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 man 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 fluoxacinil benzylpenicillin isolates was isolated. Screening tests for chlamydia, gonorrhoea, and trichomonas were negative. A 10 day course of mupirocin 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.1 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.3 Several reports have suggested that diabetic patients are more susceptible to Staphylococcus aureus bacteremia MRSA has been isolated from different sites in diabetic patients but not the genitalia.4 MRSA rarely invades intact skin; however, it can give rise to severe infections—for example, wound infection, bacteraemia, endocarditis, and osteomyelitis.5

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

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

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, course of treatment, co-infection with gonorrhoea, review by health adviser, consultation with sex health promotion and contact tracing, the number of patients tracing and treating their partner(s) compared to the proportion of those reinfected 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,1,2 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 J DHAR
Department of GUM, Leicester University Hospitals Correspondence to: E Herieka, Department of GUM, Leicester Royal Infirmary, LE1 5WW, UK. bherieka@uhl.trent.nhs.uk


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

8 Several reports
9 Contribution to: Dr E Herieka Wrote the manuscript.
The advent of ligase chain reaction technology has allowed the detection of chlamydia on meatal swabs as routine clinical practice. Further studies to confirm our findings in asymptomatic, and asymptomatic, chlamydia infection are needed before introducing this technique as routine clinical practice.

**HUMPHREY BIRLEY**

**Department of GUM Royal Liverpool University Hospital, Liverpool L7 8XP, UK**

1 Esmail A, May C. Oral exams—get them right or don’t bother. BMJ 2000;320:575.

Detection of chlamydia on meatal swabs

**EDITOR,—**The advent of ligase chain reaction (LCR) and other DNA technologies and the Apothecaries Diploma Board rejected the examination technique as routine clinical practice.

**HUMPHREY BIRLEY**

**Department of GUM Royal Liverpool University Hospital, Liverpool L7 8XP, UK**

**Patrick Clemens Clinic, Central Middlesex Hospital, London NW3 2QH, UK**

**S M MURPHY**

**Department of Microbiology**

**St Mary’s Hospital, London W2 1NY, UK**

**M S SHAIFI**

**Department of Microbiology**

**Correspondence to: Dr H Lamba, St Mary’s Hospital, Praed Street, London W2 1NY, UK**

**Letters, Notices**

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

**EDITOR,—**To reduce the risk of HIV transmission, some homosexual men have adopted a strategy whereby they only have unprotected anal intercourse (UAI) with a person of the same HIV status (i.e. "concordant 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 programme, 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%).

- **16 (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 (55.3%) 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 34.7% (42/120) (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...
Table 1: Unprotected anal intercourse (UAI) in the previous 3 months

<table>
<thead>
<tr>
<th></th>
<th>HIV negative men (n=477)</th>
<th>HIV positive men (n=126)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Main only</td>
<td>Casual†</td>
</tr>
<tr>
<td>Men in a relationship reporting</td>
<td>n=276</td>
<td>n=63</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>6.5 (18)</td>
</tr>
<tr>
<td>Total</td>
<td>35.1 (97)</td>
<td>8.0 (22)</td>
</tr>
<tr>
<td>Men not in a relationship reporting</td>
<td>n=199</td>
<td>n=63</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>

*Data on UAI or relationship status missing for two HIV negative men; †men reporting casual only or casual and partner. Men tested concordant only or men reported casual partners only. §Men reporting UAI with a partner of unknown or predominantly with a partner of unknown HIV status.

Concordant UAI whether they were in a relationship, or not (22.2% vs 20.6%, p=0.9), 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 independent variables and concordant UAI as the dependent variable, the interactions between HIV status and relationship was highly significant (p=0.001).

Serocordance 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 seroconcordant UAI among positive men carries no risk of HIV transmission to an unaffected person, it raises the possibility of reinfection on seroconcordant UAI whether they were in a relationship or not was confirmed in a multivariate model. With HIV status and relationship as independent variables and concordant UAI as the dependent variable, the interactions between HIV status and relationship was highly significant (p=0.001).

