
Up to 19 different Chlamydia trachomatis (CT) serovars which are pathogenic predominantly for the urogenital tract and numerous CT variants have been identified. An increasing number of isolates are typed worldwide and provide a wealth of information on the epidemiology of CT infections, a sexually transmitted disease (STD) for which screening has been proposed. Recent studies have demonstrated an association between CT serovar G and squamous cell carcinoma. A possible shift in the serovar distribution over time in a region or country could reveal information on changes in the epidemiology of CT infections and could potentially have clinical implications.

We therefore determined the CT serovar distribution in a large STD population in Amsterdam in 2000–2 and compared it together with all published serovar distributions since 1986 in the Netherlands to assess if serovar distribution shifts over time occurred.

Of people attending the STD outpatient clinic in Amsterdam from 2000–2, those found CT positive (n = 407) by LGX (Abbott Laboratories, Chicago, IL, USA) were genotyped as described previously. This is the largest CT population typed to date in the Netherlands. The following serovar distribution was found: B = 1%; D = 12%; Da = 0.2%; D- = 1%; E = 33%; F = 23%; G = 4%; Ga = 9%; H = 8%; I = 6%; Ia = 1%; J = 3%; K = 2%.

Literature searches identified eight serovar distribution studies in the Netherlands, of which the first was performed in 1986. With the inclusion of the present study, 2204 serovars were available for analyses. In the serovar distributions comparison, (1) did not distinguish between male and female participants, (2) did not distinguish between serovar distributions based on serotyping or genotyping techniques, (3) excluded serovars B/8a because of the low numbers, (4) excluded double infections, (5) excluded variants, and (6) classified CT serovars in the three phylogenetically based serogroups: the B group (serovars D, Da, E), the intermediate serogroup (serovars F, G, Ga), and the C group (serovars I, Ia, J, Jv, and K).

Results are shown in figure 1. In general, no statistical significant serovar distribution trends in time were observed between 1986 and 2002 when all studies were taken together. Of the nine studies, 1 and 6 represent serovar distributions from STD populations in Rotterdam and show no significant changes in general or over time (mean: C group: 30%; Int group: 21%; B group: 49%). Studies 2, 3, 4, and 9 represent serovar distributions from STD populations in Amsterdam and show no significant changes (mean: C group: 20%; Int group: 31%; B group: 49%). Studies 5, 7, and 8 represent serovar distributions from mixed symptomatic and asymptomatic infected people (5 and 7) and asymptptomatically infected populations in Amsterdam. They show no significant changes in general, over time, or compared to the Amsterdam STD based serovar distribution (C group: 17%; Int group: 30%; B group: 53%).

However, when the two geographically derived serovar distributions were compared to each other, (1) serogroup C was found more frequently in Rotterdam: 30 v 19% (p = 0.0001; OR 1.8 (95% CI: 1.4 to 2.3)), the most prominent serovar difference was serovar G (10.6 v 3.2%, p = 0.0001; OR 3.6 (95% CI 2.4 to 5.3)); (2) the intermediate serogroup was found less frequently in Rotterdam: 21 v 31% (p = 0.0002; OR 1.6 (95% CI: 1.2 to 2.0)), the most prominent serovar difference was serovar F (15 v 22%, p = 0.0018; OR 1.6 (95% CI: 1.2 to 2.1)), and serogroup B was stable (49% v 50%).

In conclusion, no changes in serovar distribution differences were found over time in the Netherlands in general or within the two different geographic areas. However, the Rotterdam population differed significantly from the Amsterdam population in having a larger incidence of C group serovars and a lower incidence of the intermediate group serovars, albeit an identical B group serovar distribution. The findings could be the result of different ethnic compositions of the studied cohorts or other confounding factors between Rotterdam and Amsterdam, a subject that warrants further study.
Surveillance of sexually transmitted infections in primary care

Surveillance for sexually transmitted infections must respond to increases in the population burden of diagnosed infections and explore associations with demographic and socioeconomic characteristics over time. Automating regular data downloads and reporting will improve the timeliness of data collection to facilitate identification and monitoring of outbreaks. The widespread coverage of the system can guide local service development and clinical practice and monitor the impact of the Sexual Health Strategy. For example, in 2001 half of all chlamydia tests and 44% of positive results came from GP, family planning, or Brook clinics. Nearly two thirds (62%) of those tested in general practice were over 25 years old in whom the positivity rate was 4% compared with 11% for 16–24 year olds.

