LETTERS TO THE EDITOR

Retrospective study of male lichen sclerosus and outcome in Leicester: 1995–9 inclusive: experience of a genitourinary medicine clinic

EDITOR,—We have studied retrospectively 76 male cases of lichen sclerosus (LS) (formerly called balanitis xerotica obliterans), that presented over the period 1995–9 inclusive, in Leicester.

These cases were predominantly diagnosed on clinical grounds by experienced clinicians with eight (10.5%) proved by a biopsy.

A clinical diagnosis was made from the presence of combinations of clinical features.

From the literature it can be found that LS is the commonest cause of meatal stenosis in adults and children.¹ Most men present with a phimosis so may require circumcision.¹ Complications include meatal or urethral stricture and some lesions progress to malignancy.¹

The fact that LS of male genitalia can involve the anterior urethra is highlighted by Barbagli *et al.*² In their series of LS cases there was external meatus involvement in 19%, fossa navicularis in 16%, penile urethra in 3%, and notably panurethral disease in 52%.²

Nasca *et al* found that malignant changes were associated with 5.8% of the cases of penile LS in their series of 86 patents from Catania and Rome.³ They emphasise that patients with genital LS are at considerable risk for the development of penile squamous cell carcinoma, as well as verrucous carcinoma and erythroplasia of Queyrat.³ They also suspect that epithelial dysplasia *per se* may be precancerous.³ Reports in general on LS from GUM clinics are rare; notably Bingham reported a solitary malignancy in LS in 1978 from a GUM clinic in a 39 year old man.⁴

Recent studies on LS have shown that susceptibility to the disease may be partly genetically predetermined by having certain human leucocyte antigens—namely, class II loci HLAs, DQ7, or DR11.⁵ Also, Clifton *et al*⁶ have recently postulated that there is evidence for the loss of androgen receptors with disease progression in LS; thus supporting a hormonal pathogenesis of LS. This assertion also provides a rationale for the use of testosterone creams in LS.

In Leicester, we have found that there is a tendency for cases to be referred to dermatologists and/or urologists early, and they are therefore lost to follow up by the GUM clinic. Eighty eight per cent of the men were white, with 9.2% being Asian; 84% were lost to follow up as at the year 2000, with 17% and 18% referred to dermatologists or urologists at any time respectively. Eighty four per cent used 1% hydrocortisone cream at any time; steroids creams stronger than 1% hydrocortisone were used in 21.1% of the cohort and 92.1% of the cohort were uncircumcised. Early referral means that procedures—for example, meatotomy or urethroplasty or therapeutic circumcision, are not recorded often in GUM notes. There was also a tendency for dermatology or urology not to “update” the GUM clinic with time. Despite

this, phimosis was found in 40.8% with meatal stricture in 19.7%, therapeutic circumcision in 15.8%, and malignancy in one case. Anterior urethral involvement was present in only 7.9% in our series, meaning that it may represent a late stage phenomenon. Biopsies were found to be 100% confirmatory of diagnosis of LS—that is, 8/8 biopsies done.

One must conclude that a multidisciplinary approach to LS care should continue to operate, and that long term follow up is mandatory.

DEREK T P EVANS

Department of Genito-urinary Medicine,
Leicester Royal Infirmary,
Leicester LE1 5WW, UK

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Chaperoning male patients

EDITOR,—Torrance *et al* reported on genitourinary physicians' experience in the use of chaperones in clinics of genitourinary medicine,¹ and Bignell broadened the debate and suggested further study of whether male genital examinations should be more frequently chaperoned.² We have carried out a small prospective questionnaire study of new male patients inquiring both about the sex of the examining doctor and the preference for a chaperone.

In all, 94 patients were questioned by either KB or CM following clinical examination. Eighty six patients were examined by a male doctor, and eight by a female doctor. Two of the male doctor's patients would have preferred a female doctor, but none of the female doctor's patients, although small in number, would have preferred a male. Fifty two patients were chaperoned and one patient subsequently decided he would have preferred not to have been. None of the 42 unchaperoned patients would have preferred a chaperone to be present, and the sex of the chaperone did not appear to be important, although in this small study a female chaperone was present with a female doctor on only two occasions.

