# Genitourinary Medicine



This *Journal,* founded by the Medical Society for the Study of the Venereal Diseases, publishes original work on the investigation and treatment of genitourinary and allied disorders, and review articles, correspondence, and abstracts.

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(1) *Scripts* must be typewritten on one side of the paper in double spacing with ample margins. Two copies should be sent; if a paper is rejected, one copy will be retained.

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(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.

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

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# Notices

**IUVDT—fourth regional meeting of the South East Asian and western Pacific region**

The fourth regional meeting of the South East Asian and western Pacific region of the International Union against the Venereal Diseases and Treponematoses will be held in Bombay, India, from Friday 18 October to Sunday 20 October, 1985. The primary theme will be the complications of STD. Secondary themes will be: viral diseases and socioeconomic aspects of STD.

Further information can be obtained from: Dr J K Maniar, Organising Secretary, 69/51 Walkeshwar Road, Bombay-400 006, India.

**Second Australian conference on sexually transmissible diseases**

The second Australian conference on sexually transmissible diseases will be held from 16 to 18 August 1985 in Perth, Western Australia. It will be presented by the Health Department of Western Australia. For details please contact the Director, VD Control, PO Box 8172, Stirling Street, Perth, WA 6001, Australia.

**Second world congress on sexually transmitted diseases (STDs)**

The second world congress on sexually transmitted diseases (STDs) will be held at the Centre International de Congres de Paris (CIP), Porte Maillot, Paris, from 25 to 29 June 1986 under the patronage of the World Health Organisation and the International Union against Venereal Diseases and the Treponematoses. The general theme will be "STDs and their social and economic consequences".

For further information concerning registration, travel arrangements, hotels, etc, please contact the Commissariat General, 4 Villa d'Orleans, 75014 Paris, France.

**International meeting of dermatological research**

The seventh meeting devoted to dermatological research will be held under the auspices of the Société de Recherche Dermatologique at Louvain University in Brussels on September 19 to 21, 1985. This meeting will be organised by the unit of occupational and environmental dermatology (director Professor J M Lachapelle).

Further information and application forms can be obtained from: Docteur D Van Neste, Unité de Dermatologie Professionnelle et de l'Environnement, Université Catholique de Louvain, UCL 3033, Clos Chapelle-aux-Champs, 30-B-1200 Bruxelles, Belgique.

# List of current publications

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



## *Syphilis and other treponematoses*

**Inadequate treatment of syphilis in pregnancy**
L MASCOLA, R PELOSI, CE ALEXANDER (Atlanta, USA). *Am J Obstet Gynecol* 1984;**150**:945-7.

**Double-conjugate enzyme-linked immunosorbent assay for immunoglobulins G and M against *Treponema pallidum***
CE FARSHY, EF HUNTER, SA LARSEN, EH CERNY (Atlanta, USA). *J Clin Microbiol* 1984;**20**:1109-13.

**Characterization of monoclonal antibodies to *Treponema pallidum***
SA LUKEHART, MR TAM, J HOM, SA BAKER-ZANDER, KK HOLMES, RC NOWINSKI (Seattle, USA). *J Immunol* 1985; **134**:585-92.

## *Gonorrhoea*

**Comparison of the effect of refrigerated versus room temperature media on the isolation of *Neisseria gonorrhoeae* from genital specimens**
HB RATNER, H TINSLEY, RE KELLER, CW STRATTON (Nashville, USA). *J Clin Microbiol* 1985;**21**:127-8.

**Urine as a holding medium for *Neisseria gonorrhoeae***
CE ROSEY AND EM BRITT (Ann Arbor, USA). *Sex Transm Dis* 1984;**4**:301-3.

**In vitro inhibition of growth of *Neisseria gonorrhoeae* by *Neisseria meningitidis* isolated from the pharynx of homosexual men**
J-G BISAILLON, P TURGEON, D DUBREUIL, R BEAUDET, M SYLVESTRE, FE ASHTON (Laval, Canada). *Sex Transm Dis* 1984;**4**:296-300.