We propose that, while behavioural data obtained from panel surveys in primary care provide depth, sentinel surveillance of laboratory-diagnosed infections in all clinical settings provides breadth, and both are needed for effective surveillance.

References


Comparison of the serological response to treatment of early syphilis in HIV positive versus HIV negative individuals

The effectiveness of treatment for syphilis is evaluated by demonstrating declining titres of the non-treponemal antibody tests—for example, the rapid plasma reagin (RPR). The serological response in HIV co-infected individuals has been the subject of debate, with some studies reporting a similar serological response and others a delayed response in HIV positive patients.

A resurgence of infectious syphilis has occurred in Manchester, United Kingdom, in recent years. From January 1999 to August 2002, 379 cases of early syphilis were...
Table 1  Number of patients in each group and the mean four dilution drop in RPR titre 3, 6, and 12 months following treatment in HIV positive compared to HIV negative individuals

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<thead>
<tr>
<th></th>
<th>3 months</th>
<th>6 months</th>
<th>12 months</th>
<th>3 months</th>
<th>6 months</th>
<th>12 months</th>
<th>3 months</th>
<th>6 months</th>
<th>12 months</th>
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</thead>
<tbody>
<tr>
<td>No of patients</td>
<td>31</td>
<td>20</td>
<td>12</td>
<td>23</td>
<td>17</td>
<td>11</td>
<td>24</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Mean drop in RPR</td>
<td>1.71</td>
<td>2.00</td>
<td>2.54</td>
<td>1.57</td>
<td>2.18</td>
<td>3.45</td>
<td>0.78</td>
<td>0.97</td>
<td>0.33</td>
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<tr>
<td>p Value (t test)</td>
<td></td>
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Initial RPR titre, and treatment regimen are required.

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References

Is it time to rethink the roles of health professionals in the HIV outpatient setting?

HIV outpatient services across the United Kingdom are seeing large increases in their patient workload. This is fuelled by the success of highly active antiretroviral therapy (HAART), resulting in fewer deaths, and by increases in the number of new diagnoses. A further rise is anticipated in England following implementation of “The national strategy for sexual health and HIV” that plans to increase HIV testing dramatically in order to reduce the number of undiagnosed HIV infections by 50% by the end of 2007. The success of HAART has also changed the focus of many doctors and health care providers towards prevention and management of opportunistic infections, to issues related to the complexities of HAART, sexual behaviour risk reduction and promoting healthy lifestyles. As a result, HIV service providers need to develop new models of care that can deliver high quality, cost effective care to meet these changing demands. We reviewed the role of the doctor in providing routine outpatient HIV care.

Data were collected prospectively on all HIV infected patients attending for routine care between 24 June 2002 and 17 July 2002. We obtained complete data for 431 of 433 consecutive patient appointments. Of these, 79/431 (18%) did not attend their appointment. Of the remaining 352, the median age was 38 years (range 17–70), the majority were male (291, 83%), of white ethnicity (251, 71%) with a median CD4 count of 531, 710 (range 10–1390) and viral load (VL) of 500 copies/ml (range <50–1.2 million).

Consultants saw two thirds of attendees, specialist registrars a third. Almost half the consultations (173/352) were with patients who were defined by their physician as being asymptomatic with respect to their HIV infection; 66/173 (38%) of these were not taking HIV therapy and 107/173 (62%) were on HAART with a sustained virological response (VL<50 for >6 months). Over the next 8 months 53/66 (80%) of those not taking HAART and 68/107 (64%) taking HAART remained well with no significant changes to their health status. Of those on HAART, few required admission to hospital (bacterial pneumonia, three; cholecystitis, one; cryptococcal septicaemia, one), 12 made changes to their therapy (therapy intolerance, four; virological rebound, three; toxicity, five) and 12 had intermittent low level viraemia (VL between 50 and 100). Other problems encountered in both groups included shingles (n = 7) and raised liver function tests (n = 11).