Table 1

	Sex of chaperone		No chaperone (%)
	Male (%)	Female (%)	
Sex of doctor			
Male	13 (100%)	32 (97%)*	41 (100%)
Female	5 (100%)	2 (100%)	1 (100%)

*Represents one patient.

The number and percentage of patients who were satisfied to be examined with a chaperone present according to the sex of the doctor and the chaperone, are summarised in table 1.

In conclusion, it appears in this study that our male patients generally feel comfortable with genital examinations by doctors of either sex, and they do not express the desire for a chaperone to be present. We obviously have not addressed the issue of whether or not it may be desirable from the doctor's point of view for a chaperone to be present.³

PETER FISK

Department of Genito-urinary Medicine,
Leicester Royal Infirmary,
Infirmary Close,
Leicester LE1 5WW, UK

KULVINDER BARMH
CATHERINE MORGAN

University of Leicester,
Robert Kilpatrick Clinical Sciences Building,
Leicester Royal Infirmary,
Leicester LE1 5WW, UK

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Ciprofloxacin 250 mg for treating gonococcal urethritis and cervicitis

EDITOR,—In the recently published UK national guidelines on sexually transmitted infections and closely related conditions¹ ciprofloxacin 500 mg orally as a single dose has been recommended for uncomplicated anogenital infection due to *Neisseria gonorrhoeae* in adults. However, some studies have shown that an oral dose of 250 mg of ciprofloxacin is an effective treatment for uncomplicated gonorrhoea.^{2,3}

In our department, we have been using ciprofloxacin 250 mg as a single oral dose as first line treatment for uncomplicated gonococcal urethritis and cervicitis and 500 mg of oral dose of ciprofloxacin for rectal and pharyngeal infections since 1997. We reviewed case notes of patients with uncomplicated gonococcal infections who attended our department between 1 January 1999 and 31 December 1999. A total of 61 patients with a positive culture were analysed. Of the 61 patients 42 patients with gonococcal urethritis and cervicitis were treated with ciprofloxacin 250 mg as a single oral dose. Eleven patients were treated with 500 mg of ciprofloxacin. Of the 11 patients five had rectal or pharyngeal infections, two were infected with a strain less sensitive to ciprofloxacin, four were initially treated with 250 mg of ciprofloxacin and subsequently given 500 mg of ciprofloxacin when rectal/pharyngeal cultures were found to be positive. Five patients with pregnancy or risk of pregnancy were treated with 3 g amoxycillin with 1 g probenecid and three patients (two pregnant patients with history of allergy to penicillin and one patient infected with a strain resistant to penicillin and less sensitive to ciprofloxacin) were treated with 2 g of intramuscular spectinomycin. In the group treated with 250 mg of ciprofloxacin, 35 (83%) patients, and in the groups treated with 500 mg ciprofloxacin, amoxycillin, and

Table 1 Minimum inhibitory concentration (MIC)

Serial No	Penicillin	Ciprofloxacin	Spectinomycin
1*	>10 µg/ml (resistant)	0.125 µg/ml (less sensitive)	16 µg/ml (sensitive)
2	0.64 µg/ml (less sensitive)	0.125 µg/ml (less sensitive)	16 µg/ml (sensitive)
3*	>10 µg/ml (resistant)	0.125 µg/ml (less sensitive)	16 µg/ml (sensitive)

*Contracted the infection in Thailand.

spectinomycin, all patients attended for at least one repeat smear and culture. In all tested cases repeat smear and cultures were negative. Of seven patients who defaulted for test of cure despite repeated recall letters, five were below the age of 19. The strains isolated in three patients were less sensitive to ciprofloxacin (see table 1). Of the three patients two had infection due to penicillinase producing *Neisseria gonorrhoeae* (PPNG) and they contracted the infection in Thailand. Two of these patients were treated with a single oral dose of 500 mg of ciprofloxacin and one patient was treated with 2 g of intramuscular spectinomycin and subsequently culture became negative.