**The systematic serology of *Neisseria gonorrhoeae:* antigens associated with pathogenesis in *Neisseria* spp from man**
KU SAIKH AND FK BHATTACHARYYA (Calcutta, India). *J Med Microbiol* 1984;**18**:347-54.

The method used in this study is the micro-Ouchterlony double diffusion absorption assay, in which antigen and antibody placed in wells in agar slides display a positive reaction as precipitin lines that may be seen with the naked eye or stained by Crowle's method.

Antiserum to a representative strain of *Neisseria gonorrhoeae* was raised in rabbits. This was then tested against the immunising antigen and isolates of *N gonorrhoeae* from Calcutta and international sources. Five major precipitin zones were detected and given the notation 1 to 5. Three of these precipitin reactions, in zones 1, 3, and 4, showed complete identity in all gonococci; one reaction, in zone 2, was strain specific and occurred in most strains from Calcutta and one of the international strains. Strain specific components were also shown in the fifth zone, and this class of antigen may prove to be useful in serotyping systems. By absorption techniques it was shown that components of zones 1-4 were located internally in the cell of the reference strain, zone 5 had a cell surface location.

The system was then similarly tested against sonicates of *N meningitidis* and other *Neisseria* species. *N catarrhalis* showed no reaction. This agrees with current views on the classification of this organism, as it has now been allocated to the genus *Branhamella*. Zones 1 and 3 were present in all other *Neisseria* species tested, but zone 2 was missing. These antigens appeared to be intracellular and present in all the "true" *Neisseria* species examined, and are therefore group antigens at the generic level. Major components of zone 5, located at the cell surface, were common to *N gonorrhoeae* and *N meningitidis*, and are therefore subgeneric. Zone 4 was not only present in *N gonorrhoeae* and *N meningitidis* but was also seen in *N flavescens*. This organism had been documented as the cause of an epidemic of meningitis, and the strain used in the study was known to have pathogenic ability. The authors discuss further the possibility that zones 4 and 5 may represent components that play a part in pathogenesis.

This paper analyses sonicates of eight *Neisseria* species from man by gel diffusion techniques. Five major precipitin zones were identified that comprised components specific for genus, species, and type. One antigen was found in all strains of three species with pathogenic ability and not in the other *Neisseria* species investigated.

*M S Sprott*

**Opsonophagocytosis of *Neisseria gonorrhoeae:* interaction of local and dissseminated isolates with complement and neutrophils**
SC ROSS AND P DENSEN (Boston, USA). *J Infect Dis* 1985;**151**:33-41.

**Cloning of the gene for the common pathogenic *Neisseria* H.8 antigen from *Neisseria gonorrhoeae***
WJ BLACK AND JG CANNON (Chapel Hill, USA). *Infect Immun* 1985;**47**:322-5.

**Red blood cells, a source of factors which induce *Neisseria gonorrhoeae* to resistance to complement-mediated killing by human serum**
PV PATEL, PMV MARTIN, M GOLDNER, NJ PARSONS, H SMITH (Birmingham, England). *J Gen Microbiol* 1984;**130**: 2767-70.

**On the role of pili in transformation of *Neisseria gonorrhoeae***
LS MATHIS AND JJ SCOCCA (Baltimore, USA). *J Gen Microbiol* 1984;**130**:3165-73.

**Single-dose treatment of uncomplicated gonorrhoea: a comparison of cefonicid and penicillin**
WC DUNCAN AND ME McBRIDE (Houston, USA). *Rev Infect Dis* 1984;**6**: Suppl 4:S875-9.

**Moxalactam treatment of uncomplicated gonorrhea in women**
RB JONES, BS RAY, BW ZWICKL (Indianapolis, USA). *Sex Transm Dis* 1984;**4**:287-90.

## *Non specific genital infection and related disorders (chlamydial infections)*

**Postabortal pelvic infection associated with *Chlamydia trachomatis* and the influence of humoral immunity**
S OSSER AND K PERSSON (Malmö, Sweden). *Am J Obstet Gynecol* 1984;**150**:699-703.