We have identified a high proportion of asymptomatic patients who are currently under regular review by medical staff and could potentially be managed by other healthcare professionals. Increased use of general practitioners and nurse practitioners are two potential options. We should review HIV outpatient service provision and move away from the “acute-terminal” model of care that has prevailed since the beginning of the epidemic and learn from the new chronic disease management models seen in other areas of the health service. As these new models are developed, in addition to staff requiring training to be conversant with common problems seen during routine routine antiretroviral therapy, it is essential that education is conducted to ensure similar levels of effectiveness, efficiency, and acceptability.

Contributors
SE and DM developed the study; SE, SD, and CG collected and analysed the data; SD and KM wrote the text. SE, DM, and CG provided comments on the text.

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www.stijournal.com
Syphilis outbreak in Milan, Italy

Infectious syphilis has been considered a sensitive marker of risky sexual behaviour. Following a decline of syphilis in Western Europe,1,2 there has been a resurgence of infectious syphilis in many countries, with a number of outbreaks in men who have sex with men (MSM).3,4

The STD centre of Milan is the biggest in northern Italy with an average of about 6000 patients per year. Most patients are offered screening tests for syphilis using treponemal particle agglutination test (TPPA) and rapid plasma reagin (RPR).

The number of cases of early syphilis (primary, secondary, and early latent asymptomatic with probable infection <12 months previously) has increased from 46 to 211 between 2000 and 2002. Over the same period, the number of cases of late syphilis (asymptomatic with probable infection >12 months previously) has remained stable. Most cases of early syphilis in 2001 and 2002 (261/306, 85%) were in MSM. Fig 1 shows the trends.

Following a decline of syphilis in Western Europe,5,6 there has been a resurgence of infectious syphilis in many countries, with a number of outbreaks in men who have sex with men (MSM).7,8

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Online HIV/STI Chinese clinician training

The spread of HIV in China is accelerating and many Chinese physicians are poorly trained to address it.2 We review clinician training and the internet in China, and present the results of a convenience sampling of 136 Chinese clinicians regarding their access and attitudes towards computer based HIV/STI training.

Having been trained in an era of virtual STI eradication, many Chinese physicians are inadequately prepared to respond to the current HIV epidemic.1 Medical student curricula frequently lack STI coursework, and a European Union-China Project (EUCP) study in 2000 showed as few as 5% of physicians had ever received any HIV/STI training.19 Coinciding with the spread of HIV is the exponential growth of the internet and computer technology, reaching over 68 million internet users in 2003.2 Computer based resources can potentially serve as a powerful medium for the training of clinicians.

To investigate this opportunity, we adapted Chinese language HIV/STI materials developed by the EUCP to create an online HIV/STI training page for the website of the Chinese National AIDS Prevention and Control Center (www.aids.net.cn). We then presented the site and distributed paper based surveys to 136 clinicians recruited during STI training courses in several urban areas. The response rate was 97% (132/136). Among those sampled, 95% reported having computer access and 86% reported having internet access, defined as access at home, work, or internet cafes. Similar access levels were reported by the subset of respondents (17%) who reported having had no HIV/AIDS training in medical school or in continuing medical education (CME). All 132 respondents reported a willingness to utilise computer based training.

This study found a surprisingly high level of computer and internet access among a convenience sample of STI specialists from several urban areas in China. The main limitation of this study was the non-representative sampling, which makes generalisation to other Chinese physicians difficult. Despite this, we believe that these results can be cautiously applied to significant numbers of urban Chinese physicians who share similar levels of access and interest with this study population.

Online CME presents a promising way to take advantage of growing computer/internet access in China. Chinese physicians can already obtain many of their required CME credits online, with the subset of respondents (27%) who are CME eligible (www.cmecchina.net) training over 50 000 users annually.20 Notably, HIV/AIDS training is not available.

Other potential uses of computer/internet resources include creating training centres to serve as clearing houses for up to date training materials. Especially in those areas where extreme geographic barriers limit the scope of traditional training methods, the internet can help remote hospitals and physicians engage in distance learning.

As China strives to control a growing HIV epidemic with a limited budget, low cost,high output resources like computer/internet training cannot be overlooked.21 While further investigation is needed to show training efforts positively affect outcomes, the computer/internet revolution offers an immediate and cost effective opportunity to train many urban and some rural physicians. This study suggests that the technical access and clinician willingness necessary for such HIV/STI training may already exist.

