This Journal, founded by the Medical Society for the Study of the Venerable Diseases, publishes original work on the investigation and treatment of venereal diseases, sexually transmitted diseases and allied disorders, and review articles, correspondence, and abstracts.

Advice to authors Papers for publication, which will be accepted on the understanding that they have not been and will not be published elsewhere and are subject to editorial revision, should be sent in duplicate to Dr A McMillan, Department of Genitourinary Medicine, Royal Infirmary, Lauriston Place, Edinburgh EH3 9YW. The covering letter should contain a statement signed by all authors that the manuscript has been seen and approved by them. Any change of address of the corresponding author between submission and publication of the paper should be notified in advance to the Technical Editor, c/o BMA House. Manuscripts will only be acknowledged if a stamped addressed postcard or international reply coupon is enclosed.

Full details of requirements for manuscripts in the Vancouver style (Br Med J 1982; 284: 1766-70) are given in Uniform requirements for manuscripts submitted to biomedical journals, available from the Publishing Manager, British Medical Journal, BMA House (50p post free). Briefly details are as follows:

1. Scripts must be typewritten on one side of the paper only in double spacing with ample margins, and two copies should be sent.

2. Each script should include, in the following order: a brief summary, typed on a separate sheet, outlining the main observations and conclusions; the text divided into appropriate sections; acknowledgements; tables, each on a separate sheet; and legends for illustrations.

3. The title of the paper should be as brief as possible.

4. The number of authors should be kept to the minimum, and only their initials and family names used.

5. Only the institution(s) where work was done by each author should be stated.

6. SI units are preferred. If old fashioned units are used SI units should be given in parentheses or, for tables and figures, a conversion factor given as a footnote.

7. Only recognised abbreviations should be used.

8. Acknowledgements should be limited to workers whose courtesy or help extended beyond their paid work, and supporting organisations.

9. Figures should be numbered in the order in which they are first mentioned, referred to in the text, and provided with captions typed on a separate sheet. (Diagrams: use thick white paper and insert lettering lightly in pencil. Photographs: should be marked on the back with the author’s name and indicating the top edge. They should be trimmed to include only the relevant section (sizes 23/4" or 5 1/4" wide, maximum 5 1/4" x 7") to eliminate the need for reduction. Photomicrographs must have internal scale markers. X ray films should be submitted as photographic prints, carefully prepared so that they bring out the exact point to be illustrated.

10. Tables should be numbered, have titles, and be typed on separate sheets. Please avoid large tables.

(11) References should be numbered consecutively the first time they are cited and identified by arabic numbers in the text, tables, and legends to figures. Authors must take full responsibility for the accuracy of their references, and the list should be kept as short as practicable. It should be in the order in which references are first mentioned, and should include (in the following order), journals: author’s name and initials, title of paper, name of journal (in full or abbreviated according to the list in Index Medicus, year of publication, volume number, and first and last page numbers; books: author’s name and initials, full title, edition, place of publication, publisher, and year of publication. When a chapter in a book is referred to, the name and initials of the author of the chapter, title of the chapter, “In:”, name and initials of the editor, and “ed” should precede book title, etc as above. In references to journals or books, when there are seven or more authors the names of the first three should be given followed by “et al.”

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TO THE EDITOR, Genitourinary Medicine

Condylomata acuminata in children and sexual abuse

Sir,
The paper by Baruah et al on condylomata acuminata in a male child gives a misleading impression of the occurrence and transmission of venereal warts in childhood.1 Reports may be difficult to find because of the diversity of specialties to which such children may be referred, such as dermatology, paediatrics, and infectious diseases, but reports do exist. Several reports had been published before 1983, including four since 1976, in which sexual abuse was recognised as the cause of condylomata acuminata.2-5 Histological confirmation was specifically mentioned by Mininberg and Rudick4 and DeJong et al.5 These studies reported on a total of 12 children, eight of whom had been sexually abused. Five of the 12 were boys, of whom two had urethral condylomata acuminata and three had perianal lesions.