**The epidemiology of chlamydial infections in childhood: a serological investigation**
P BURNEY, T FORSEY, S DAROUGAR, Y SITTAMALAM, P BOOTH, R CHAMBERLAIN (London, England). *Int J Epidemiol* 1984; **13**:491-5.

**Infection with *Chlamydia trachomatis* in female college students**
WM McCORMACK, B ROSNER, DE McCOMB, JR EVRARD, SE ZINNER (New York, USA). *Am J Epidemiol* 1985;**121**:107-15.

**Analysis and detection of chlamydial DNA**
T HYYPIÄ, SH LARSEN, T STÅHLBERG, P TERHO (Turku, Finland). *J Gen Microbiol* 1984; **130**:3159-64.

**Monoclonal antibody based ELISA for detecting *Chlamydia trachomatis***
EO CAUL AND ID PAUL (Bristol, England). *Lancet* 1985;i:279.

***Chlamydia trachomatis* sampling during erythromycin treatment**
A-M WORM AND CS PETERSEN (Copenhagen, Denmark). *Dan Med Bull* 1984;**31**:500-1.

Fifteen chlamydia positive patients with non-gonococcal urethritis were treated in Copenhagen, Denmark, with erythromycin 1 g daily for six days, and were subsequently monitored for chlamydia on days 2, 4, 7, and 14. All patients became chlamydia negative no later than four days after the start of treatment, and remained so at 14 days.

It is suggested that an erythromycin regime of shorter duration should be evaluated.

*R R Willcox*

(Reprinted from *Abstracts on Hygiene* by permission of the Editor)

**The activity of ciprofloxacin and other 4-quinolones against *Chlamydia trachomatis* and *Mycoplasmas* in vitro**
GL RIDGWAY, G MUMTAZ, FG GABRIEL, JD ORIEL (London, England). *Eur J Clin Microbiol* 1984;**3**:344-6.

## *Non-specific genital infection and related disorders (mycoplasmal and ureaplasmal infections)*

**The role of mycoplasmas in sexually transmitted vaginitis**
GF ALTOMARE, MM POLENGHI, PD PIGATTO, G BELLA, R VIVANTI, P ITALIANO (Milan, Italy). *Boll Ist Sieroter Milan* 1984;**63**: 348-51.

**Do mycoplasmas inhibit the human sperm fertilizing ability *in vitro?***
F BUSOLO AND R ZANCHETTA (Padua, Italy). *Israel J Med Sci* 1984;**20**:902-4.

**A prospective study of mycoplasma infection in the preterm infant**
PT RUDD, MB BROWN, GH CASSELL (Norwich, England). *Israel J Med Sci* 1984;**20**: 899-901.

**Serological cross-reactions between *Mycoplasma genitalium* and *Mycoplasma pneumoniae***
K LIND, BØ LINDHARDT, HJ SCHÜTTEN, J BLOM, C CHRISTIANSEN (Copenhagen, Denmark). *J Clin Microbiol* 1984;**20**: 1036-43.

## *Non-specific genital infection and related disorders (general)*

**Spontaneous abortion—an infectious aetiology?**
PE MUNDAY, R PORTER, PF FALDER, *ET AL* (Harrow, England). *Br J Obstet Gynaecol* 1984;**91**:1177-80.

## *Pelvic inflammatory disease*

**Pelvic inflammatory disease after hysterosalpingography associated with *Chlamydia trachomatis* and *Mycoplasma hominis***
BR MØLLER, J ALLEN, B TOFT, KB HANSEN, D TAYLOR-ROBINSON (Harrow, England). *Br J Obstet Gynaecol* 1984;**91**:1181-7.

**The development of infections of the genitourinary tract in the wives of infertile males and the possible role of spermatozoa in the development of salpingitis**
A TOTH, ML LESSER AND D LABRIOLA (New York, USA). *Surg Gynecol Obstet* 1984; **159**:565-9.

## *Reiter's disease*

**Is Reiter's syndrome caused by Chlamydia?**
LEADING ARTICLE. *Lancet* 1985;i:317-9.

## *Candidosis*

**Oral yeast flora and antibiotics to *Candida albicans* in homosexual men**
H SCHØNHEYDER, M MELBYE, RJ BIGGAR, P EBBESEN, CY NEULAND, A STENDERUP (Aarhus, Denmark). *Mykosen* 1984;**27**: 539-44.