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References

Treatment of vulval vestibulitis with a potent topical steroid

Vulval vestibulitis (vestibulodynia) is characterised by penetrative introital pain and erythema and tenderness localised to the vestibular glands. The aetiology is unknown and most treatment strategies are based on anecdote.22 Some clinicians recommend the use of a topical steroid but there are no published data to support this.23

We designed a randomised double blind crossover study to compare a potent topical steroid, Dexamove ointment (clobetasol propionate 0.05%), with a very mild steroid, 0.3% hydrocortisone ointment. The hydrocortisone acted as a placebo as it was impossible to obtain a matching placebo for Dexamove ointment. To demonstrate a 20% difference...
between Dermovate and hydrocortisone treated episodes if the placebo effect was 40%, 110 patients were needed. Unfortunately, recruitment was slow and the study ended when the expiry date of the medications was reached.

This report describes the outcomes in the patients who participated. The ethics committee of the National Health Service Trust approved the study; patients gave written informed consent. All patients had introital pain, tenderness, and erythema compatible with a diagnosis of vulval vestibulitis. The study comprised three phases:

1. emollients only for 2–8 weeks,
2. tube one of the study medication, applied to the vestibule each night for 28 nights,
3. tube two of medication used similarly.

The tubes were identical and the study was designed so that within blocks of 10 patients, half would use each medication first. The same clinician assessed each patient at 14 day intervals using a three point scale for each of the parameters—pain, tenderness, and erythema (maximum score 9; minimum score 0 for each visit). The scores obtained at entry (minimum 3) and after each phase were noted.

Twenty two patients were recruited, but some patients withdrew or were excluded for protocol violations. Fourteen patients completed all phases of the study and two completed the first two phases. After emollient use, nine patients had improved (mean score −1.1; range −0.5 to −2); after Dermovate, 11 improved (mean score −2.7; ranges −0.5 to −8); after hydrocortisone nine improved (mean score −1.8; range −1 to −3) (table 1). Eight patients who used both treatments had a better response to Dermovate and four had a better response to hydrocortisone (p<0.07). Eight patients expressed a definite preference, seven for Dermovate and one for hydrocortisone. There may, however, have been an effect of the order of the treatments as two patients did better on their first treatment whereas nine did better on their second (p=0.06).

Although this study was not completed, some conclusions can be reached. Short term use of a potent topical steroid preparation did not produce a clinically important improvement in all cases but some patients had very good responses, which were maintained. This may reflect the fact that the aetiology of vulval vestibulitis is multifactorial and where there has been an inflammatory, infective, or irritant cause, topical steroids may be helpful. There is an urgent need to identify and classify the causes of this syndrome so that appropriate treatment can be targeted more accurately.

Acknowledgements
I wish to thank Glaxo-Wellcome (now Glaxo-Smith Kline) for the supply of the study medication.

Table 1 Treatment outcomes

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<th>Emollient</th>
<th>Dermovate ointment</th>
<th>Hydrocortisone ointment</th>
</tr>
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<tbody>
<tr>
<td>Improved</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Unchanged</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Worse</td>
<td>2</td>
<td>5</td>
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References


Unexpected resistance in an African immigrant: lessons for the unwary

The number of people emigrating from Africa to the United Kingdom is becoming more numerous. They contribute to the increasing number of homosexuals with HIV in the United Kingdom. Increasingly, developing countries are improving their access to antiretroviral drugs through global funds for AIDS and other sources. It is well known that resistance to antiretrovirals develops with therapy and that such resistance is associated with poor outcome.

A Zimbabwean man aged 47 was admitted to the Royal Sussex County Hospital, in August 2001 with lobar pneumonia. He had excellent response to the appropriate antivirals. He reported receiving treatment for tuberculosis twice in the past. He had a positive HIV antibody test which was done after pretest discussion. The baseline CD4 count and viral load were consistent with advanced infection, 20 ×10^9/l (2%) and 134 000, respectively.

He was commenced on combination antiretroviral therapy with combivir and efavirenz, and had a good initial virological response with a drop of his viral load to 1230 (3.09 logs) in 2 weeks. However, his viral load rebounded to 71 000 at 6 weeks. He was thought to be non-adherent to the antiretrovirals at this stage and was questioned extensively regarding adherence. He claimed 100% adherence to his medication and denied any missed or late doses. Interactions with prescribed and non-prescribed medications were excluded.

