobacterium avium complex infection with a leukoaeum reaction following institution of highly active antiretroviral therapy

EDITOR,—The impact of highly active antiretroviral therapy (HAART) on the incidence of opportunistic infections (OI) in HIV infected patients has been well documented. HAART also frequently alters the clinical course of OI. Increasingly, immune reconstitution disease is recognised after starting HAART in patients with latent or established OI.1,2 Despite the marked reduction in incidence of disease due to Mycobacterium avium complex (MAC) in the HIV infected population over the past 5 years, this OI is often implicated in immune reconstitution disease and may be difficult to treat.3,4 Focal mycobacterial lymphadenitis appears to be the commonest manifestation,5 but other organs may be involved.

A 40 year old white HIV positive man presented with Staphylococcus aureus tricuspid valve endocarditis; blood cultures also grew MAC. He had a history of cutaneous Mycobacterium avium complex infection. He presented with acute disseminated MAC, pleural effusion, and inguinal lymphadenopathy.

A 40 year old white HIV positive man presented with acute disseminated MAC, pleural effusion, and inguinal lymphadenopathy.

MAC infection. Patient’s right skin and ankle showing painless dermal papules and nodules. A skin biopsy has been performed on the right shin. (B) Five days after re-presentation. Medial aspect of left ankle. There are two erythematous lesions, which were tender to touch. Both have a putterl centre.

1 Hopwood J, Mallinson H, Wellsteed S. Canary to sparrow; what is in a name? Sex Transm Inf 2000;76:321.

Kaposi’s sarcoma and oesophageal candidiasis. After inpatient treatment of the endocarditis he defaulted from outpatient follow up. Five months later he re-presented with a 3 month history of fever, cough, malaise, and painless skin lesions on both arms and legs. Examination showed multiple dermal papules and nodules with necrosis and some scarring (fig 1A). The CD4 count was 10 cells × 10^9/l and the HIV viral load 202 300 copies/ml. Skin biopsy revealed multiple poorly formed granulomata; numerous acid fast bacilli (AFB) were seen and MAC was subsequently cultured from skin, sputum, urine, and blood. He was treated with rifabutin, clarithromycin, ethambutol, and isoniazid; treatment was reduced to clarithromycin and ethambutol alone, after 6 weeks when the mycobacterium was speciated. HAART,
commenced.

EDITOR,—The report by Rogstad et al.1

3 Whitely W, Tariq A, Peters B, et al.2

and legs. These were tender, erythematous, and had a pustular centre (fig 1B). The monocyte count peaked at 43.2×10^9/l on the sixth day. Aspiration of pus from a skin lesion revealed an AFB; MAC was consequently cultured. Antimycobacterial therapy was intensified with addition of rifabutin, intravenous amikacin, and prednisolone (60 mg once daily reducing to zero over 14 days). This result can in poor rates of partner notification, an increased likelihood of further transmission, a reduction in the impact of testing on disease incidence, and an increased risk of complications. In GUM clinics, diagnosis generally results in treatment and consequently surveillance data derived from this setting, the KC60 dataset, can be used as a measure of treatment success. In a previous study, two large public studies suggest that a proportion of diagnoses made in primary care may not be treated. This questions the validity of using diagnosed infection as an outcome measure for evaluating sexual health interventions in primary care. It also emphasises the significant role of clinical audit in the improvement of the quality of patient management. Ultimately the effectiveness of intervention should be measured in terms of a reduced prevalence of pelvic inflammatory disease and associated sequelae.4 However, other more pragmatic outcome measures may need to be used. The UK NHS C trachomatis screening pilot is evaluating feasibility and acceptability of opportunistic screening in primary and secondary healthcare settings in two health authorities.5 Three of the primary outcome measures that are being evaluated are the number of positive diagnoses, the proportion of the positive diagnoses treated, and the rate of patient or provider led partner notification. In the pilot, patient management has been improved by recalling positive patients to a community outreach team, and being GUM health advisers. Preliminary data indicate that out of 900 positive patients identified through the Wirral arm of the pilot, treatment was recommended to 40 (4.4%) patients. Separate studies in Liverpool are also evaluating how patient management could be enhanced by GUM health advisers working in outreach sessions in a community FPC (AMCW) and a department of obstetrics and gynaecology (E Bateman, submitted to British Journal of Family Planning). Results from these studies will provide further evidence to guide the development of patient management and the outcome measures that could be used to assess future intervention strategies.

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Accepted for publication 2 February 2001

Obituaries

EDITOR,—The obituaries of three physicians, Ambrose King, Eric Dunlop, and David Oriel, appeared in quick succession in your columns.

By the time I started training in venereology, as it was then called (not a bad name incidentally because it means the science of the act of love which encompasses STIs, colposcopy, HIV disease, and sexual dysfunction) at the Whitechapel Clinic of the London Hospital in 1973, Ambrose King had already left. However, the clinic still sparkled (not physically you understand) from his inspirational radiance and he was spoken of in hushed, reverential tones.