## Genital herpes

**Frequency and duration of patient-observed recurrent genital herpes simplex virus infection: characterization of the non lesional prodrome**
SL SACKS (Vancouver, Canada). *J Infect Dis* 1984; **150**:873-7.

**Serologic analysis of first-episode nonprimary genital herpes simplex virus infection. Presence of type 2 antibody in acute serum samples**
DI BERNSTEIN, MA LOVETT, YJ BRYSON (Los Angeles, USA). *Am J Med* 1984; **77**: 1055-60.

The authors evaluated non-primary first episode genital herpes for the presence of type specific antibody to herpes simplex types 1 and 2 in patients who attended a medical centre between January 1981 and June 1982. Acute serum samples were obtained from 24 patients less than six days after the onset of genital ulceration. Type 2 herpes simplex virus was isolated from all genital lesions. A standard microneutralisation assay and western blot analysis, which identified the response to individual polypeptides of type 1 and type 2 herpes, were performed using both unadsorbed serum samples and serum samples adsorbed with either type 1 or type 2 antigens to remove cross reacting antibodies.

Of 24 samples studied, seven were found to have type 1 antibody alone, 11 had type 2 antibody alone, and six had both type 1 and type 2 antibody. Thus 17 of 24 patients with type 2 antibody could represent a group with reinfection or a group with previously subclinical or unrecognised type 2 infection. Remarkably, only four of 18 patients with non-primary disease could elicit a history of genital herpes infection in recent sexual partners.

The authors therefore advise that clinicians evaluating patients with first episode genital herpes should recognise the possibility of earlier acquisition of an unrecognised infection and the absence of herpes simplex virus infection in current sexual partners.

*F M M Mulcahy*

**Polypeptide specificity of the early antibody response following primary and recurrent genital herpes simplex virus type 2 infections**
R EBERLE, S-W MOU AND JA ZAIA (Duarte, USA). *J Gen Virol* 1984; **65**: 1839-43.

**Detection of virus-specific antigens of adenoviruses and herpes simplex virus in patients with malignant diseases of the genital tract**
TA POSEVAYA, G KULCSAR, I HORVARTH, *ET AL* (Moscow, USSR). *Vopr Virusol* 1984; **6**: 727-30.

**Alteration of lymphocyte transformation response to herpes simplex virus infection by acyclovir therapy**
WE LAFFERTY, LA BREWER, L COREY (Seattle, USA). *Antimicrob Agents Chemother* 1984; **26**: 887-91.

**Augmentation of immunity to herpes simplex virus by *in vivo* administration of interleukin 2**
BT ROUSE, LS MILLER, L TURTINEN AND RN MOORE (Knoxville, USA). *J Immunol* 1985; **134**: 926-30.

## Genital warts

**Screening for wart virus infection in normal and abnormal cervices by DNA hybridisation of cervical scrapes**
C WICKENDEN, A STEELE, ADB MALCOLM, D COLEMAN (London, England). *Lancet* 1985; i: 65-7.

Human papillomaviruses (HPV) types 6, 11, 16, and 18 have been implicated in cancers of the female lower genital tract and carcinoma of the penis. Types 6 and 11 are associated with benign condylomata acuminata and the premalignant cervical intraepithelial neoplasias (CIN), whereas HPV16 is also associated with invasive carcinomas, and HPV18 almost exclusively detected in malignant disease. Infection with a particular type of HPV may increase the risk of a progressive disease leading to invasive carcinoma. If this is the case it would be important to diagnose the type of HPV infection.