The proportion of quinolone resistant *Neisseria gonorrhoeae* isolates is rising throughout the world and the levels of resistance in these isolates have risen substantially in recent years.⁴ In Britain, ciprofloxacin resistance is associated with imported cases especially from the Far East⁵ and high level resistance to ciprofloxacin has also been reported.⁶ However, treatment failure remains low especially if the infection is acquired within the United Kingdom.⁵ Moreover, it has been reported that failure rate of ciprofloxacin treatment is lower than the percentage of ciprofloxacin resistant isolates and therefore in vitro resistance to ciprofloxacin may not translate into clinical treatment failure.⁴

A single oral dose of 100 mg ciprofloxacin has been reported to be effective in eradicating uncomplicated urethral gonorrhoea in men.² In our study a single oral dose of 250 mg of ciprofloxacin was found to be effective for treating uncomplicated gonococcal urethritis and cervicitis. However, consideration may be given to a higher dose of ciprofloxacin or other alternatives when the infection may have been acquired in locations where resistant strains are endemic.

NELSON DAVID
GILLIAN WILDMAN
SASIKALA RAJAMANOHRAN
Department of GU Medicine,
Royal Berkshire Hospital,
Reading RG1 5AN, UK

Correspondence to: Dr Nelson David

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Investigation of the increased incidence of gonorrhoea diagnosed in GUM clinics in England, in 1994-6

EDITOR,—Hughes *et al*¹ recently presented an investigation of the increased incidence of gonorrhoea diagnosed in GUM clinics in England, in 1994-6 within which they have included the data from our clinic.

We reviewed the incidence of gonococcal infection diagnosed in the department of genitourinary medicine, Coventry Healthcare NHS Trust in 1994 and 1996, using the same criteria which had been applied in their study (see table 1).

Similar to Hughes *et al*, we found that the incidence of gonorrhoea had increased remarkably in 1996 compared with 1994 (48 cases in 1994 and 94 in 1996). Of the total number of patients, 49 had other acute STIs at the time of presentation including 37 of them with chlamydial infection; 13 patients were homosexual and four had infection in the oropharyngeal, rectal, or both sites; 39 patients had attended the clinic previously and eight of them suffered from gonococcal infection.

We found a completely different picture with respect to the incidence of penicillin resistance in the gonococcal isolates; while six patients (13.5%) were found to be penicillin resistant in 1994 only three (3.03%) were found to be penicillin resistant in 1996; four homosexual patients were found to be penicillin resistant and two of them had contacts who lived outside Coventry. We have been using penicillin as the first line of treatment for gonorrhoea for the past 20 years or more and the incidence of treatment failure in our area is very low. Accordingly, we believe that the causes of increased incidence of gonococcal infection in the Coventry area are not related to penicillin resistance.

Although most of the patients infected were white, 117 cases (82%), the incidence of gonococcal infection was disproportionately high in black ethnic group, 19 cases (13%); this group however contributed 1.9% of the population in Coventry. Six patients were of Asian origin and interestingly they were second generation Asians and five of them were male, single, of 20-25 age group, and having three or more sexual partners.

S DAS
P S ALLAN
A A H WADE

Table 1 Incidence of gonorrhoea in 1994 and 1996

Subjects	1994	1996
Cases	48	94
Male	34	65
Female	14	34
Heterosexuals	43	86
Homosexual	5	8
white	36	81
African/Caribbean	9	10
Asian	3	3
Penicillin resistance	6	3
Other STI	13	34
Chlamydia	10	27

GU/HIV/AIDS Medicine, Coventry Healthcare NHS Trust, Coventry and Warwickshire Hospital, Sney Stanton Road, Coventry CV1 4FH, UK

Correspondence to: Dr Das

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Perceptions of disease and therapy are factors influencing adherence to antiretroviral therapy

EDITOR,—HIV infection is now considered a chronic condition. Patients will have to learn to live with the disease for their life. Therefore, the management of psychological aspects, besides clinical ones, is becoming increasingly important. In most cases the infection can be controlled by effective but complex treatments. On the other hand, people living with HIV face everyday problems related to the disease, the therapy, and a persisting social stigma which inevitably influences their behaviour. Based on this, the patients' perceptions of disease and therapy may be important in adherence of patients to treatment,¹ which is now an important aspect in HIV care.^{2,3} The study, "Compliance in HIV" has analysed the role of these factors on adherence to therapy.