Eric Dunlop was the senior physician at that time. To a very junior doctor he was literally an awe inspiring figure. By today’s standards he did not educate or teach. Rather you were well aware that he had laid a “golden egg” and that there was a touch of colour and brilliance in his research work and lectures. I was taught basic day to day venerology by the senior charge nurses at that department. Eric Dunlop’s lucidity was legendary. We took nine specimens from each woman to screen for Chlamydia trachomatis (including three cervical curettings) and a vaginal biopsy. The purpose built Dunlop-Jones male urethral curette was a most efficient method of obtaining chlamydial material, although its contemporaneous thalamic overstimulation did not endear it to the patients. This meticulousness transferred itself to one’s own attitude to research, and many of us also aspired to achieve Eric Dunlop’s larger than life persona and facility for developing new ideas (never really worked for me) I later worked for David Oriel. He made advances by quietly yet relentlessly pushing away at the broad front of research and clinical medicine. He was attracted by many of the sensible, practical, therapeutic approaches of our American colleagues—for example, benzathine penicillin for syphilis, doxycycline for chlamydia, which were far from routinely practised in the United Kingdom at that time. David Oriel also insisted on each set of clinical notes being audited on a daily basis. This was in 1978, well before clinical audit became routine.

But Eric Dunlop and David Oriel were wholly generous and encouraging to a young

This is a follow up on the author's 1976 Report on Female Sexuality. It confirms the findings of her earlier report on American women and includes a "postscript" which reports similar findings in UK, Australian, and New Zealand women. The emphasis is on orgasm frequency.

In the American part of the study three versions of a questionnaire (labelled I, II, and III) augment the earlier 1972-6 study (labelled IV). Altogether, the number of questionnaires distributed was 100 000 with 3019 returned. The number of questionnaires I, II, and III returned was 1844. Replies received from UK, Australian, and New Zealand women to questionnaire IV numbered 511. The author claims that, especially, questionnaires I, II, and III give a true representation of women of all ages and occupations. The figures are presented partly in the text and by detailed appendices. The text provides detailed individual quotes in abundance on all aspects of female sexuality and orgasm.

In brief, there is little new to report. Masturbation remains the surest source of orgasm for many women and includes a "postscript" which reports similar findings in UK, Australian, and New Zealand women. The emphasis is on orgasm frequency.

The findings confirm those of Freud, Kinsey et al as well as Masters and Johnson and make it clear that men not only need to take the clitoris seriously but to ensure that its function is more regularly fulfilled whatever the form of sexual congress.

R S MORTON


Over the years, many books on the use of antimicrobials in the treatment of infectious disease have been written. Although few of these books have a subtitle implying that resistance will be specifically dealt with (as with this book), most of them by necessity write about this topic. I approached this book with a degree of cynicism, expecting to find the same tales retold in the same formulaic way. The first part of the book was not what I expected and I was pleasantly surprised. The first seven chapters dealt with the science of resistance generally, and then with specific examples, in a way that was informative and relevant to many clinicians. These early chapters also information on epidemiology, public health measures, and vaccination that are relevant to managing the problems of resistant organisms. Although this is a multi-author book, there seemed to be more consistency in approach and writing in these early chapters than those found later. The latter part of the book was little more than the systems based summary of antimicrobial use found in so many books.

As is to be expected with a book written by American authors, there are differences in practice from that in the United Kingdom: recommendations for treatment of community acquired pneumonia differ from those of the British Thoracic Society; recommendations for the treatment of infective endocarditis differ from those of the ESC Working Party. Although generic drugs, some of these are different (although comparable) from those we would use in the United Kingdom. The authors frequently recommend the use of trimethoprim-sulphamethoxazole; because of the risk of sulphonamide toxicity, the CSM only recommends the use of this combination for specific indications in the United Kingdom. In the chapter on meningitis the authors do not recommend the immediate use of penicillin upon clinical suspicion (UK guidance). The controversy of use of antibiotics in the treatment of infective diarrhoea is not discussed. Most importantly, the adverse effects of using antibiotics in shigellosis in children and EHEC infection are not mentioned.

The chapters on the treatment of sexually transmitted infections and HIV are short for a specialist reader, and there really should have been a separate chapter on hepatitis. I doubt there is much in this book that the established GUM clinician or scientist will find helpful. The trainee GUM physician may be confused or misled.

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Quality Council (Australia), NSW Health (Australia) and Ministry of Health (New Zealand). Further details: quality@bma.org.uk; fax +44 (0) 7383 6869.

41st St Andrew's Day Festival Symposium on Therapeutics
The 41st St Andrew's Day Festival Symposium on Therapeutics will be held on 6–7 December 2001 at the Royal College of Physicians of Edinburgh. Further details: Ms Eileen Strawn, Symposium Co-ordinator (tel: 0131 225 7324; fax: 0131 220 4393; email: e.strawn@rcpe.ac.uk; website: www.rcpe.ac.uk).

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).

5th World Congress of Perinatal Medicine, 23–27 September 2001, Palau de Congressos de Barcelona - Avda Maria Cristina s/n, Barcelona, Spain
Further details: Dr Francesc Figueras, Congress Promotion Secretary (fax: +34.93.451.74 38; www.perinatology2001.com).

Second International Conference on Sexual Health, to be held in Bangkok, Thailand on 23–28 February 2002. Calls for abstracts deadline 1 September 2001
Further details: European Secretariat, Dr Richard Burack (tel: +44 (0) 20 8599 8029; email: siamcare@aol.com).

20th World Congress of Dermatology, Paris, 1–5 July 2002
Further details: P Fournier, Colloquium, 12 rue de la Croix St Faubin, 75011 Paris, France (rel: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fournier@coloquium.fr; website: www.derm-wcd-2002.com).
Genital herpes may mask underlying neoplasia

T Green, K E Rogstad and M E L Paterson

*Sex Transm Infect* 2001 77: 148-149
doi: 10.1136/sti.77.2.148-a

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