At this stage a genotypic resistance test was organised from the sample, with a viral load of 71 000 and he was admitted to the local respiratory unit (The Sussex Beacon) for directly observed therapy (DOT). The viral load after 2 weeks of DOT was 240 000.

A genotypic resistance test revealed the following mutations: K65R, D67N, K70R, K103N, M184V, G190A, T215F, K219Q, suggesting that he had extensive resistance to nucleoside analogues and to all non-nucleosides. When he was reviewed with his resistance test result, he volunteered knowledge of HIV testing or treatment in Zimbabwe, but identified combivir tablets as part of his anti-tuberculosis medication. Genotypic resistance testing of his archived sample before his commencement of treatment showed: M41L, V118I, M184V, T215F.

He was then commenced on a salvage regimen of didanosine, tenofovir, kalecta, and saquinavir and had a good virological response with a viral load drop of 1350 (3.13 logs) in 4 weeks.

It remains uncertain whether in this case the individual had been aware of his HIV status. It is possible that antiretroviral medications may have been included as part of an unorthodox anti-tuberculosis regimen, given the high co-infection rate in Zimbabwe, without the individual having been informed. Alternatively, the individual may have been unwilling to disclose his status for fear of rejection of his legal claim to stay in the United Kingdom or for other sociocultural reasons.

Either way, the choice of initial therapy was inappropriate, given the underlying resistance to reverse transcriptase analogues, and resulted in the subsequent rapid accumulation of NNRTI resistance.

While it is known that acquired resistance mutations may disappear with discontinuation of therapy, a genotypic resistance test had been performed at presentation in this case a more effective regimen would have been selected. Current BHIVA guidelines recommend resistance testing before therapy only in the context of demonstrable transmitted drug resistance.

As antiretroviral therapies become increasingly available in developing countries and while stigma regarding disclosure of HIV status for immigrants remains, we believe that similar cases will occur.

We strongly suggest that immigrants with a new HIV diagnosis should be closely questioned regarding previous diagnosis and treatment, and also baseline resistance testing should be routinely considered.

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References

Increased uptake of HIV screening following introduction of ‘opt out’ testing and results by telephone

Rogstad et al showed an increase both in the number of patients who were offered the HIV test and those who took the test following the use of a leaflet. We report the increased uptake rate of HIV testing since the introduction of ‘opt out’ testing and giving results by phone.

Before January 2002, patients attending our clinic were offered an HIV test if they belonged to high risk groups such as men who have sex with men or injecting drug users. Pretest counselling was done by our health advisers and patients were required to return to the clinic to receive their test results. In 2001, 904 of 2930 new and re-registered patients (31%) underwent HIV testing.

The UK government’s national strategy for sexual health and HIV set its target for reducing undiagnosed HIV in genitourinary medicine clinics by increasing the uptake of HIV testing to 40% by the end of 2004 and to 60% by the end of 2007.

From January 2002, we introduced an ‘opt out’ system, whereby all patients were offered HIV tests, regardless of risk category. This led to an increase in HIV test uptake in the following 3 months to 37% (272 of 740 new patients).

This caused an increase in the workload of our health advisers, who were spending much time in pretest counselling low risk patients and giving negative HIV results. It became apparent that exhaustive, in-depth HIV pretest counselling was impractical and inappropriate when the majority of those tested were “low risk.” Accordingly, we decided that only high risk patients should be referred pretest to the health advisers.

It was also observed that some patients who initially agreed to undergo HIV testing changed their minds when they learned that they would be required to return to the clinic to collect their result. We decided to offer HIV results by telephone, in line with our policy for all other screening tests. High risk patients, however, were encouraged to attend in person for their result. In the next 3 months 44% (322 of the 740 new patients) took HIV tests. Five patients tested HIV positive, but only one received the result by telephone.

The introduction of a telephone HIV results system enabled us to exceed the Department of Health target for 2004. The new system was adopted after consideration of the pros and cons in a departmental meeting in which the opinions of all staff were canvassed. Some concern was expressed about the potential for patients to be referred pretest given bad news outside the clinical setting. We tried to minimise such outcomes by encouraging patients to telephone in the presence of their partner, a friend, or a relative. Results were only given by telephone when the patient could be seen in clinic on the following day at the latest.