This is a multicentre observational study focused on evaluating the level of adherence to anti-HIV therapies conducted in Italy. Eligible for the study were HIV+ patients, aged >18 years using combination therapy (bi- and tri-combination therapy) identified in randomly selected days during June 1998 at five outpatient clinics (Milan, Brescia, Florence, Rome, and Naples). Patients were asked to read and sign the informed consent form. They were interviewed by trained psychologists. The questionnaire includes information on general characteristics, clinical conditions, therapy, adherence to therapy, expectation, personal relationship, and perceptions of life, the future, disease, and therapy. In particular, patients were asked to indicate how they perceive HIV disease (among the following adjectives: enslaving, cruel, threatening, invasive, constructive) and the therapy (among the following adjectives: protective, reliable, allied, exigent, enslaving). Each subject could indicate more than one adjective. Less than 5% of eligible subjects refused the interview. Adherence was measured as the number of errors made in the previous week and the past 2 months. Errors made in the previous week were indicated first and then errors made in the previous 2 months in order to help patients to recall less recent events. The kinds of errors investigated included: missing doses of one specific drug, interrupting the entire combination, altering time schedule, wrong association with food, wrong association of drugs, wrong count of pills. Adherence to treatments was defined as follows: high: less than 2 errors; medium: 3-4; low: 5 or more during the 2 months before interview.

In all, 214 HIV infected subjects were enrolled: 63.6% were males and 36.4% females. The age distribution was <24 years 3.8%; 25-34 years 43.4%; 35-44 years 37.4%; 45 years 15.4%. The average time from HIV diagnosis was 6.8 years; 61.2% of respondents reported having HIV related symptoms (currently or in the past). Combination therapies most used were: stavudine, lamivudine, in-

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Table 1 Perception of disease and treatment and adherence level

	Adherence level			p Value*
	High (n=84)	Medium (n=55)	Low (n=75)	
Perception of disease (No (%))				
Enslaving	30 (35.7)	21 (38.2)	20 (26.7)	0.3
Cruel	26 (31.0)	14 (25.4)	23 (30.7)	0.7
Threatening	23 (27.4)	17 (30.9)	22 (29.3)	0.9
Invasive	24 (28.6)	13 (23.6)	20 (26.7)	0.8
Constructive	12 (14.3)	7 (12.7)	17 (22.7)	0.23
Perception of therapy (No (%))				
Protective	42 (50.0)	21 (38.2)	25 (33.3)	0.09
Reliable	37 (44.1)	28 (50.9)	20 (26.7)	0.01
Allied	31 (36.9)	23 (41.8)	28 (37.3)	0.82
Exigent	25 (29.8)	18 (32.7)	29 (38.7)	0.49
Enslaving	17 (20.2)	14 (25.4)	29 (38.7)	0.03

* χ^2 adjusted for age, sex, and clinical status (symptomatic and asymptomatic).

danavir (25.2%)/zidovudine, lamivudine, indinavir (10.7%)/stavudine, lamivudine (8.4%)/stavudine, lamivudine (7.0%)/zidovudine, lamivudine (6.5%)/zidovudine, lamivudine, saquinavir (6.0%).

Most respondents perceive HIV disease as enslaving (33.2%), cruel (29.4%), and threatening (29%). Among the respondents' choices, the connotation "constructive" was indicated by 36 subjects (16.8%). With regard to the perception of therapy, most patients perceived therapy as protective (88 subjects).

Table 1 shows adherence level according to perception of disease and therapy.

The perception of disease was not associated with adherence level. However, the perception of therapy as protective or reliable was associated with higher levels of adherence, and the perception of therapy as enslaving with lower ones. These findings were confirmed after taking into account potential confounding factors (including sex, age, and clinical status) and, in particular, the perception of therapy was an independent factor of adherence in strata of different perception of the disease (data not shown).

In conclusion, the patients' attitudes toward therapy emerge as important in ensuring high adherence levels. As correct adherence to treatment is a necessary condition in order to obtain therapy efficacy, these findings suggest it would be useful to consider perception of therapy by the doctor in patients' management.

