Letters to the editor

Methicillin resistant _Staphylococcus aureus_ (MRSA) balanoposthitis in an insulin dependent diabetic male

Editor,—Balanoposthitis is a common condition affecting 11% of the male attendees at GUM clinics.1 It is an inflammation of the glans penis and the prepuce, and its causes include bacterial and yeast infections, parasitic infestations, trauma, and irritants.2 However, to our knowledge, no case has been reported to be caused by MRSA.

A 49 year old insulin dependent diabetic male presented as an inpatient for repair of a upper jaw fracture developed a penile itch with swollen foreskin, which was difficult to retract, together with longitudinal fissures on the prepuce and subpreputial discharge. In his recent past he had had two incidents of unprotected sexual intercourse with two known females. He was clinically diagnosed as having candida balanitis and was commenced on clotrimazole cream, which did not produce a clinical response over the course of a week. The swabs taken before the commencement of clotrimazole cream failed to grow candida; however, MRSA resistant to erythromycin, penicillin, and flucloxacillin was isolated. Screening tests for chlamydia, gonorrhoea, and trichomonas were negative. A 10 day course of mupiricin 2% ointment completely resolved his symptoms. Subpreputial swab after treatment was negative.

MRSA has been a well recognised cause of hospital acquired infections worldwide since it was first detected in Europe in the 1960s.3 The organism can survive for long periods in both the hospital and the home environment and can colonise the skin, nose, or throat of patients and healthcare staff.4 Several reports have suggested that diabetic patients are more susceptible to _Staphylococcus aureus_ bacteremia5 MRSA has been isolated from different sites in diabetic patients but not the genitalia.6 MRSA rarely invades intact skin; however, it can give rise to severe infections—for example, wound infection, bacteraemia, endocarditis, and osteomyelitis.7 This case illustrates the fact that MRSA is an organism to consider in patients who develop balanoposthitis while in hospital or shortly after discharge especially those whose immune system is incompetent.

There may be implications of spread of MRSA in the community for sexual contacts of patients carrying MRSA in the genital area.

Contributors: Both authors managed the patient and wrote the manuscript.

E HERIEKA 
FISK
Department of GUM, Leicester Royal Infirmary, Leicester LE1 5WW, UK

Correspondence to: Dr E Herieka
Bherieka@ulh.trent.nhs.uk

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Letters to the editor

Chlamydia trachomatis reinfection rate: a forgotten aspect of female genital chlamydia management

Editor,—Hillis et al reported that repeated episodes of infection of female genital tract with _Chlamydia trachomatis_ increase the risk of hospital admission for pelvic inflammatory disease and ectopic pregnancy. The first diagnosed attack of genital infection with chlamydia presents the clinician with a unique opportunity to implement measures to minimise the risk of reinfection—that is, health promotion and contact tracing. During April–June 1998 we reviewed the case notes of female patients who were diagnosed with genital chlamydia at Leicester Royal Infirmary and Derbyshire Royal Infirmary GUM clinics in the year 1996 for evidence of repeat episode of genital chlamydia. We also noted the following data: age at presentation with the first episode of infection, time for presentation with reinfection, test of cure if performed, co-infection with gonorrhoea, review by health adviser, contact(s) traced and treated in the first 3 months after diagnosis. For the purpose of the study we defined reinfection as a patient testing positive for genital chlamydia 30 days or more after the completion of treatment. We also looked at the genital chlamydia treatment protocols in both clinics.

A total of 540 female patients were diagnosed with chlamydia (311 at Leicester and 229 at Derby). The patients’ mean age at first episode was 22.6 years for Leicester and 23.4 years for Derby. The health advisers had made contact with 94.5% (294) in Leicester and 97.8% (224) in Derby; 85.2% (265) of the patients diagnosed at Leicester returned at 30 days or more and were retested for chlamydia compared with 87.3% (200) at Derby; 9% (24) episodes of repeat infection were identified in Leicester group compared to 17% (34) episodes in the Derby cohort. The mean period for presentation with reinfection was 9.4 months (range 3–25) at Leicester and 9.8 months (range 2–24) at Derby. At Leicester the contacts of 66.5% (207) patients were traced and treated compared to 64.6% (148) at Derby. A test of cure was performed on 282 patient in Leicester (where it was routine practice); 2.5% (seven) were found to be positive for chlamydial infection, while the test of cure was performed on 22 patients in Derby (where it was performed selectively) revealed no positive cases.