More recently, White et al reported three cases of condylomata acuminata in boys aged two, 10, and 12, all of whom were victims of sexual abuse.6 Since 1979 four girls, aged 2, 4, 5, and 7 have presented at our clinic with condylomata acuminata, all of whom were found to have been sexually abused. With the possible exception of young infants, the presence of condylomata acuminata in a prepubertal child should be considered to be an indication of sexual abuse until proved otherwise. Parental denial of abuse in no way rules it out. The probability of obtaining an accurate history depends a great deal on the skill and techniques of the interviewer and subsequent investigation by the social services. These efforts may not obtain a history of abuse, even when it is highly suspected. Young boys are not exempt from sexual abuse. About 20% of our sexually abused children were boys. Our youngest such patient was a six month old male infant who sustained severe rectal and anal tears from sexual abuse. We have found that the perpetrators are almost always known to the children. In our population about 80% of the abusers have been the child's father, stepfather, or a boyfriend living with a woman relative.

It must be recognised that sexually transmitted diseases of adults are sexually transmitted in children as well. To fail to make this diagnosis leaves children open to further abuse.

Yours faithfully,
Marcia Herman-Giddens

Child Protection Team, Department of Pediatrics, Box 2998
Durham University Medical Center, Durham, North Carolina 27710, USA

References

TO THE EDITOR, Genitourinary Medicine

Proctology

Sir,
We welcome your decision to change the title of the journal to "Genitourinary Medicine", thus widening its scope,1 and also agree with your hope that material relating to a wider aspect of medical gynaecology and urology will be submitted to the journal. We think however, that there is a serious omission, namely medical proctology.

As most homosexual men2-3 and 8% of women4 regularly practise anal receptive intercourse, not only will patients present with anorectal infections that are sexually transmitted, but some anal disorders that are not usually regarded as being sexually related (such as, fissure and fistula) may have anal usage as their basis. We feel this subject merits further investigation. We have recently set up a combined clinic, primarily for studying the natural history of anal warts after scissor excision,5 but which provides the opportunity for joint consultation in difficult anorectal problems.

The anorectum as a site for sexually transmitted disease should not be forgotten by coloproctologists, neither should more conventional disorders be overlooked by those specialising in genitourinary medicine.

Yours faithfully,
James P S Thomson
Paul Simmons

*St Mark's Hospital, London EC1
†St Bartholomew's Hospital, London EC1

References

Notices

Conference of the African Union Against Venereal Diseases and Treponematoses

The African Union Against Venereal Diseases and Treponematoses will be holding a conference on 1-5 April 1985 in Libreville, Gabon. There will be a workshop on chlamydial infections on 1 and 2 April and a conference on infertility and STD in Africa from 3 to 5 April.

International conference on AIDS

An international conference on the acquired immune deficiency syndrome (AIDS) will be held on 15-17 April, at the World Congress Center, Atlanta, Georgia, United States. It will be sponsored by: the Centers for Disease Control; the National Institutes of Health; the Food and Drug Administration; the Alcohol, Drug Abuse, and Mental Health Administration; the Health Resources and Services Administration; and the World Health Organisation. The purpose of the meeting is to review strategies for the prevention and control of AIDS and to exchange information on screening and diagnostic tests for AIDS and on the epidemiology, virology, immunology, clinical manifestations, and treatment of AIDS. Seating will be available for 1800 participants. To obtain further information and future announcements, please contact: AIDS Conference, Building 1, Room 2047, Centers for Disease Control, Atlanta, Georgia 30333, USA.
List of current publications

These selected abstracts and titles from the world literature are arranged in the following sections:

**Syphilis and other treponematoses**
- Candidosis
- Genital herpes
- Genital warts
- Acquired immune deficiency syndrome
- Other sexually transmitted diseases
- Genitourinary bacteriology
- Public health and social aspects
- Miscellaneous

**Syphilis and other treponematoses**

The human respiratory nasal mucosa in nasal syphilis

Aortic valve prolapse due to syphilitic aortitis

The role of protein component of *T. pallidum* in inducing skin reaction for delayed hypersensitivity

Comparative evaluation of commercial fluorescent treponemal antibody absorbed test kits

This paper describes the comparative laboratory evaluation of four commercial FTA-ABS test kits, using serum from 150 selected patients. All kits were used exactly according to the recommendations of the manufacturer. The ability of the test kits to detect reactive serum samples varied from 82.5% to 95%, and non-reactive serum samples from 80-9% to 96-4%. Reproducibility of results from individual assays and by comparative studies of assays averaged 42%. The variation in performance between kits is probably related to one or more of the kit components, and these factors are fully discussed. The development of an immunological standard for use in the manufacture of FTA-ABS kits is recommended in an effort to obtain uniform performance characteristics among commercial test kits.