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M MARTINI
P NASTA

LILA Lega Italiana per la Lotta contro l'AIDS
(Italian League for the fight against AIDS), National
Research Centre, Milan, Italy

E RICCI
F PARAZZINI
Istituto di Ricerche Farmacologiche, "Mario Negri",
Milan, Italy

V AGNOLETTI
LILA Lega Italiana per la Lotta contro l'AIDS,
Via Rogoredo, 41, 20138, Milan, Italy

Correspondence to: Dr V Agnoletto

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The power of information and contraceptive choice in a family planning setting in Mexico

EDITOR,—In the article by Lazcano Ponce *et al.*,¹ the proportion of women receiving IUDs fell in the intervention arm. As the authors state, most methods of contraception do not protect against STI acquisition. Most of the women choosing not to use IUDs in this trial probably selected oral contraceptives, another non-barrier method. These women, too, would be unprotected against STI, so the benefit of this intervention is unclear. In addition, most other methods of contraception have higher pregnancy failure rates than IUDs; thus, women deterred from IUDs in this trial may have had more unplanned pregnancies, with their attendant risks and cost, as a result of the intervention.

Fully informed choice for all family planning clients is an estimable standard of care. But the authors' unstated assumption seems to be that too many women at risk of STI receive IUDs for family planning.¹ While IUDs cause a transient increase in the risk of pelvic inflammatory disease, they have no documented adverse effect on STI acquisition or ascent thereafter.² IUDs offer safe, effective, affordable long term contraception. Given the low prevalence of cervical infection among family planning clinic attenders in this trial¹ and others, we need guidelines to "rule in" the great majority of women who are uninfected, rather than inappropriately label large numbers of women ineligible for IUD use.

PAUL FELDBLUM
Family Health International, Clinical Research
Department, PO Box 13950, Research Triangle Park,
NC 27709, USA

1 Lazcano Ponce EC, Sloan NL, Winikoff B, *et al.* The power of information and contraceptive choice in a family planning setting in Mexico. *Sex Transm Inf* 2000;76:277-81.

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AIDS and globalisation

EDITOR,—I commend Shamanesh *et al.*¹ for their searching and informed account of the impact of globalisation on the world AIDS

problem. Revisiting Alma Ata 1978: the existence of gross inequalities between advantaged and disadvantaged peoples is "politically, socially and economically" unacceptable. Twenty two years on, are we closer to the ideal of "health for all" or further away. When will we learn?

MIKE GRIFFITHS
SHO Public Health/Non-Principal GP,
West Midlands, UK

michael.griffiths@dudley-ha.wmids.nhs.uk

1 Shamanesh M, Shamanesh M, Shamanesh R. AIDS and globalisation. *Sex Transm Inf* 2000;76:154-5.

WSW status needs further definition

EDITOR,—Fether *et al.* present a very interesting case-control study on STIs in women who have sex with women (WSW).¹ This was not a community based sample and thus prone to selection bias. In order to appreciate the results in full it would help to know how cases and controls were identified and how controls were selected. Bisexual or homosexual orientation may be difficult to disclose even in a sympathetic and non-judgmental setting. Studies using self reported sexual orientation to determine case or control status will always have a degree of differential misclassification. It is likely that WSW who volunteer this information differ not only from women who do not have sex with women but also from WSW who do not volunteer the information but admit it when prompted, and from those who do not admit it even when prompted. Without this information it is difficult to determine the importance of various prevalences quoted in the paper. All I learn from this paper at present is that women who have sex with women also take other risks.

RUDIGER PITTROF
St George's Hospital, London, UK
rudiger_pittrof@hotmail.com

1 Fethers K, Marks C, Mindel A, *et al.* Sexually transmitted infections and risk behaviours in women who have sex with women. *Sex Transm Inf* 2000;76:345-9.

BOOK REVIEWS

A Physician's Guide to Clinical Forensic Medicine. Ed Margaret M Stark. Pp 326; \$79.95. Totowa: Humana Press, 2000. ISBN 0-896-03742-8.

Forensic examination of those alleging sexual assault can be appropriately provided within sexual health services, but requires additional skills. The examinations are lengthy, detailed, frequently nocturnal, and often lead to an appearance at the Old Bailey. A distressed individual will need to be examined from head to toe, with every injury described, measured, and drawn. The correct samples must be taken, timed, labelled and bagged with due attention to the chain of evidence. Subsequently the doctor may need to interpret the findings for the police, write a detailed statement, and withstand the adversarial setting of the court.