Of the reinfected patients 58.3% (14) at Leicester were reinfected because of failure to trace and treat their partner(s) compared to 35.5% (12) at the Derby clinic.

Both clinics manage genital chlamydia with what was considered standard treatment and perform contact tracing wherever possible. Two reinfected patients from each clinic were also co-infected with gonorrhea.

Other risk factors for reinfection—for example, ethnic origin, number of sexual partners,9 were not analysed as these data was not discernible from the notes. This retrospective study highlights the fact that a substantial number of patients get reinfected with chlamydia despite health education and counselling by health advisers. Though the figures (66.5% and 64.6%) for partner notification and treatment were close to that proposed by the Central Audit Group (70%), the proportion of MRSA cases is still too high. Does the message that repeat episodes of genital chlamydia are more damaging get through to our patients or do we need a new health education strategy?

Currently, as the success of treatment of genital chlamydia is evaluated by the level of contact tracing, the number of patients referred to health advisers, and number of contacts per index patient seen and treated,10 we believe it is time to evaluate outcome measures in terms of reinfection rates. Large prospective studies need to be done to elucidate this aspect of chlamydial infection management.

Contributions: PS had the original idea; EH collected and analysed the data EH and JD wrote the manuscript.

E HERIEKA
P SCHOBER
J DHAR
Department of GUM, Leicester Royal Infirmary
Leicester LE1 5WW, UK
bherieka@ulh.trent.nhs.uk

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Accepted for publication 8 March 2001

The Society of Apothecaries Diploma examination in Genitourinary Medicine: death of the viva voce?

Editor,—The London Apothecaries Diploma in Genitourinary Medicine is likely to become even more important in the near future as all specialist registrars and probably...
Detection of chlamydia on meatal swabs

Editor,—The advent of ligase chain reaction (LCR) and other DNA technologies and their greater sensitivity has allowed the possibility of taking samples other than from the urethra in men, including urine samples.² ³

Although urine samples have the advantage of being collected non-invasively, the sensitiv- ity of LCR tests on such samples is less than for urethral samples.² This may be due to the presence of inhibitors in urine.² The reduced sensitivity on urine samples may be unacceptable, particularly if testing populations with a high prevalence of chlamydial infection. Further processing of urine samples is more laborious.

It is currently recommended that spec- imens for the detection of genital Chlamydia trachomatis infection by LCR are taken 2–4 cm from the urethral orifice and the swab rotated for 3.5 seconds.² Many men are unable to tolerate this. It is often painful and may discourage patients from seeking med- ical attention.

A pilot study was conducted to compare the sensitivity of LCR testing for genital chlamydial infection in men, taken from the meatus itself against the standard technique. All male patients attending the GUM clinic over a 3 month period were included in the study if they had symptoms or signs compat- ible with chlamydia, or if a contact of a known case of chlamydia. A swab was taken from the urethra in the standard fashion. A second swab was taken from the meatus. After the sixth week of the study the order of the first and second swabs was changed, in order to evaluate any bias related to the order of the swabs. Specimens were processed using Abbott Laboratories LCR Chlamydia and handled according to the manufacturer’s guidelines.

Twenty five patients were asked to evaluate the swabs and to state which swab caused least discomfort or if there was no difference between them. A total of 208 men were recruited to the study. The overall prevalence of genital chlamydia infection in our popula- tion was 25% (52/208). A confirmed diagno- sis was made of 94% of the samples performed from the same man were positive for chlamydia, or if one sample was positive together with an equivocal result. There were no false positive tests using these criteria giv- ing all methods 100%.

There was no significant difference in detection rates between the subgroups where the order of swabs was changed.

A meatal swab for the detection of chlamy- dia is more acceptable to patients and has a similar sensitivity to the traditional technique of urethral sampling.

Urine samples, although non-invasive, are less likely to yield a definitive diagnosis compared to urethral/meatal swabs and require extra processing by laboratories.

In a high prevalence setting (such as a sexual health clinic), the meatal technique provides a specific, sensitive, and well tolerated sampling method for the detection of chlamydia infection in men.

Further studies to confirm our findings in symptomatic, and asymptomatic, chlamydia infection are needed before introducing this technique as routine clinical practice.

Contributors: HLM, principal investigator and author; SMM, investigator and edited final draft; JLD, data collection and obtained specimens; MSS, investigator and processed specimens.