This paper attempts to use the technique of DNA/DNA hybridisation to diagnose the HPV infection in cells from a cervical smear rather than from a colposcopically directed biopsy. The technique involves transferring extracted DNA from cervical cells, taken in a similar manner as those for a Pap stain, to nitrocellulose filters and hybridising with radiolabelled HPV probes. This method is preferable to using biopsy material because it is less invasive, and smears can be taken from a wider range of women who are at risk for CIN. The authors used HPV type 6 probes only, but interestingly detected in two of 19 women HPV6 DNA sequences even though they had a normal Pap smear. These women were attending a genitourinary medicine clinic and had no history of genital warts or CIN, but were a high risk group. HPV6 was also detected in two of 20 women who had been treated for CIN but had a history of recurrent disease, and in two of four women with cytological evidence of HPV infection. The numbers in the latter group are very small and it is difficult to draw any conclusions about how sensitive this technique will be in screening women for particular HPV infections, especially when 16% of the smears were rejected because the amounts of DNA extracted from cervical smears were too small.

Although this technique in its present form would not be available for diagnostic purposes, the substitution of radiolabelled probes with non-radiolabelled probes may speed their use as a diagnostic tool. Their use would certainly be warranted if infection with particular HPV types is shown to increase a woman's risk of developing malignant disease of the cervix.

*D J McCance*

**Identification of human papilloma virus in cervical swabs by deoxyribonucleic acid in situ hybridization**
D WAGNER, H IKENBERG, N BOEHM, L GISSMANN (Freiburg, Federal Republic of Germany). *Obstet Gynecol* 1984; **64**: 767-72.

**Transcription of episomal papillomavirus DNA in human condylomata acuminata and Buschke-Löwenstein tumours**
H LEHN, T-M ERNST AND G SAUER (Heidelberg, Federal Republic of Germany). *J Gen Virol* 1984; **65**: 2003-10.

**Immunoperoxidase staining for identification of human papilloma virus in cervical epithelium**
AR CHANG AND HJ NEAL (Dunedin, New Zealand). *Proceedings of the University of Otago Medical School* 1984; **62**: 105-6.

**Comparison of 5-fluorouracil and $CO_2$ laser for treatment of vaginal condylomata**
A FERENCZY (Montreal, Canada). *Obstet Gynecol* 1984; **64**: 773-8.

**The management of warts of the oral cavity**
NJ FIUMARA (Boston, USA). *Sex Transm Dis* 1984; **4**: 267-70.

## *Acquired immune deficiency syndrome*

**Hepatitis B virus in the acquired immunodeficiency syndrome**
VK RUSTGI, JH HOOFNAGLE, JL GERIN, *ET AL* (Stanford, USA). *Ann Intern Med* 1984; **101**: 795-7.

**Enteric coccidiosis among patients with the acquired immunodeficiency syndrome**
ME WHITESIDE, JS BARKIN, RG MAY, SD WEISS, MA FISCHL, CL MacLEOD (Miami, USA). *Am J Trop Med Hyg* 1984; **33**: 1065-72.

**Meningoencephalitis due to *Listeria monocytogenes* in a patient with AIDS**
S KERNBAUM AND A FRANCILLON (Paris, France). *Br Med J* 1985; **290**: 606.

**Persistence of *Pneumocystis carinii* in lung tissue of acquired immunodeficiency syndrome patients treated for pneumocystis pneumonia**
JH SHELHAMER, FP OGNIBENE, AM MACHER, *ET AL* (Bethesda, USA). *Am Rev Resp Dis* 1984; **130**: 1161-5.

**Nucleotide sequence of the AIDS virus, LAV**
S WAIN-HOBSON, P SONIGO, O DANOS, S COLE, M ALIZON (Paris, France). *Cell* 1985; **40**: 9-17.

**Complete nucleotide sequence of the AIDS virus, HTLV-III**
L RATNER, W HASELTINE, R PATARCA, *ET AL* (Bethesda, USA). *Nature* 1985; **313**: 277-84.

**Characterization of long terminal repeat sequences of HTLV-III**
B STARCICH, L RATNER, SF JOSEPHS, T OKAMOTO, RC GALLO, F WONG-STAAL (Bethesda, USA). *Science* 1985; **227**: 538-40.

**Sequence homology and similarity of HTLV-III and visna virus, a pathogenic lentivirus**
MA GONDA, F WONG-STAAL, RC GALLO, JE CLEMENTS, O NARAYAN, RV GILDEN (Frederick, USA). *Science* 1985; **127**: 173-7.