A Physician's Guide to Clinical Forensic Medicine covers areas relevant to general forensic

medical examiners, but several chapters will be of particular value to those examining victims of sexual assault. The chapter on fundamental principles is a useful overview that includes consent as well as pertinent but brief advice on preparation of reports and attendance at court. The chapter on sexual assault examination is generally excellent, giving detailed descriptions of the methods for taking and handling samples, and summarising studies relevant to the interpretation of findings. Although most of the advice is clear, there are exceptions; for example, people frequently ask whether it is still worth taking forensic samples a week or more after the assault, and this information is hard to tease out from the section on persistence data. The chapter includes a succinct section on sexually transmitted infections which summarises current debate on prophylaxis against bacterial infections, hepatitis B, and HIV, but stops short of giving any recommendations for immediate care or later referral. It is a sign of how rapidly the field is moving that drug assisted rape, now so widely discussed in the media, is mentioned only briefly. The drugs γ -hydroxy butyrate and ketamine are discussed in the section on substance misuse, but not in relation to sexual assault.

Doctors working in sexual health are often inexperienced in the interpretation of injuries, but such expertise is crucial for forensic work. Crane's chapter is authoritative and intelligible on common areas of difficulty—for example, the differences between abrasions, lacerations, and incisions, and the possible interpretations of these injuries.

I was delighted to receive a review copy of this book. Otherwise I would certainly have bought one, and would recommend it to others with a medicolegal interest.

JAN WELCH

Department of Sexual Health, Caldecot Centre,
London SE5 9RS

Sexually Transmitted Diseases. 3rd ed. Ed King K Holmes, P Frederick Sparling, Per-Anders Mardh, Stanley M Lemon, Walter E Stamm, Peter Piot, Judith N Wasserheit. \$170.50. New York: McGraw Hill, 1999. ISBN 0-07-029688-X.

The new edition of this classic is long overdue. It would be no exaggeration to say that the readers will not be disappointed. The basic layout and chapters' sequence are similar to the 1990 edition, but with the introduction of several sections to each of the 10 parts of the book. This new structure allows better grouping of topics and concepts, and makes referencing extremely easy from the list of contents. Prime examples of this are chapters dealing with HIV infection, which are grouped under their own designated sections, rather than being part of a subsection of viral STDs, as was in earlier editions.

The new edition contains 107 chapters, with expanded sections on socioeconomic impact of STD, epidemiology in both developed and developing world, sexuality and behaviour profiles of groups in need of intervention. Further chapters towards the end of the book devote entirely to STD/HIV prevention in a global context. Finally, legal, political, and ethical issues were dealt with in depth. My only regret is the omission of the chapters on anatomy of the normal genital tracts. However, normal genital flora and mucosal defences are well covered. These are in addition to the extremely comprehensive

review of the medical aspect of STD/HIV management. The most impressive aspect of this book, despite its size and time taken to press, is the updated information available, especially pertaining to antiretroviral therapy and drug interactions. The appendix with list of internet resources further allows readers to obtain necessary state of the art information.

This book is one of the "must have" books for any clinicians dealing with these infections, and an essential reference book for any medical library. It is also a valuable source of compact information for anyone whose work requires an understanding of issues surrounding STD/HIV, including epidemiologists, sociologists, behaviour scientists, policymakers, and politicians, to name just a few.

MIA HUENGSBERG

Department of Genitourinary Medicine,
Whitall Street Clinic, Birmingham B4 6DH

WEBSITE REVIEW

IHMF website. The website of the International Herpes Management Forum can be found at <http://www.IHMF.org>

The range of the website is greater than I expected, covering CMV, EBV, HHV-6, 7, and 8, varicella, as well as HSV-1 and HSV-2. The search option gives a rapid indication of the scale of the site. I was impressed with the search by "free text query." My 20 word query concerning recurrent herpes in the third trimester revealed 162 relevant references on the website.

The website contains a library consisting of recent papers and a series of monographs produced by the IHMF. Arising out of these monographs are management guidelines on various aspects of herpes viruses. Updates on key issues are to be found in the *Herpes Journal*, published three times a year, and reproduced in full on this site.

Further useful aspects of this site include PowerPoint slides, which can be downloaded, covering background scientific information as well as some presentations of IHMF meetings. Abstracts from these meetings may also be downloaded as well as posters summarising recommendations. A list of forthcoming events and reports from past meetings can also be accessed.

