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 Ranatunga, Dr Seanan, Dr George Gossa, 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 her care and support as a fellow human for the society when Maggie Godley sadly died following her two year illness. She will be remembered for all the work he put into running both MSSVD and AGUM and for her care and support as a fellow human being.

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MSSVD continues to provide meetings in conjunction with other societies. These have included the SSSTDA/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.

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 DFFP 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 Vale, David Daniels, Mary Stevenson, and Stephen Green, infectious disease consultant at Sheffield, entertained us on Saturday evening. Pfizer 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
Papulonecrotic tuberculides 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 present episode of painful ulceration had been lasting for 6 months or so. In spite of various treatments received from various private practitioners, his genital sore did not heal completely. Even though it is considered to be rare, tuberculosis of the penis is the most common manifestation of genitourinary tuberculosis. Clinically, it may present as superficial ulcers of the penis or tuberculous cavernositis. Papulonecrotic tuberculides, a form of cutaneous tuberculides, 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 as seen in our case. The diagnosis of papulonecrotic tuberculides in our case was based on the well laid down criteria.

Papulonecrotic tuberculides are mostly extragenital, but rarely genitalia may be involved. Sometimes, the glans penis alone may be involved as in our patient and then diagnosis becomes difficult. Under these circumstances, it needs to be differentiated from atypical soft sore, syphilis, recurrent herpes simplex, and malignant ulcer. The diagnosis of such cases rests on biopsy, tuberculoid testing and, in doubtful cases, a therapeutical test is usually decisive. The possibility of tuberculosis as a cause of chronic ulcer on the penis has to be kept in mind especially in countries like India, where tuberculosis is still prevalent.

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

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<th>Male (n=86)</th>
<th>Female (n=123)</th>
<th>p Value</th>
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<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>
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*ATG = Attitudes to Gay Men.
†ATL = Attitudes to Lesbians.

We wish to report encouraging attitudes in a minority of medical students. Homophobia is recognised as a barrier to accessing health care, specifically on “lack of interest” or homophobia contributing to the paucity of interest into STI risk among WSWs. Homophobia is considered to be rare, Tuberculides of the penis: report of 2 cases. J Urol 1980;124:927.


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results are presented in table 1. The majority of the sample displayed positive attitudes to lesbians and homosexual men with female students exhibiting statistically more positive views especially in relation to homosexual men. However, a significant minority of men (11.8%) exhibited extremely negative attitudes to homosexual men.

We are encouraged by these results which are contrary to much of the published data on attitudes among physicians, nurses, and medical and non-medical students. However, we must continue to challenge negative attitudes as studies show that teaching and promoting tolerance can result in change. Otherwise difficulties with disclosure in medical settings will continue to impact on provision of health care to WSW and homosexual men and further hamper research in this area.

Questionnaires and postal research: more than just high response rates

EDITOR,—In the recent editorial by Bates and Rogstad the authors describe the problems associated with conducting postal research, including response rates, use of incentives, bias, mailing clinical specimens, and ethical issues. We would like to add that there are other important issues to consider when undertaking questionnaire research.

The effectiveness of incentives to increase response rates remains controversial. Kalantar and Talley recommend using a lottery incentive as it increases response rates after the first mailing. However, differences between groups were not large, and decreased during follow up and disappeared by the fourth mailing. Koloski et al found that the use of lottery tickets increase response rates, but may be limited when using them with long questionnaires (32 pages). Moreover, they compared the length of questionnaire (28 or 32 pages) which, while being different, did not reach statistical significance.

The most important aspect of postal research is the questionnaire itself. While high response rates are desirable, it is critical that the information provided by participants is of high quality. The quality of the data may differ between short and long questionnaires and to our knowledge this has never been validated. When participants fill out a long questionnaire they may rush or mark incorrect responses purely because they have lost 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 the questionnaires used in this study? In comparison with a four or 10 page questionnaire they are still long. Studies are lacking which highlight 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 to 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 embarrassing. The researcher should not promise greater confidentiality than he/she can provide remembering that coders and 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 ups 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.