**Inactivation of lymphadenopathy-associated virus by heat, gamma rays and ultraviolet light**
B SPIRE, D DORMONT, F BARRÉ-SINOUSSI, L MONTAGNIER, J CHERMANN (Paris, France). *Lancet* 1985; ii: 188-9.

**Needlestick transmission of HTLV-III from a patient infected in Africa**
LEADING ARTICLE. *Lancet* 1984; ii: 1376-7.

**Risk of nosocomial infection with human T-cell lymphotropic virus III (HTLV-III)**
MS HIRSCH, GP WORMSER, RT SCHOOLEY, *ET AL* (Boston, USA). *N Engl J Med* 1985; **312**: 1-4.

Eighty five hospital workers who had been in regular clinical contact with patients with acquired immune deficiency syndrome (AIDS) over a two year period were examined for evidence of antibody to HTLV-III, the causative agent of AIDS. Thirty had reported needle stick injuries, and thus parenteral exposure to small quantities of blood contaminated with HTLV-III. Employees included endoscopists (nine), morbid pathologists (eight), nurses, laboratory technicians, and research workers. The duration between exposure and serology testing ranged from two weeks to 20 months (mean eight months). Serum samples were tested for viral antibody by enzyme linked immunosorbent assay and electrophoretic (western blot) techniques.

Whereas 100% of patients with AIDS who were tested by the above methods were seropositive for antibody to HTLV-III, all the exposed hospital workers gave negative results. The authors conclude that hospital exposure to AIDS carries a low risk of nosocomial infection, and that needle stick injuries appear to carry little additional risk. By contrast, the incidence of acute hepatitis B infection after needle stick exposure is 10-15%.

This paper must be viewed in the light of a leading article in the Lancet (*Lancet* 1984; ii: 1433-5), which describes a nurse who seroconverted to HTLV-III seropositivity (by radioimmunoassay) at 42 days after a needle stick injury with micro innoculation from a patient with AIDS of African origin. It is also germane to note that the duration between infection and seroconversion is unknown, as are the numbers of infected people who may be seronegative, and that no hospital or health care worker has developed AIDS as an unequivocable result of professional exposure. It is therefore reasonable to state that the risk to health workers is genuinely small, and considerably less than with hepatitis B. All needle stick injuries or mucosal contamination must, however, be avoided at all costs. Although this paper is reassuring, it is by no means the final word on this issue.

*J N Weber*

**Screening test for HTLV-III (AIDS agent) antibodies: specificity, sensitivity, and applications**
SH WEISS, JJ GOEDERT, MG SARNGADHARAN, *ET AL* (Bethesda, USA). *JAMA* 1985; **253**: 221-5.

**HTLV-III in symptom free seronegative persons**
SZ SALAHUDDIN, JE GROOPMAN, PD MARKHAM, *ET AL* (Bethesda, USA). *Lancet* 1984; ii: 1418-20.

**HTLV-III serology distinguishes atypical and endemic Kaposi's sarcoma in Africa**
AC BAYLEY, RG DOWNING, R CHEINGSONG-POPOV, RS TEDDER, AG DALGLEISH, RA WEISS (London, England). *Lancet* 1985; i: 359-61.

**The incidence rate of acquired immunodeficiency syndrome in selected populations**
AM HARDY, JR ALLEN, WM MORGAN, JW CURRAN (Atlanta, USA). *JAMA* 1985; **253**: 215-20.

**Mothers of infants with the acquired immunodeficiency syndrome: evidence for both symptomatic and asymptomatic carriers**
GB SCOTT, MA FISCHL, N KLIMAS, *ET AL* (Miami, USA). *JAMA* 1985; **253**: 363-6.

**Ribavirin suppresses replication of lymphadenopathy-associated virus in cultures of human adult T lymphocytes**
JB McCORMICK, JP GETCHELL, SW MITCHELL, DR HICKS (Atlanta, USA). *Lancet* 1984; ii: 1367-9.