M S Sprott

**Gonorrhoea**

A new previously undescribed plasmid in penicillinase-producing *Neisseria gonorrhoeae* in Spain

Ability of monomeric peptidoglycan fragments from *Neisseria gonorrhoeae* to damage human fallopian-tube mucosa

Inhibition of *Neisseria gonorrhoeae* growth due to hydrogen peroxide production by urogenital streptococci

Absence of bactericidal antibodies against group-I lipopolysaccharide determinants of *Neisseria gonorrhoeae* during human infection

Arrangement of pili in colonies of *Neisseria gonorrhoeae*

Treatment of penicillin-resistant *Neisseria gonorrhoeae* with oral norfloxaclin

A case-control study of spermicides and gonorrhea

**Non-specific genital infection and related disorders (chlamydial infection)**

Chlamydial pneumonitis and its serodiagnosis in infants
Prevalence of *Chlamydia trachomatis* cervical infection in female adolescents

*Chlamydia trachomatis* infection in sexually active adolescents—prevalence and risk factors

Surface structure of chlamydial elementary bodies

Comparison of the in vitro activities of ofloxacin and tetracycline against *Chlamydia trachomatis* as assessed by indirect immunofluorescence

In vitro activity of clindamycin against strains of *Chlamydia trachomatis*, *Mycoplasma hominis* and *Ureaplasma urealyticum* isolated from pregnant women

Non-specific genital infection and related disorders (mycoplasma and ureaplasma infections)

The occurrence of genital mycoplasmas in babies with and without respiratory distress

Non-specific genital infection and related disorders (general)

Mucopurulent cervicitis—the ignored counterpart in women of urethritis in men

Pelvic inflammatory disease

Serological evidence implicating *Mycoplasma genitalium* in pelvic inflammatory disease

Contraceptives and acute salpingitis

A first episode of salpingitis in 546 women was studied by laparoscopy in Lund, Sweden. Of 191 women not using an intrauterine contraceptive device (IUD) or oral contraceptives (OCs) the inflammation of the fallopian tubes was mild in 51.3%, moderate in 34.6%, and severe in 24.1%. For the 185 patients using an IUD the corresponding figures were 54.6%, 29.7%, and 15.7%; and for the 170 in those using OCs 73.5%, 17.1%, and 9.4% respectively. The difference regarding milder degrees of inflammation in women using OCs compared with those using IUDs or neither method was significant.

Reiter’s disease

Reactive arthritis, a renewal of infectious arthritis, or the borders of ankylosing spondylitis

Candidosis

Critical role of germ tube formation in the pathogenesis of candidal vaginitis

Genital herpes

Comparison of standard tissue culture, tissue culture plus staining, and direct staining for detection of genital herpes simplex virus infection

Secretory IgA antibody in cervicovaginal secretions from women with genital infection due to herpes simplex virus
Preventing neonatal herpes
NJ BINKIN, JP KOPLAN, AND W CATES

Prophylactic oral acyclovir in recurrent genital herpes
A MINDEL, IVD WELLER, A FAHERTY, ET AL

In a randomised double blind trial, 56 patients with at least four recurrent episodes of genital herpes a year were given either oral acyclovir 200 mg or placebo four times daily for 12 weeks. Patients were seen and swabs sent for virus culture every two weeks during the 12 week treatment period and monthly for the next six months. The mean recurrence rate per month with treatment was 1.4 in the patients receiving placebo and 0.05 in those treated with acyclovir (p < 0.0001). The median time to first recurrence after the start of treatment was 14 days in patients receiving placebo and 100 days in those receiving acyclovir (p < 0.0001). The recurrence rate in the two groups was similar after the end of treatment. Although no important side effects were recorded in this study, the safety of long term acyclovir has not been fully evaluated except in small numbers of immunocompromised patients. The authors also calculated that the cost for a single patient using this regimen for a year would be £1460, which also is an obvious deterrent to regular use.

R S Pattman

The following two articles report similar findings for the use of acyclovir in recurrent genital herpes.

Genital warts
Vaginal carcinoma arising in vaginal condylomata. Case report

Genital warts and cervical cancer. V. The tissue basis of colposcopic change
R REID, BR HERSCHMAN, CP CRUM, ET AL

Cervical papillomavirus infection and intraepithelial neoplasia: a study of male sexual partners

Topical idoxuridine for genital condyloma acuminate
K HASUMI, T KOBAYASHI, AND M ATA
(Tokyo, Japan). Lancet 1984; i: 968.