These data provide further evidence that HIV positive and negative homosexual men have both adopted HIV risk reduction strategies, with 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 21.6% (26) of HIV positive men (p=0.4). 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).

In conclusion, HIV negative and positive homosexual men have adopted different strategies for reducing the risk of HIV transmission with their sexual partners. HIV negative men predominantly reported concordant UAI with a main partner in the context of a relationship while HIV positive men were more likely to report concordant UAI with a casual partner. HIV prevention programmes need to reinforce risk reduction strategies, tailored to a person’s HIV status, while simultaneously addressing high risk sexual behaviour.

Jonathan Elford
Graham Bolding

Department of Primary Care and Population Sciences
Royal Free and University College Medical School, University College London, London, UK

Mark Maguire
Lorraine Sherr

Department of Primary Care and Population Sciences
Royal Free and University College Medical School, University College London, London, UK

A NEWELL
Department of Genitourinary Medicine, Mayday Hospital, London Road, Thornton Heath, UK

Correspondence to: Jon.Elford@pcps.ucl.ac.uk


Accepted for publication 8 March 2001

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% (93/129) 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 C6A.

On examination there were no abnormalities seen, there were no polymorphs on microscopy, swabs for gonorrhoea, chlamydia, and trichomonas were all clear. He was treated with a 5 day course of metronidazole as per MSSVD guidelines.

If this patient had turned up without a contact slip, epidemiological treatment of trichomoniasis is unlikely to have been instituted and contact tracing would have been impossible. Thanks to the use of text messaging on this man’s mobile phone, appropriate treatment was initiated. Certainly patients and health advisers appreciate the security offered by mobile phones (no other family members can take the calls), the instant access, and it avoids additional paper work. The use of text messaging and mobile phones for contact tracing may be considered as an adjunct to contact slips in GU clinics.

A NEWELL
Department of Genitourinary Medicine, Mayday Hospital, London Road, Thornton Heath, UK

Correspondence to: Tony.Newell@nhs-tr.nhs.uk

Chaperoning male patients

Editor,—I was delighted to see the letter by Pisk et al in the journal. My staff and I were becoming alarmed at the suggestion that male patients should have a chaperone when they are being examined by a male doctor. Was common sense finally leaving the specialty? There are thousands of consultations taking place throughout the country, in both primary and secondary care, where sexual issues are discussed. These often include a genital examination, and just because there is a problem found with one or two individual patients or doctors it doesn’t mean the whole national service has to be turned upside down. Surely, the last thing an overworked, under pressure, genitourinary medicine service needs is to have another section of its skilled staff standing idly by in a room, while either a consultation or examination is taking place. I have never found any difficulty in taking the swabs on my own, and labelling the stuff myself, and have never felt the need for another person handing me things during a male examination. Indeed, I could easily see that interfering with the process at times, as there are some issues patients feel more comfortable discussing on a one to one basis, and they can feel embarrassed and hindered if there is a chaperone present.

An occasional complaint is a small price to pay for the 99.9% otherwise effective consultations that occur. It’s lovely to see work like this being published, as it becomes part of the evidence base that says we don’t need this.
kind of interference, and that basic common sense should prevail.

COLM O’MAHONY
Department of Genito-Urinary Medicine,
Countess of Chester Hospital, Liverpool Road,
Chester CH2 1UL, 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).1 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 paraembedded 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 summarized 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). 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 HPVs, 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
Dermatologic Clinic, University of Catania, Italy

DANIELE INNOCENZI
Dermatologic 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
cidermct@dimtel.nti.it


Table 1 Clinical and histopathological features of eight cases of carcinoma on penile lichen sclerosis