Genital herpes may mask underlying neoplasia

EDITOR,—Lesions that fail to heal despite appropriate therapy should always be biopsied to look for an underlying diagnosis. We have seen a 44 year old woman who presented with genital ulceration and lichen sclerosus and was culture positive for herpes simplex virus (HSV) type 1. After treatment with two courses of oral aciclovir there was some reduction in ulceration and resolution of symptoms. However, in view of the persisting solitary ulcer and the presence of lichen sclerosus (fig 1) a biopsy was performed. Histology was reported as showing poorly differentiated invasive squamous cell carcinoma with vulval dystrophy but no features of wart virus infection. She was promptly referred to the gynaecological oncology department where local radiotherapy and chemotherapy were the initial treatments of choice as the tumour extended close to the anal margin. The immediate response was encouraging but subsequently vaginal adhesions and difficulty with micturition developed. A pelvic CT scan showed bilateral inguinal node involvement (fig 2). Radical block dissection was subsequently performed but lymphoedema and local skin nodules developed and she died 2 years after diagnosis.

Figure 1 Appearance of the vulva—ulceration remains despite therapy for HSV. Note white plaques, small haemorrhages, and labial resorption typical of lichen sclerosus.
Sexually shared infections

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 then this happened.”

The third one was a chlamydia reinfection. 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 had protected sex but the condom split and the girl was reinoculated. When I mentioned the “shared” element she frowned, “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 gynaecology 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.

RAVI GOKHALE
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Deterioration of disseminated cutaneous Mycobacterium avium complex infection with a leukoaeid 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.1,4 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.1,5 Focal mycobacterial lymphadenitis appears to be the commonest manifestation,1,6 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 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. A skin biopsy was 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 pustular centre.

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The inappropriate or inadequate treatment, low rate of partner notification, and lack of referral to genitourinary medicine (GUM) clinic described were similar to the observations made in two recent studies. An investigation in Merseyside family planning clinics (FPC) showed that of 80 infected patients identified (n = 958) only 34% were treated within 1 month of diagnosis, 24% had no proof of treatment, and 13% never found out they were infected. Similarly, a study of 112 women diagnosed with Chlamydia trachomatis attending FPC showed that only 48% were known to have been treated 3 months after the test had been carried out. If diagnosis does not result in immediate treatment, patients can be lost to follow up. In turn, this can result 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 conclusion, the above 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. 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. 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 by a community officer staffed by GUM health advisers. Preliminary data indicate that out of 900 positive patients identified through the Wirral arm of the pilot, treatment was achieved for 304 (44%) 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 (G W H). 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.

**Detection or treatment: which outcome measure?**

**Editor,---** The report by Rogstad et al is a timely description of the problems associated with the management of patients diagnosed with genital chlamydial infection within and between established healthcare settings. The

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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 a return rate of 30%. The number of questionnaires I and II 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 in the single and multiple. Orgasm “rarely” occurs during intercourse without additional stimulation. Most women were willing to accept sex with a man even if she did not experience an orgasm with him. Lesbianism was a regular source of orgasm for a few women but many more would “like to try” such a relationship.

From the answers to questions and the personal views presented by women, it is clear that the majority support Hite’s view that a “sexual revolution” is needed. They see the way forward as through greater openness. “sexual revolution” is needed. They see the way forward as through greater openness. The controversy of use of antibiotics in shigellosis in children and EHEC infection are not mentioned. The authors frequently recommend the use of trimethoprim-sulfamethoxazole; because of the risk of sulphonamide toxicity, the CSM only recommends the use of this combination for specific indications in the United Kingdom. The authors frequently recommend the use of trimethoprim-sulfamethoxazole; because of the risk of sulphonamide toxicity, the CSM only recommends the use of this combination for specific indications in the United Kingdom. The controversy of use of antibiotics in shigellosis in children and EHEC infection 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.
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 Pauvin, 75011 Paris, France (tel: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fournier@colloquium.fr; website: www.derm-wcd-2002.com).
Deterioration of disseminated cutaneous *Mycobacterium avium* complex infection with a leukaemoid reaction following institution of highly active antiretroviral therapy

M Brown, I G Williams and R F Miller

*Sex Transm Infect* 2001 77: 149-150
doi: 10.1136/sti.77.2.149-a

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