Intramuscular human interferon-β injections in treatment of condylomata acuminate
A SCHONFELD, S NITKE, A SCHATTNER, ET AL

Laser therapy of genital condylomata acuminate

Acquired immune deficiency syndrome
Coccioidiomycosis in acquired immune deficiency syndrome. A case of depressed humoral as well as cellular immunity

Longitudinal study of persistent generalised lymphadenopathy in homosexual men: relation to acquired immunodeficiency syndrome
U MATHUR-WAGH, RW ENLOW, J SPIGLAND, ET AL

Persistent diffuse lymphadenopathy in homosexual men: endpoint or prodrome?

Detection of IgG antibodies to lymphadenopathy-associated virus in patients with AIDS or lymphadenopathy syndrome
F BRUN-VEZINET, C ROUZIOUX, F BARRE-SINOUSI, ET AL

and

Seroepidemiological studies of human T lymphotropic retroviruses type III in acquired immunodeficiency syndrome
B SAFAI, MG SARGADHARAN, JE GOOPRAN, ET AL

In 1983 the French workers isolated a human T cell tropic retrovirus from a homosexual man with persistent lymphadenopathy (lymphadenopathy virus (LAV)). They subsequently isolated similar viruses (immune deficiency associated virus (IDAV)) from patients with AIDS and from two siblings with haemophilia B, one of whom had AIDS. The American workers initially investigated whether other human T cell lymphotropic viruses (HTLV-I and -II), which had previously been associated with human T cell malignancies, were associated with AIDS. During the course of this work other T cell retroviruses were isolated. The development of a suitable permissive cell line for culture and identification showed that they belonged to a subgroup of human T lymphotropic viruses (HTLV-III).

Both papers described the results of assays for antibodies to this new subgroup of human T lymphotropic retroviruses (anti-LAV or anti-HTLV-III) in patients with AIDS, at risk for AIDS, and heterosexual controls.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No (%) with anti-LAV*</th>
<th>No (%) with anti-HTLV-III**</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>18/48 (37-5)</td>
<td>34/34 (100)</td>
</tr>
<tr>
<td>Lymphadenopathy</td>
<td>38/51 (74-5)</td>
<td>16/19 (84)</td>
</tr>
<tr>
<td>At risk</td>
<td>8/44 (18-0)</td>
<td>3/14 (21)</td>
</tr>
<tr>
<td>Controls</td>
<td>1/130 (10-0)</td>
<td>0/14 (0)</td>
</tr>
</tbody>
</table>

*Brun-Vezin et al (France); **Safai et al (USA)
The lower prevalence of antibody to LAV in the French patients with AIDS and lymphadenopathy was explained in an addendum to their paper whereby a modification of the assay increased sensitivity such that 75% of the patients with AIDS and over 90% of those with lymphadenopathy were found to be seropositive. The absence of antibodies in controls with lymphomas in the American study and the high prevalence in patients with generalised lymphadenopathy in both studies argues against HTLV-III being an opportunist in immunocompromised patients. LAV, IDAV, and HTLV-III would seem to be very similar, if not the same, but further characterisation of the viruses and antibody specificity are required. Both studies strengthen the evidence that a new subgroup of human T lymphotropic viruses are aetologically related to AIDS. Furthermore, from the prevalence of the viruses in asymptomatic homosexuals and patients with lymphadenopathy it seems probable that a considerable proportion of patients with evidence of exposure to these viruses may not develop overt AIDS. However, the latent period and the role of cofactors in expression of disease in seropositive patients has yet to be estimated in prospective studies.

**Acquired immunodeficiency syndrome in a heterosexual population in Zaire**


**Other sexually transmitted diseases**

**Characteristics of Haemophilus ducreyi in culture**


**Protozoal infections in homosexual men**


**Enteric pathogenic protozoa in homosexual men from San Francisco**


**Clinical evaluation in healthy adults of a hepatitis B vaccine made by recombinant DNA**


This important paper details the first report of a hepatitis B vaccine prepared by recombinant DNA technology used in man. Thirty seven ‘low risk’ employees of Merck and Co Inc were inoculated with a vaccine formulated from hepatitis B surface antigen (HBsAg) produced by a recombinant strain of the yeast Saccharomyces cerevisiae. After serological evidence of previous hepatitis B virus infection had been excluded, the participants received an intramuscular injection containing 10 µg HBsAg at zero, one, and six months.

