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 reviews 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Advice to authors Papers for publication, which will be accepted on the understanding that they have not been and will not be published elsewhere and are subject to editorial revision, should be sent in duplicate to Dr A McMillan, Department of Genitourinary Medicine, Royal Infirmary, Lauriston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. All authors must give signed consent to publication. The editor should be notified of any change of address of the corresponding author. Manuscripts will only be acknowledged if a stamped addressed postcard or international reply coupon is enclosed.

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1. 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.

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

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

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

5. 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.

6. Only recognised abbreviations should be used.

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

8. 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 lightly on the back with the author’s name and indicating the top, and should not be attached by paper clips or pins. They should be trimmed to include only the relevant section (sizes 2 ½” x 3 ½” wide, maximum 5 ¼” 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.

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

10. 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.” Names of journals no longer published should be given in full — for example, British Journal of Venereal Diseases.

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Notices

Organisers of meetings who wish to insert notices should send details to the editor (address on the inside front cover) at least eight months before the date of the meeting or six months before the closing date for applications.

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.

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.

Correction

Diagnostic facilities for Chlamydia trachomatis in men

We regret that an error occurred in this letter (June 1985; 61:211-2) from Dr G Sharmacharja. We omitted the name of the coauthor of the letter, Dr T R Moss, Consultant in Genitourinary Medicine, Doncaster Royal Infirmary, and Honorary Clinical Lecturer, University of Sheffield.
List of current publications

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

Syphilis and other treponematoses

Antigens of *Treponema pallidum* recognized by IgG and IgM antibodies during syphilis in humans

Lack of utility of *Limulus* amoebocyte lysate assay in the diagnosis of urethral discharges in men

Comparative study of ceftriaxone and spectinomycin for treatment of pharyngeal and anorectal gonorrhea

Genital infections with *Chlamydia trachomatis* in women attending an antenatal clinic

A study was carried out to assess the incidence of infection with *Chlamydia trachomatis* in 252 unscreened patients on their first visit to an urban antenatal clinic. The clinical appearance of the cervix was noted, and endocervical swabs were taken into transport medium, kept at 4°C, and inoculated into cycloheximide treated McCoy cell cultures within 24 hours. Blood was examined for antichlamydial antibodies by the microimmunofluorescence technique.

*C trachomatis* was isolated in 18 (7%) patients, and antichlamydial antibody found in 48 (19%); 10 patients were culture
and antibody positive, and 38 had antibody alone. Culture positive patients were re-examined for chlamydial in the cervix, urethra, rectum, and throat; one patient had urethral chlamydial infection and one other had cervical gonorrhoea and vaginal trichomoniasis. All patients were asymptomatic, and no significant differences in age, marital status, previous obstetric history, gestational period, or social class were found between the chlamydial positive and negative groups. Significant differences were found in the incidence of hypertrophic cervical ectopy in the infected group (33%) compared with uninfected patients (8%) and in the presence of mucopurulent cervical discharge (56% compared with 12%). Of the 38 women who were chlamydial antibody positive but culture negative, four had received antibiotics in the previous month; six other patients showed a fourfold rise in titre on retesting in spite of continued non-isolation of C. trachomatis, and in 11 women antibody was no longer detectable. Twelve male contacts of the 18 chlamydial positive women were all asymptomatic, but signs of non-specific urethritis were seen in 10, though C. trachomatis was only isolated from one. The lack of symptoms and low isolation rate probably indicated low grade infection.

Other studies are quoted in which the incidence of chlamydial infection in women attending antenatal clinics and urban general practices was similar to that found here. Selective screening of pregnant women on grounds of symptoms and clinical findings would lead to many omissions, and routine testing of women at different stages of pregnancy and of their babies and consorts would impose impossible demands on laboratory services unless more resources are made available.

C Dixon

Chlamydia trachomatis as a cause of prepubertal vaginitis

Illnesses in infants born to women with Chlamydia trachomatis infection: a prospective study

Evidence of chlamydial infection in infertile women with and without fallopian tube obstruction

Serological evidence that chlamydial and mycoplasmas are involved in infertility in women

Serological evidence for chlamydial infections in patients with acute diarhoea

Chlamydia endocervical infections and cytologic findings in sexually active female adolescents

Cytologic manifestations of cervical and vaginal infections: II. Confirmation of Chlamydia trachomatis infection by direct immunofluorescence using monoclonal antibodies
NB Kiwiat, M Peterson, E Kinney-Thomas, M Tam, WE Stamm, and KK Holmes (Seattle, USA). JAMA 1985; 253:997-1000.