HUMPHREY BIRLEY
Department of GUM Royal Liverpool University Hospital, Liverpool L7 8RX, UK

1 Esmail A, May C. Oral exams—get them right or don’t bother. BMJ 2000;320:375.


7 Abbott Diagnostics Division. Package Insert for LCx™ Chlamydia. Accepted for publication 8 March 2001

HIV positive and negative homosexual men have adopted different strategies for reducing the risk of HIV transmission

Editor,—To reduce the risk of HIV trans- mission, some homosexual men have adopted a strategy whereby they only have unpro- tected anal intercourse (UAI) with a person of the same HIV status (known as “concord- ant UAI”). In London, homosexual men in a relationship are more likely to know the HIV status of their UAI partner than men not in a relationship and so establish concordance. However, this was not examined for HIV positive and negative men separately. A survey conducted in January–February 2000 among homosexual/bisexual men attending one of six gyms in central London, as part of an ongoing behavioural surveillance pro- gramme,¹ has allowed risk reduction strategies to be considered by HIV status. A total of 792 homosexual men (median age 35 years) completed a confidential questionnaire (estimated response rate 50–60%)²; 126 (16.0%) were HIV positive, 477 (60.2%) HIV negative, while 169 (21.3%) had never had an HIV test (data missing for 20 men). Just under half the men (55.4%) said they were currently in a relationship with another man; this did not differ significantly by HIV status (p=0.1).

Our analysis focused on how sexual risk behaviour varied both by HIV as well as by relationship status. For HIV negative and positive men, UAI was classified as either concordant (UAI with a partner of the same HIV status) or non-concordant (UAI with a partner of unknown or discordant HIV status). Men reporting more than one UAI partner were classified as concordant only if all UAI partners were of the same HIV status as themselves. Men also indicated whether they had had UAI with a main partner only, casual partner(s), or both. One third of all men (32.9%, 259) reported UAI in the previous 3 months; HIV positive men 42.1% (53/ 126) HIV negative 34.2% (34/99) (data missing for two men) (p=0.1). Overall, concordant UAI was reported by 18.7% (89) of HIV negative and 21.4% (27) of HIV positive men (p=0.4). For HIV negative men, concordant UAI was predominantly reported by those in a relationship and rarely by men who were not (28.6% v 5.0%, p<0.001) (table 1). Concordant UAI was usually with a main partner alone. By way of comparison, HIV positive men were just as likely to report

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concordant UAI whether they were in a relation-
ship, or not (77.2% vs 20.6%), often with a casual rather than main partner. The observation that HIV negative men were more likely to report concordant UAI in the context of a relationship while HIV positive men were just as likely to report concordant UAI whether they were in a relationship or not was confirmed in a multivariate model. With HIV status and relationship as independ-
tent variables and concordant UAI as the dependent variable, the interactions between HIV status and relationship was highly significant (p=0.001).
Seroconcordance among negative men can only be established with confidence if both men test for HIV together. For this reason it is difficult for HIV negative men to establish concordance with a casual partner. On the other hand, HIV positive men can establish concordance with it with a casual or regular partner, simply by mutual disclosure. This requires no confirmatory test. Although sero-

Table 1: Unprotected anal intercourse (UAI) in the previous 3 months
Age

<table>
<thead>
<tr>
<th>Type of partner for UAI</th>
<th>Men in a relationship reporting</th>
<th>Men not in a relationship reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Main only</td>
<td>Casual†</td>
</tr>
<tr>
<td>HIV negative men (n=177)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concordant UAI</td>
<td>27.1 (75)</td>
<td>1.5 (4)</td>
</tr>
<tr>
<td>Non-concordant UAI</td>
<td>8.0 (22)</td>
<td>6.2 (18)</td>
</tr>
<tr>
<td>Total</td>
<td>35.1 (97)</td>
<td>8.2 (22)</td>
</tr>
<tr>
<td>HIV positive men (n=126)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concordant UAI</td>
<td>2.5 (5)</td>
<td>2.5 (5)</td>
</tr>
<tr>
<td>Non-concordant UAI‡</td>
<td>1.5 (3)</td>
<td>16.1 (32)</td>
</tr>
<tr>
<td>Total</td>
<td>4.0 (8)</td>
<td>18.6 (37)</td>
</tr>
</tbody>
</table>

*Men reporting casual partners only or contact men reported casual partners only. †Men reporting UAI with a partner of known or predominantly with a partner of unknown HIV status.
‡Men reporting UAI with a partner of unknown or discordant HIV status. Non-concordant UAI was usually reported by 15.8% (75) of HIV negative and 3.2% (2) of HIV positive men respectively.