## *Other sexually transmitted diseases*

**Infectious antecedent of immunoblastic lymphoma. Progressive immunosuppression in a patient with lymphogranuloma venereum**
D SENITZER, J GIBBONS, A GOHARA, EH FREIMER (Toledo, USA). *Am J Med* 1985; **78**: 163-7.

The authors describe a previously healthy 21 year old woman admitted for the investi-

gation of generalised lymphadenopathy, fever, and weight loss. Her fiance had recently returned from South East Asia and had developed swellings in his groin. He was an intravenous drug abuser, whereas she admitted only to the oral misuse of drugs. She had multiple red, raised lesions on her face and back and a discharging sinus in her groin. She had polymorphonuclear leucocytosis with a decreased T cell and an increased B cell lymphocyte population. Cutaneous anergy and a decreased response to mitogens by her peripheral lymphocytes were shown. The lymphogranuloma venereum (LGV) titre was 1/32 by complement fixation and 1/256 by immunofluorescent antibody test. Lymph node examination showed inclusion bodies consistent with chlamydial elementary bodies, capillary proliferation, and partial nodal effacement by atypical lymphocytes and B lymphocytes. Syphilis, hepatitis B virus, cytomegalovirus, and Epstein-Barr virus infections were excluded by serological testing. A diagnosis of angioimmunoblastic lymphadenopathy and LGV was made, and the patient responded slowly to treatment with tetracycline. She was readmitted a month later with further lymphadenopathy, and rapidly died despite high dose steroid treatment. Necropsy showed extensive immunoblastic lymphoma.

The authors describe angioimmunoblastic lymphadenopathy and discuss its association with *Plasmodium malariae,* the Epstein-Barr virus, and the acquired immune deficiency syndrome. They recommend that further studies on immunodeficiency disorders should consider chlamydial infections.

Omissions from this report are results of serology tests for human T cell lymphotropic virus III or lymphadenopathy associated virus, results of histology tests of the skin lesions, and details of her fiancé's illness.

*K M Saravanamuttu*

**Mediastinal and supraclavicular lymphadenopathy and pneumonitis due to *Chlamydia trachomatis* serovars $L_1$ and $L_2$**
DI BERNSTEIN, T HUBBARD, WM WENMAN, *ET AL* (Torrance, USA). *N Engl J Med* 1984;**311**:1543-6.

**Lack of deoxyribonucleic acid relatedness between *Haemophilus ducreyi* and other *Haemophilus* species**
I CASIN, F GRIMONT, PAD GRIMONT, M-J SANSON-LE PORS (Paris, France). *International Journal of Systematic Bacteriology* 1985;**35**:23-5.

**Hepatitis B core antigen synthesised in *Escherichia coli:* its use for antibody screening in patients attending a clinic for sexually transmitted diseases**
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## *Genitourinary bacteriology*

**The prevalence, six-month persistence, and predictive values of laboratory indicators of bacterial vaginosis (nonspecific vaginitis) in asymptomatic women**
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**Role of *Bacteriodes bivius* β-lactamase in β-lactam susceptibility**
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**Risk factors for prematurity and premature rupture of membranes: a prospective study of the vaginal flora in pregnancy**
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The vaginal flora in early pregnancy were assessed and subsequently related to the development of premature rupture of the membranes in preterm labour. Among 233 patients evaluated, premature rupture of the membranes was noticeably associated with the presence of *Trichomonas vaginalis* and *Staphylococcus epidermidis,* while *Bacteroides* sp was found appreciably more often in women who had preterm premature rupture of the membranes. *Bacteroides* sp was also isolated more frequently from women who delivered before 37 weeks and from those who gave birth to low birth weight infants. Preterm labour was noticeably more prevalent in women from whom *Ureaplasma urealyticum* was isolated. Stepwise multiple logistic regression analysis showed that the observed associations were not related to maternal age or the number of previous abortions, preterm deliveries, or full term deliveries. The authors concluded that microbiological screening in early pregnancy may help in assessing which patients may be at high risk for preterm delivery.

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**Adhesion of group-B streptococci to vaginal epithelial cells**
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## *Public health and social aspects*

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## Miscellaneous

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