The telephone results system is very popular. One patient said, he would far rather receive bad news in the familiar surroundings of home, than in the clinic. Why do it, if it is psychologically harmful (or indeed beneficial) for patients to receive a positive HIV result by telephone; research is needed to answer this question.

Given the drive to reduce the number of people who remain HIV infected and the demands of working life, we believe telephone results are here to stay.

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References

Topics in International Health:
Sexually Transmitted Infections, 2nd ed

Institutional licence £120; individual licence £30; developing world licence £20. CD-Roms are not Apple Mac compatible. Disc adviser: Dr J E Richens, Department of Sexually Transmitted Diseases, Royal Free and University College London Medical School, UK. London: The Wellcome Trust, 2003. ISBN 0 85199 631 0.

Having previously resisted the temptation to upgrade from printed text to the 21st century, I was suitably impressed by both the technical design and the factual content of this 2nd edition CD-Rom. As a bit of a computer novice I found the software easy to install and navigate with helpful instructions at the touch of a button. The program itself runs on Windows 95, 98, 2000, NT4, or XP and needs 32MB of RAM with at least a 120 MHz Intel Pentium processor (or equivalent).

The CD-Rom provides a vast wealth of information on all aspects of common and tropical STIs that are presented in the form of 18 interactive tutorials, each reviewed by expert authors, and a collection of about 800 images. The material covers ranges from history taking and clinical examination to epidemiology, laboratory diagnosis, and syndromic management of STIs. It includes in-depth tutorials on individual STIs that provide up to date research and management useful both in the developing and developed world. HIV/AIDS is covered in a separate CD-Rom. However, there is detailed mention here of epidemiological synergy with common STIs and tools for the control of STIs to reduce transmission of HIV.

The 18 tutorials consist of 50–70 slides on each topic. The CD-Rom is therefore topic led with no search facility for those wishing to access a list of differential diagnoses by symptoms and signs. The user’s attention span is maximised by a mixture of high quality images interspersed with relevant yet concise text and a useful summary of all sections. Interactive quizzes and diagrams help to reinforce learning and a notepad is strategically placed for users wishing to go back to basics and include their own free text. A glossary is available on each page should on screen terms need further clarification and all text is fully referenced. The pictures used in all the tutorials appear chronologically in the image collection and can be printed. They can also be sorted and saved in groups of your choice. The only hitch is that they can’t be downloaded into presentations, personal slide libraries, or palm pilots—shame!

The detail presented is still not enough to rival textbooks such as King Holmes’s Sexually Transmitted Disease but this is not the purpose of the CD-Rom. It is ambitiously designed for use as an educational resource in both developed and developing countries and I think it serves this purpose well. Its appeal spans a broad range: medical students swatting for exams (and SpSs sitting Dip GUM!); academic researchers as a useful point of reference and all healthcare professionals involved in direct clinical care of patients with STIs including nurses and health advisers.

Overall, the CD-Rom is a highly interactive way of accessing and assimilating a huge amount of information on all aspects of STIs. It is definitely much more user friendly than luggih a huge textbook around and gets a big thumbs-up from me!

K P Prime

CD-ROM REVIEW

8th European Society of Contraception Congress

The 8th European Society of Contraception Congress will be held from 23–26 June 2004 in Edinburgh, Scotland, UK. For further details please contact ESC Central Office, c/o Orga-Med Congress Office, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 15 15; email: organiz@pandora.be; and website: http://www.contraception-esc.com/edinburgh.htm).

The statistical calculation of this table combined all women, regardless of age. The authors have recalculated this table, and the revised version is available on the website (http://sti.bmjournals.com/cgi/data/79/1/22/DCI/1 with the correct age restriction – female participants 16 to 24 years only, as originally specified. The majority of these data (general practice, family planning, and youth clinics) have only changed marginally; the main differences lie within the GUM clinics, due to the wider age of women tested at this setting. The conclusions, however, are unaffected by this error. The authors stand by their assertion that prevalence tends to be higher in those reporting and attending with symptoms than those screened opportunistically.

CORRECTION


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PostScript

156 PostScript
Syphilis outbreak in Milan, Italy

M Cusini, M Ghislanzoni, C Bernardi, G Carminati, R Zerboni, E Alessi and B Suligoi

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