In conclusion, HIV negative and positive homosexual men have both adopted HIV risk reduction strategies. None the less, high risk sexual behaviours have both occurred and drug resistance for the men themselves.

These data provide further evidence that HIV positive and negative homosexual men have both adopted HIV risk reduction strategies. But the less, high risk sexual behaviour (that is, non-concordant UAI) was reported. Overall, non-concordant UAI was reported by 15.8% (75) of HIV negative and 2.5% (2) of HIV positive men respectively. No significant differences were seen when stratified by either relationship or HIV status (table 1). In the multivariate model there was no significant association between non-concordant UAI and either HIV status (p=0.4) or being in a relationship (p=0.7).

Non-concordant UAI was usually reported with a casual partner with one notable exception. HIV negative men in a relationship were equally likely to report non-concordant UAI with a main partner alone (8.0%) as with a casual partner (6.5%) highlighting the continuing risk for HIV transmission between regular partners. However, for most men the risk of HIV transmission occurred in the context of a casual sexual encounter. Surveys conducted in the gyms in 1998 and 1999 revealed similar patterns of sexual risk behaviour (data available from authors).

A mobile phone text message and Trichomonas vaginalis
EDITOR,—Over the past decade vast numbers of the general population have accepted the internet, email, and mobile phones. Among new patients attending our centre 70.3% (90/128) of men and 73.7% (93/123) of women provide mobile telephone numbers for contact. However, the use of mobile phones as a mechanism for contact tracing as far as I am aware has not been reported previously.

A 26 year old Afro-Caribbean man presented to our clinic and informed us that his girlfriend had attended a GUM clinic but unfortunately he did not know why. However, he informed us that he had a text message on his mobile. He duly brought up the message, which gave the woman’s clinic number and the KC60 diagnosis of C06A.

On examination there were no abnormalities seen, there were no polymorphs on microscopy, swabs for gonorrhoea, chlamy-

To: Tony.Newell@nhs-tr.tra.nhs.uk
kind of interference, and that basic common sense should prevail.

COLOM O’MAHONY
Department of Genito-Urinary Medicine,
Countess of Chester Hospital, Liverpool Road,
Chester CH1 2UL, UK


Accepted for publication 15 February 2001

Lichen sclerosis of the glans is significantly associated with penile carcinoma

EDITOR,—We read with interest the article by Riddell et al on 66 men with penile lichen sclerosus (PLS) attending a department of genitourinary medicine.1 In this study, the authors found no cases of malignancy. We have previously reported a retrospective study on the incidence of cancer on 86 cases of PLS retrieved from our histopathological files over a 10 year period (1987–97).2 In that study, five cases showed malignant transformation—namely, squamous cell carcinoma (SCC) (three cases), in situ carcinoma (one case), and verrucous carcinoma (one case).

Since that report, we decided to interview all PLS patients in order to rule out any further malignancy that occurred over time. Of 86 patients identified, 60 were evaluated at our clinic. Among these, we found three additional patients treated with partial penectomy for invasive SCC at other institutions. Their medical records were obtained together with paraffin embedded tissue samples to perform polymerase chain reaction (PCR) for human papillomavirus (HPV) testing. Clinical and laboratory information for these cases, together with previously reported patients, are summarised in table 1.

In this current study, eight (9.3%) out of 86 patients with PLS developed an epithelial cancer. Data analysis using the t test confirmed in our series a statistically significant risk of malignant degeneration (p <0.05). Clinically, the most common presentation of epithelial cancer arising with PLS was that of an infiltrated or ulcerated plaque followed, in decreasing order of frequency, by a nodular lesion or verrucous papules. The glans was the most commonly affected area. The average age of onset of PLS was 45 years, and that of development of cancer was 62 years. The average lag time from onset of PLS to cancer development was 18 years (range 10–34 years). This long latency time might explain the paucity of cases, mostly anecdotal, reported in the literature in the past 22 years (approximately 20).2,3 compared with our study, in which a long follow up disclosed 9.3% malignant degeneration in a series of 86 patients.