Of only 15 subjects receiving all three doses, 40% had a detectable titre of anti-HBs within one month of the first dose, 93% by two months, and 100% by three months. A large rise in titre was noted after the third dose at six months. The antibody formed was shown to be predominantly specific for the α determinant of HBsAg. Apart from transient pain at the injection site, no serious reactions attributable to the vaccine were recorded.

**In comparison with the present vaccine produced from limited supplies of infected plasma, the potential for a ready supply of vaccine lacking the theoretical risk of concomitant infection is stressed. The acid test will come, however, when vaccinated subjects are exposed to hepatitis B virus infection.**

R S Pattman

**Genitourinary bacteriology**

**Clinical and microbiological characterisation of patients with non-specific vaginosis associated with motile, curved anaerobic rods**


**Mobiluncus gen nov, Mobiluncus curtisii subsp curtisii sp nov, Mobiluncus curtisii subsp holmesii subsp nov, and Mobiluncus mulleris sp nov, curved rods from the human vagina**

CA SPIEGEL AND M ROBERTS (Milwaukee, USA). International Journal of Systematic Bacteriology 1984; 34: 177-84.

Organisms like vibrios were observed in vaginal fluids as early as 1891 and first isolated from the female genital tract by Curtis in 1913. They are of interest as they may be found in association with bacterial vaginosis. The taxonomic position of these organisms is uncertain and the authors have characterised 22 strains and compared them with phenotypically similar species.

Results show that these organisms are morphologically, biochemically, and genetically distinct from species in previously described genera. A new genus is therefore proposed: Mobiluncus (mobilis capable of movement, active; uncus a hook). This includes curved, anaerobic, motile, rod shaped bacteria that have multiple subpolar flagella and multilayered gram variable cell walls, produce succinate and acetate, and contain 490-520 mol/l guanine and cytosine. Strains that are small (length 1-7 µm) stimulated by arginine, and produce ammonia from arginine are designated Mobiluncus curtisii. Mobiluncus curtisii subsp curtisii includes strains that migrate through soft agar and are nitrate negative. Mobiluncus curtisii subsp holmesii includes strains that do not migrate through soft agar and are nitrate positive. A group of isolates that are large

**Ocular findings in the acquired immunodeficiency syndrome**


**Pulmonary complications of AIDS—radiologic features**


**Central nervous system mass lesions in the acquired immunodeficiency syndrome (AIDS)**


**Acquired immunodeficiency syndrome in Rwanda**

(length 2.9 μm) gram negative, produce acid from glycogen, and are CAMP test positive are designated Mobiluncus mulieris.

Falcivibrio grandis gen nov sp nov and Falcivibrio vaginalis gen nov sp nov, a new genus and species to accommodate anaerobic motile curved rods formerly described as Vibrio mulieris (Prevot 1940)

Breed et al 1948


Over the past few years many departments have independently reported the isolation of morphologically similar anaerobic rods from women with non-specific vaginitis. This report characterises the vaginal and cervical isolates from several centres.

Although other organisms share characteristics with the isolates studied, there is no overall correlation. It is therefore proposed that they be assigned to a separate genus. Falcivibrio (falx sickle, crescent; vibrio move rapidly too and fro). This will include anaerobic, motile, crescent shaped rods, with a content of 500-540 mol/l guanine and cytosine.

Morphologically and biochemically the strains may be divided into two species: Falcivibrio vaginalis (cells 2.3 μm in length, with flagella on the concave side, assacharolytic, nitrates reduced to nitrites) and Falcivibrio grandis (cells 2.5-5 μm in length with subpolar, polar, or bipolar flagella, saccharolytic, nitrates not reduced). The organisms may be isolated from patients with vaginitis but their role in pathogenicity is not known.

M S Sprott

Public health and social aspects

Non-sexual transmission of sexually transmitted diseases: an infrequent occurrence


Miscellaneous

Human vaginal pH and sexual arousal


Colposcopic findings in virgin and sexually active teenagers


Prostatitis syndrome: pathophysiology, differential diagnosis and treatment

JN Krieger (Seattle, USA). Sex Transm Dis 1984; 11: 100-12.

Hepatic lesions in sexually transmitted diseases