Another section on this site allows you to click anywhere on a world map to find organisations working on herpes. A click in the UK revealed the MSSVD, the Herpes Special Interest Group, and the British Co-operative Clinical Group.

This site is useful in many ways and provides an authoritative source of information. There is a section for feedback so that users of the site can contribute to keeping it accurate and up to date.

CHRIS CARNE

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 in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

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: pubsvic@tsp.sheridan.com).

Royal Society of Medicine and National Institutes of Health International Conference, RSM London, 7-8 December 2000

The RSM in London, UK, and the NIH in Bethesda, Maryland, US, are organising an international conference to be held at the RSM on "New trends in HIV management and research." Further details: Victoria Boswell, Academic Conference Assistant, Royal Society of Medicine (tel: +44 (0)20 7290 2965; fax: +44 (0)20 7290 2977; email: victoria.boswell@roysocmed.ac.uk).

International Symposium on Disorders of the Prostate, 21-23 March 2001, Castres, France

Further details: Dr Mike Briley, Scientific Director, Pierre Fabre Medicament, Parc Industriel de la Chartreuse, F-81106 Castres Cedex, France (tel: +33 563 714 501; fax: +33 563 725; email: briley@pierre-fabre.imagenet.fr).

Call for papers—6th European Forum on Quality Improvement in Health Care, 29-31 March 2001, Bologna, Italy

Further details: BMA/BJM Conference Unit, BMA House, Tavistock Square, London WC1H 9JP, UK (tel: +44 (0) 20 7383 6409; fax: +44 (0) 20 7383 6869; email: quality@bma.org.uk; website: www.quality.bmjpg.com).

6th European Conference on Experimental AIDS Research (ECEAR '2001), 23-26 June 2001, Heriott-Watt University, Edinburgh, UK

Further details: ECEAR '2001 Conference Secretary, Division of Retrovirology, NIBSC, Blanche 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@cpcb.de).

10th International Congress on Behçet's Disease will be held in Berlin 27-29 June 2002

Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de).

CURRENT PUBLICATIONS

Selected titles from recent reports published worldwide are arranged in the following sections:

Gonorrhoea
Chlamydia
Candidiasis
Bacterial vaginosis
Trichomoniasis
Pelvic inflammatory disease
Syphilis and other treponematoses
Herpes
Human papillomavirus infection
Cervical cytology and colposcopy
Microbiology and immunology
Dermatology
Miscellaneous

Gonorrhoea

Improvements of clinical algorithms for the diagnosis of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* by the use of gram-stained smears among female sex workers in Accra, Ghana.

G DECEUNINCK, C ASAMOAHADU, N KHONDE *et al.* *Sex Transm Dis* 2000;27:401–10

Detection of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* colonization of the gravid cervix.

LL ASBO, RV HIGGINS, Z BAHRANIMOSTAFAVI *et al.* *Am J Obstet Gynecol* 2000;183:340–4

Development of gemifloxacin in vitro susceptibility test methods for gonococci including quality control guidelines.

RN JONES, ME ERWIN. *Diag Microbiol Infect Dis* 2000;37:195–202

In vitro susceptibilities of 400 Spanish isolates of *Neisseria gonorrhoeae* to gemifloxacin and 11 other antimicrobial agents.

S BERRON, JA VAZQUEZ, MJ GIMENEZ *et al.* *Antimicrob Agents Chemother* 2000;44:2543–6

Antigenic and sequence diversity in gonococcal transferring-binding protein A.

CN CORNELISSEN, JE ANDERSON, IC BOULTON, PF SPARLING. *Infect Immun* 2000;68:4725–35

Use of the neisserial lipoprotein (Lip) for subtyping *Neisseria gonorrhoeae*.

DL TREES, AJ SCHULTZ, JS KNAPP. *J Clin Microbiol* 2000;38:2914–6

Alteration of epithelial cell transferring-iron homeostasis by *Neisseria meningitidis* and *Neisseria gonorrhoeae*.

RABONNAH, SW LEE, BL VASQUEZ *et al.* *Cell Microbiol* 2000;2:207–18

The membrane phospholipids of *Neisseria meningitidis* and *Neisseria gonorrhoeae* as characterized by fast atom bombardment mass spectrometry.