Also, the latency time was shorter in the HPV positive patients (average 15 years) compared with the HPV negative patients (average 23 years). The role of HPV in the pathogenesis of penile cancer is not fully understood. Some HPVVs, such as type 16 and 18, are likely to play a part, but not all penile carcinomas are HPV positive, as shown in our study. Also, PLS is not commonly associated with HPV infection.1 In our study we found five patients positive for HPV 16 infection, and this may have hastened the progression towards cancer resulting in a shorter lag time. However, routine HPV testing on larger series is necessary in order to draw any definitive conclusion.

Similarly to vulvar lichen sclerosus, which has been observed to undergo malignant degeneration in 3–6% of women,4 a likely malignant evolution of PLS should be considered. Careful and systematic histopathological evaluation of any ulcerated or indurated plaques developing within PLS is therefore strongly recommended. The association between PLS and cancer may very well be underestimated and there is a need for further investigation that includes long term follow up and routine PCR analysis for HPV infection.

GIUSEPPE MICALI
MARIA RITA NASCA
Dermatology Clinic, University of Catania, Italy
DANIELE INNOCENZI
Dermatology Clinic, University “La Sapienza,” Rome, Italy

Correspondence to: Giuseppe Micali, MD, Clinica Dermatologica, Università di Catania, Piazza S Agata La Vetere, 6, 95124 - Catania, Italy
cldermct@dimtel.nti.it

1 Riddell L, Edwards A, Sherrard J. Clinical and laboratory information for these cases, together with previously reported patients, are summarised in table 1.

Table 1 Clinical and histopathological features of eight cases of carcinoma on penile lichen sclerosus Patient No Age of onset of PLS (years) Age of onset of Ca (years) Lag time (years) Site Clinical aspect of malignancy on PLS Histopathology PCR testing for HPV

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Age of onset of PLS (years)</th>
<th>Age of onset of Ca (years)</th>
<th>Lag time (years)</th>
<th>Site</th>
<th>Clinical aspect of malignancy on PLS</th>
<th>Histopathology</th>
<th>PCR testing for HPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>41</td>
<td>62</td>
<td>21</td>
<td>glans</td>
<td>fungating keratotic nodule with a white-yellowish hue slightly elevated verrucous papules</td>
<td>SCC</td>
<td>negative</td>
</tr>
<tr>
<td>2*</td>
<td>36</td>
<td>59</td>
<td>23</td>
<td>glans, coronary sulcus</td>
<td>multiple erythematous, indurated, and ulcerated plaques sharply circumscribed, erythematous, eroded and slightly infiltrated plaque</td>
<td>well differentiated SCC</td>
<td>HPV 16</td>
</tr>
<tr>
<td>3*</td>
<td>41</td>
<td>55</td>
<td>14</td>
<td>glans, coronary sulcus</td>
<td>sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>well differentiated SCC</td>
<td>HPV 16</td>
</tr>
<tr>
<td>4*</td>
<td>39</td>
<td>49</td>
<td>10</td>
<td>glans, coronary sulcus, inner aspect of the foreskin</td>
<td>sharply circumscribed, erythematous, eroded, crusted, and indurated plaque</td>
<td>well differentiated SCC</td>
<td>HPV 16</td>
</tr>
<tr>
<td>5*</td>
<td>29</td>
<td>47</td>
<td>18</td>
<td>glans</td>
<td>exophytic verrucous whitish nodule sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>SCC</td>
<td>negative</td>
</tr>
<tr>
<td>6</td>
<td>75</td>
<td>85</td>
<td>10</td>
<td>glans</td>
<td>sharply circumscribed, erythematous, eroded, crusted, and indurated plaque</td>
<td>SCC</td>
<td>HPV 16</td>
</tr>
<tr>
<td>7</td>
<td>66</td>
<td>70</td>
<td>15</td>
<td>glans, coronary sulcus</td>
<td>sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>well differentiated SCC</td>
<td>HPV 16</td>
</tr>
<tr>
<td>8</td>
<td>33</td>
<td>67</td>
<td>34</td>
<td>glans, coronary sulcus</td>
<td>sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>undifferentiated SCC</td>
<td>negative</td>
</tr>
</tbody>
</table>

*Previous reported cases.1

PLS = penile lichen sclerosus; Ca = carcinoma; PCR = polymerase chain reaction; HPV = human papillomavirus; SCC = squamous cell carcinoma; VC = verrucous carcinoma.