<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, corona sulcus</td>
<td>multiple erythematous, indurated, and ulcerated plaques sharply circumscribed, erythematous, and ulcerated 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, corona sulcus, inner aspect of the foreskin</td>
<td>exophytic verrucous whitish nodule 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</td>
<td>sharply circumscribed, erythematous, eroded, crusted, and indurated plaque</td>
<td>well differentiated SCC</td>
<td>negative</td>
</tr>
<tr>
<td>5*</td>
<td>29</td>
<td>47</td>
<td>18</td>
<td>glans</td>
<td>sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>HPV 16</td>
<td>HPV 16</td>
</tr>
<tr>
<td>6</td>
<td>75</td>
<td>85</td>
<td>10</td>
<td>glans</td>
<td>sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>HPV 16</td>
<td>HPV 16</td>
</tr>
<tr>
<td>7</td>
<td>66</td>
<td>70</td>
<td>15</td>
<td>glans, corona sulcus</td>
<td>sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>HPV 16</td>
<td>HPV 16</td>
</tr>
<tr>
<td>8</td>
<td>33</td>
<td>67</td>
<td>34</td>
<td>glans</td>
<td>sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>HPV 16</td>
<td>HPV 16</td>
</tr>
</tbody>
</table>

*Previously reported cases.1

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

Letters, Notices

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 high seroprevalence areas of high seroprevalence2 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 be offered and recommended to all pregnant women in high seroprevalence areas.3 In 1999 the Department of Health extended these recommendations to all regions aiming to reduce neonatal HIV infection by 80% by 2002.4 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 from the 12th week of gestation and was HIV seronegative at 29 weeks. To investigate a

Preterm delivery is the most common complication of HIV infection in pregnancy, occurring in 25% of cases.5 The diagnosis of PCP in the newborn is not infrequent.6 In this patient the diagnosis of PCP was confirmed by the presence of HIV-DNA in PBMC, the finding of maternal viraemia in first trimester and the absence of maternal antibodies at 29 weeks. The mother had probably become infected in the third trimester and had no documented history of blood transfusion or intravenous drug use. Spontaneous vaginal delivery and breast feeding were the likely modes of transmission.

John H Mclaren
Department of Genito-Urinary Medicine, University of Cambridge, Cambridge

Accepted for publication 22 March 2001


The HIV antibody test is usually performed at the booking visit with other routine antenatal screens. This allows the parents to discuss the sexual transmission of infections, to emphasise that the negative results cannot be extrapolated to the partner, and advocate safer sex which is commonly abandoned following conception.

repeat antenatal screening late in pregnancy, as is recommended for syphilis in the United States, 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 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 mater- nal and infant infections could be prevented (and the infected male may benefit from early diagnosis and treatment) but would require a fundamental change to antenatal care. A practical approach, which may prevent maternal and neonatal infection (but not identify the infected male) is to use the opportunity, when giving negative HIV, hepatitis B, and syphilis results to the mother, to discuss the sexual transmission of infections, to emphasise that the negative results cannot be extrapolated to the partner, and advocate safer sex which is commonly abandoned following conception.
testing positive by LCR alone were restated 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 and 10/153 (7%) from female patients were positive for Chlamydia trachomatis by LCR (see fig 1).

The sensitivity, specificity, negative and positive predictive values, and cost/test of LCR and EIA, respectively, were 100%, 99%, 100%, 90%, £2.64 and 58%, 100%, 95%, 100%, £4.05.

Of 33 cases of chlamydial infection, 15 cases (45.5%) were found in men and two (20.0%) in women, which would have remained undetected if EIA had been used alone.

Although EIA tests cost less than LCR, the lower detection rate for EIA (17 patients screened per case detected) was also included in analysis of the results. The cost per case 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 LCR would cost £564 and detect all 11 cases. Testing the cohort with EIA would cost £405 and would detect 6.4 of the 11 cases.

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 (www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy. The guidelines are available online at www.hermes.org.uk.

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

A catalogue of publications is available online at www.paho.org. The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tpsp.sheridan.com).
Third trimester screening or safer sex to prevent mother to child transmission of HIV

P K C Goon, R P F Watkins, E G H Lyall, J Parry and G P Taylor

Sex Transm Infect 2001 77: 226-227
doi: 10.1136/sti.77.3.226-a

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