MM RAHMAN, VSK KOLLI, CM KAHLER *et al.* *Microbiology-UK* 2000;146:1901–12

***Neisseria gonorrhoeae* elicits membrane ruffling and cytoskeletal rearrangements upon infection of primary human endocervical and ectocervical cells.**

JL EDWARDS, JQ SHAO, KA AULT, MA APICELLA. *Infect Immun* 2000;68:5354–76

Syndecan-1 and syndecan-4 can mediate the invasion of Opa(HSPG)-expressing *Neisseria gonorrhoeae* into epithelial cells.

E FREISSLER, AMAD HEYDE, G DAVID *et al.* *Cell Microbiol* 2000;2:69–82

Chlamydia

High-resolution genotyping of *Chlamydia trachomatis* from recurrent urogenital infections.

LN PEDERSEN, HO KJAER, JK MOLLER *et al.* *J Clin Microbiol* 2000;38:3068–71

Characterization of lymphocyte response in the female genital tract during ascending chlamydial genital infection in the guinea pig model.

RG RANK, AK BOWLIN, KA KELLY. *Infect Immun* 2000;68:5293–5305

Quantitative *Chlamydia trachomatis* cultures: correlation of chlamydial inclusion-forming units with serovar, age, sex and race.

LO ECKERT, RJ SUCHLAND, SE HAWES *et al.* *J Infect Dis* 2000;182:540–4

Expression of two novel proteins in *Chlamydia trachomatis* during natural infection.

GSA MYERS, R GRINVALDS, S BOOTH *et al.* *Microbial Pathogen* 2000;29:63–72

Coincubation of human spermatozoa with *Chlamydia trachomatis* in vitro causes increased tyrosine phosphorylation of sperm proteins.

S HOSSEINZADEH, IA BREWIS, AA PACEY *et al.* *Infect Immun* 2000;68:4872–99

Amino acid transport into cultured McCoy cells infected with *Chlamydia trachomatis*.

A HARPER, CI POGSON, JH PEARCE. *Infect Immun* 2000;68:5439–42

***Chlamydia trachomatis* infection of epithelial cells induces the activation of caspase-1 and release of mature IL-18.**

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Role of Nramp1 deletion in *Chlamydia* infection in mice.

S PAL, EM PETERSON, LM DELAMAZA. *Infect Immun* 2000;68:4831–3

Candidiasis

Fungal culture findings in cyclic vulvitis.

VL HANDA, CW STICE. *Obstet Gynecol* 2000;96:301–3

Transcription factors in *Candida albicans*—environmental control of morphogenesis.

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Vaginal clindamycin and oral metronidazole for bacterial vaginosis: a randomized trial.

J PAAVONEN, C MANFIONI, MA MARTIN, CP WAJSZCZUK. *Obstet Gynecol* 2000;96:256–60

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Molecular epidemiology of metronidazole resistance in a population of *Trichomonas vaginalis* clinical isolates.

LJ SNIPES, PM FAMARD, EM NARCISI *et al.* *J Clin Microbiol* 2000;38:3004–9

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MR MENDOZALOPEZ, C BECERRILGARCIA, LV FATTIELFACENDA *et al.* *Infect Immun* 2000;68:4907–12

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Syphilis and other treponematoses

Evaluation of the Bio-Rad syphilis IgG test performed on the CODA system for serologic diagnosis of syphilis.

CA THOLCKEN, GL WOODS. *Diag Microbiol Infect Dis* 2000;37:157–160

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EAC NEWTON, JM JUDER. *Sex Transm Dis* 2000;27:363–70

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F MADEB, O NATIV, D BENILEVI *et al.* *Clin Infect Dis* 2000;30:982–3

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K BUCHACZ, E MCFARLAND, M HERNANDEZ *et al.* *Sex Transm Dis* 2000;27:393–4000

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N ABUHARFEIL, MM MEQDAM. *Microbiologica* 2000;23:235–40

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Immunological hiding of herpesvirus-infected cells.

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N BOURNE, LR STANBERRY, ER KERN *et al.* *Antimicrob Agents Chemother* 2000;44:2471–4

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J CUZICK, P SASIENI, P DAVIES *et al.* *Br J Cancer* 2000;83:561–5

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