Accepted for publication 22 March 2001

Third trimester screening or safer sex to prevent mother to child transmission of HIV

EDITOR,—Since 1992 Department of Health guidelines have recommended that HIV screening be offered to all pregnant women in areas of high seroprevalence5 but implementation and uptake has been poor. In 1998 an intercollegiate working party recommended that HIV testing be integrated with antenatal screening for other infections and that the test should be offered and recommended to all pregnant women in high seroprevalence areas.6 In 1999 the Department of Health extended these recommendations to all regions aiming to reduce neonatal HIV infection by 80% by 2002.7 We present the case of an infant with symptomatic HIV infection, whose mother’s antenatal HIV test was negative and discuss the implications.

A 3 month old female, born at term by spontaneous vaginal delivery and breastfed, presented with a 1 week history of increasing respiratory difficulty. Following further deterioration, she was transferred to St Mary’s Hospital and ventilated. Pneumocystis carinii pneumonia (PCP) was diagnosed on bronchoalveolar lavage. Anti-HIV antibodies were present in serum and HIV infection was confirmed by the detection of HIV-DNA in peripheral blood mononuclear cells (PBMC) by PCR amplification. HIV-1 infection was confirmed in both parents. Her asymptomatic mother had received antenatal care and was transferred to St Mary’s Hospital and ventilated.


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Letters, Notices

Table 1 Peripartum HIV test results

<table>
<thead>
<tr>
<th>Time (in weeks of gestation)</th>
<th>Hospital where blood taken</th>
<th>HIV antibody screening tests</th>
<th>HIV specific antibody tests (CPHL in-house EIAs)</th>
<th>HIV western blot</th>
<th>HIV RNA (copies/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 T = 12 weeks (“Booking blood”)</td>
<td>X Blood was stored and retrospectively tested</td>
<td>Clear negative Detect-HIV$^a$ ii Wellcozyme HIV Recombinant$^b$ OD=0.030, CO=0.144 OD=1.179, CO=0.696</td>
<td>Clear negatives, (OD/CO) HIV IgG=1.49, IgM=0.36, IgA=0.14</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>2 T = 29 weeks</td>
<td>Y Index antenatal test (serum not available for repeat retrospective testing)</td>
<td>Strong positives (OD/CO) HIV IgG=12.34, IgM=10.94, IgA=5.28</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3 T = 33 weeks (“Booking blood”)</td>
<td>Y Blood was stored and retrospectively tested</td>
<td>Strong positives for IgG and IgA: weak positive IgM (OD/CO) HIV IgG=15.41, IgM=3.14, IgA=4.18</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4 T = 13 weeks post partum (child presents)</td>
<td>St Mary's</td>
<td>Strong positive</td>
<td>strong positive</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

$^a$Enzyme immunoassay (EIA) for detection of antibody to HIV-1 and 2. Biochem Immunosystems Inc, Montreal, Quebec, Canada.

$^b$EIA for detection of antibody to HIV-1 (Abbott Murex), Murex Biotech Ltd, Dartford, UK.

$^a$EIAs for qualitative detection for HIV-1 and 2. Abbott Laboratories, IL, USA.

$^b$EIA for detection of antibodies to HIV-1 and 2 (Abbott Murex), Murex Biotech Ltd, Dartford, UK.

$^a$Passive particle agglutination test for detection of antibodies to HIV-1 and 2 Fujirebio Inc, Tokyo, Japan.

$^b$Western blot for detection of antibodies to HIV-1 and 2. Genelabs Diagnostics, Singapore.

$^a$Polymerase chain reaction (PCR) for quantitative detection of HIV-1 RNA. Roche Diagnostics, Branchburg, NJ, USA.

$^b$Signal amplification nucleic acid probe assay for quantitative detection of HIV-1 RNA. Chiron Corp Emeryville, CA, USA.

possible false negative result, other sera stored at various times were retrieved and tested. The results, which show seroconversion late in pregnancy, are summarised in table 1.

The HIV antibody test is usually performed at the booking visit with other routine antenatal screens. This allows the parents to consider family planning issues and interventions to minimise the risk of mother to child transmission. In addition, mothers with advanced immunosuppression benefit from antiretroviral therapy.

