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 Seanan; 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 memoir, which will be in the form of a prize given to the best presentation from a district with the o

Educational initiatives

The Education Sub-Committee met on five occasions. Following discussion at the Education Sub-Committee, it was agreed that in 2000–1, one of the ordinary general meetings’ format would be altered to take into account adult learning theory; the meeting will be in March 2001 and run by the HPV Special Interest Group. The “Induction training steering group” has achieved its objective of producing an educational package suitable for the RSM, 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 BPME, 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 (FPPRHC). 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 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

www.sextransinf.com
Papulonecrotic tuberculide 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 respond.

On physical examination, this moderately nourished individual had a single well defined ulcer on the glans penis near the urethral meatus, measuring 5 × 5 mm. The edge of the ulcer was undermined and its floor had necrotic slough. The ulcer had perforated deeply into the urethra, resulting in dribbling of urine through it (Fig 1). Multiple puckered scars over the glans penis circumferentially, just distal to the coronal sulcus, were evidence of previous episodes of similar ulcerations. The inguinal lymph nodes were not significantly enlarged. His systemic examination was unremarkable.

The haemogram revealed a raised erythrocyte sedimentation rate (64 mm in the first hour). The Mantoux test was strongly positive (20 × 20 mm). VDRL and HIV serology was non-reactive. Radiological investigations did not demonstrate any focus of tuberculosis in the chest or genitourinary system. Smear and culture of discharge from the ulcer and also of urine for acid fast bacilli were negative. Histopathological examination of the ulcer (glans penis) revealed ulcerated epidermis. In the deep dermis, by the side of the ulceration, there were caseating tuberculous granulomas along with perivascular inflammatory infiltrate with vessel wall thickening and endothelial cells swelling. Fite’s stain for acid fast bacilli was negative. These features were consistent with the diagnosis of papulonecrotic tuberculide. The patient was treated with a four drug regimen for antituberculous therapy to which he responded favourably. At the end of 2 months, the ulcer had healed completely.

Even though it is considered to be rare, tuberculosis of the penis may manifest as primary, secondary, or papulonecrotic tuberculide type. Clinically, it may present as superficial ulcers of the penis or tuberculous cavernositis. Papulonecrotic tuberculide, 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 tuberculosis is often not clinically active at the time of eruption as seen in our case. The diagnosis of papulonecrotic tuberculide 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 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, tuberculin testing and, in doubtful cases, a therapeutic 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.

The Sexual Health and HIV Strategy due governance, funding of sexual health services, BMA AIDS foundation, “Access to clinics” report for CMO, liaison with FFPHRHC, and reciprocal CME.

The Sexual Health and HIV Strategy due to report in early 2001 may have a significant impact on services providing sexual health care. The challenge for our specialty is to be at the forefront of these changes, being part of the broader picture and outward looking into the communities which we serve, in contrast to a more passive approach of waiting for the “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 Lesbians and Gay Men (ATLG) Questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Male (n=86)</th>
<th>Female (n=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>ATLG* mean (range)</td>
<td>40.9 (10–90)</td>
<td>31.8 (10–62)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ATLG† 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. †ATLG = Attitudes to Lesbians.
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 SW and homo-sexual men and further hamper research in this area.

**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 associated with conducting postal research. The presentation of the questionnaires will also influence the response rates to postal surveys.

Questionnaires that are profession-ally 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 that their confidentiality and this can improved 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 infor-mation.

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 tech-niques 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 scler-ois (fig 1) a biopsy was performed. Histology was reported as showing poorly differen-tiated 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 subse-quently performed but lymphoedema and local skin nodules developed and she died 2 years after diagnosis.
EDITOR,—Those who have spent some time sexually shared infections

human papillomavirus (HPV) types. STDs other than HPV are also associated with an increase in the risk of developing vulval neoplasia. The presence of antibodies to HSV type 2 has been implicated as a risk for cervical pathology but a role for HSV in vulval neoplasia is unclear. Vulval basal cell carcinoma presenting as culture negative genital herpes has been reported. In our case the carcinoma was culture positive for HSV; this may have been due to new infection or to reactivation of pre-existing HSV in the presence of malignancy. This case highlights the need for biopsy of herpetic lesions which fail to respond to standard therapy.

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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 or specialist clinics to psychosocial health departments but also the name 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 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 reinected. 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 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. 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. Focal mycobacterial lymphadenitis appears to be the commonest manifestation 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 MAC. He had a history of cutaneous azid; treatment was reduced to clarithromycin; rifampicin 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,

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 × 10⁹/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,
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dale Avenue, London NW9 5EQ, UK

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, Eric Dunlop had already moved on. I was taught basic day to day venereology by the senior charge nurses at that department. Eric Dunlop’s meticulousness was legendary. We took nine specimens from each woman to screen for Chlamydia trachomatis (including three cervical curatings) and a single cervical biopsy. Eric Dunlop-Jones male urethral curette was a most efficient method of obtaining chlamydial material, although its contemporaneous thalamic stimulation 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 longer life persona and facility for developing new ideas (never really worked for me, I confess).

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 his contemporaneous radiology, although its contemporaneous material, although its contemporaneous 'golden egg' and that there was a touch of laziness from his inspirational radiology, 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, Eric Dunlop had already moved on. I was taught basic day to day venereology by the senior charge nurses at that department. Eric Dunlop’s meticulousness was legendary. We took nine specimens from each woman to screen for Chlamydia trachomatis (including three cervical curatings) and a single cervical biopsy. Eric Dunlop-Jones male urethral curette was a most efficient method of obtaining chlamydial material, although its contemporaneous thalamic stimulation 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 longer life persona and facility for developing new ideas (never really worked for me, I confess).

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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 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 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. There is a need to destroy double standards—for example, the concept that sexy women, in contrast with sexy men, are not respectable. In addition, it is clear women would like it noted that they would appreciate the pattern and definition of sex to include greater diversity. Sexual intercourse on its own is not enough for many. Greater diversity is called for. In other words women's desires and needs, not least in achieving orgasm more regularly, need to be taken into account.

By way of summary, Hite calls for greater dissemination of data regarding the anatomical basis and the physiology of female orgasm with emphasis on the role of the clitoris. In her revolutionary terms she sees orgasm as a metaphor for women's power in society.
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 (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).
Detection or treatment: which outcome measure?

I Simms, H Mallinson, J Hopwood, A M C Webb, K Fenton and J Pimenta

*Sex Transm Infect* 2001 77: 150
doi: 10.1136/sti.77.2.150

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