Although rarely reported, an HIV seronegative mother whose partner has undiagnosed HIV infection is at continued risk of infection. This may become more common in the United Kingdom as heterosexual intercourse is now the most common risk for HIV infection in newly diagnosed patients.$^3$ Primary HIV infection during gestation or lactation is associated with an increased risk of mother to child transmission.$^3$

Repeat antenatal screening late in pregnancy, as is recommended for syphilis in the United States,$^4$ would identify some primary HIV infections during gestation. However, if maternal infection is not prevented transmission during lactation would remain a risk and there would be significant logistic and cost implications. The extension of testing for HIV (and other infections) to the partners of pregnant women is appealing as both maternal and neonatal infection would remain a risk and there would be significant logistic and cost implications.


Accepted for publication 3 April 2001
testing positive by LCR alone were retested by an alternative PCR assay for DNA sequences coding for the major outer membrane protein (MOMP) of Chlamydia trachomatis.

A total of 148 male and 153 female patients were tested; 23/148 (16%) swabs from male patients were positive for Chlamydia trachomatis.

Results and Discussion

Increased case detection rate, the cost of LCR was double that of EIA, the previous standard diagnostic test. Because of its improved sensitivity and cost-effectiveness, the previous standard diagnostic test (EIA) would have been missed had EIA been used alone.

Although EIA tests cost less than LCR, the false-negative rate for EIA (17 patients need to be screened per case detected) was compared with LCR (nine patients screened per case detected) was also included in analysis of the results. The number of chlamydial infection detected using EIA in this population was £65, compared with £50 for LCR.

In a hypothetical cohort of 100 GUM attendees, with an 11% prevalence of chlamydial infection (as in the present study), testing with EIA would cost £405 and would detect 6.4 of the 11 cases. Testing the cohort with EIA would cost £405 and would detect 4.6 additional cases. The additional cost of LCR per additional case detected is £34.

The sensitivity, specificity, negative and positive predictive values, and cost/test of LCR and EIA, respectively, were 100%, 95%, 100%, 100%, £2.64 and 58%, 100%, 95%, 100%, £4.05.

Of 33 cases of chlamydial infection, 15 cases (12 (92.2%) in men and two (20.0%) in women) had remained undetected if EIA had been used alone.

In summary, this study demonstrates that the use of LCR provides additional benefits compared with EIA.

Contribution to COST Action B12

Acknowledgement

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Informed consent was obtained from all patients.

Reference


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NOTICES

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections.

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Pan-American Health Organization, regional office of the World Health Organization

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).


Further details: ECEAR 2001 Conference Secretary, Division of Viral Microbiology, NBSC, Bianche 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, Krausenstrasse 63, D-10117, Berlin, Germany (tel: +49-30-204 500 41; fax: +49-30-204 500 42; email: berlin@cpb.de).

1st Asia Pacific Forum on Quality Improvement in Health Care

The 1st Asia Pacific Forum on Quality Improvement in Health Care will be held from 19–21 September 2001 in Sydney, Australia. Presented by the BMJ Publishing Group (London, UK) and Institute for Healthcare Improvement (Boston, USA), with the support of the Commonwealth Department of Health and Aged Care (Australia), Safety and Quality Council (Australia), NSW Health (Australia) and Ministry of Health (New Zealand).

Further details: quality@bma.org.uk; fax +44 (0) 7383 8609.

10th International Congress on Behcet'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).

International Congress on HIV/AIDS 16–19 December 2001, Mumbai, India

Further details: Dr Chander P Puri, President, Indian Society for Study of Reproduction and Fertility, Institute for Reserach in Reproduction, Jehangir Merwani Street, Parel, Mumbai 400012, India (Tel: 4137730 (Direct), 4132111-2-6-7; fax: 091-022-4964853 or 091-022-4139412; e-mail: vichin@bom4.vsnl.net.in OR dirirr@vsnl.com).

10th International Symposium on Human Chlamydial Infection, 16–21 June 2002, in Antalya, Turkey

The scientific programme will encompass the breadth of chlamydial research from clinical and epidemiological studies to molecular and cell biology of all species of Chlamydia.

Further details: Professor A Demir Sert, Department of Clinical Microbiology and Infectious Diseases, Ege University, Faculty of Medicine, 35100 Bornova, Izmir, Turkey (Fax: 90 232 343 71 30; e-mail: ISHCiC@tasa.ucsf.edu).

20th World Congress of Dermatology, Paris, 5–9 July 2002

Further details: P Fournier, Colloquium, 12 rue de la Croix St Faubin, 75011 Paris, France (ref: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; e-mail: p.fournier@colloquium.fr; website: www.derm-wcd-2002.com).
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E Herieka and P Fisk

*Sex Transm Infect* 2001 77: 223
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