Properties of monoclonal antibodies to the genus-specific antigen of Chlamydia and their use for antigen detection by reverse passive haemagglutination

Interferon-induced inhibition of Chlamydia trachomatis: dissociation from antiviral and anti proliferative effects

Non-specific genital infection and related disorders (general)

Chlamydia, mycoplasmas, ureaplasmas and yeasts in the lower genital tract of females: comparison between a group attending a venereal disease clinic and a control group

Use of Kova-slide II with grid and uncentrifuged segmented urine specimens in the diagnosis of nongonococcal urethritis: a quantitative technique

Pelvic inflammatory disease

Endometritis and acute salpingitis associated with Chlamydia trachomatis and herpes simplex virus type two

Haemophilus influenzae causes purulent salpingitis

Tubal infertility and the intrauterine device

Oral contraceptives, Chlamydia trachomatis infection and pelvic inflammatory disease: a word of caution about protection

Cefotaxime treatment for women with community-acquired pelvic abscesses
**Trichomoniasis**

Effect of culture medium iron content on the biochemical composition and metabolism of *Trichomonas vaginalis*  

Use of a time-kill technique for susceptibility testing of *Trichomonas vaginalis*  

Reduction of nitroimidazole derivatives by hydrogenosomal extracts of *Trichomonas vaginalis*  

**Candidosis**

Management of recurrent vulvovaginal candidiasis with intermittent ketoconazole prophylaxis  

**Genital herpes**

Fulminant hepatic failure caused by genital herpes in a healthy person  

Genital herpes: a pervasive psychosocial disorder  

A prospective study of herpes simplex virus infection in a defined population in Houston, Texas  

Frequency of acquisition of first-episode genital infection with herpes simplex virus from symptomatic and asymptomatic source contacts  

Evaluation of a commercial enzyme-linked immunosorbent assay for the detection of herpes simplex virus  

Experimental model for activation of genital herpes simplex virus  

Role of antibody in primary and recurrent herpes simplex virus infection  

Systemic acyclovir in pregnancy: a case report  

**Genital warts**

Condyloma acuminatum of the bladder and ureter: case report and review of the literature  

Increased risk of cervical neoplasia in consorts of men with penile condylomata acuminata  

Twenty five women, who were the only sexual consorts for at least one year of men with pre-existing condylomata acuminata, were examined to assess the incidence of lower genital tract human papilloma virus (HPV) infection and premalignant disease of the cervix. They had no history of genital wart virus infection before the relationship and did not use a barrier method of contraception. Nineteen (76%) had evidence of condylomata acuminata of the lower genital tract.

Abnormal cervical cytology was reported in nine (36%), and disease was confirmed in all of these after colposcopic examination. Associated HPV infection, detected by DNA-DNA hybridisation, was found in seven (77%) of these cases. Human papilloma virus 16 DNA, found universally in malignant squamous cervical lesions, was detected in seven of nine cervical biopsies and six of nine men who were consorts of women with cervical epithelial disease.

Comparison was made with a control group of 20 age matched women whose sexual partners of at least 12 months had developed non-specific urethritis. No woman in this group had cytological or colposcopic abnormalities consistent with HPV infection or cervical intraepithelial neoplasia, though four had inflammatory changes. There was no difference in sexual behaviour between women with cervical disease and those yielding normal cytology smears. No cervical disease was found in the control women, who were as sexually active as the study group and 4% of whom had other sexually transmitted infections. The association of penile HPV infection with a high risk of cervical neoplasia in sexual partners was stressed.

KM Saravanamuttu

Colposcopy in women with papillomavirus lesions of the uterine cervix  

Prevalence of papillomavirus infection in colposcopically directed cervical biopsy specimens in 1972 and 1982  
Acquired immune deficiency syndrome

Special report. The AIDS epidemic

During 1984 1000 homosexual men living in Sydney were enrolled in a prospective immunoenepidemiological study. Of 140 men re-evaluated at six months, 12 showed seroconversion for acquired immune deficiency syndrome (AIDS) associated retrovirus (ARV). On further questioning, 11 of the 12 had experienced an acute infectious mononucleosis like illness during the intervening six months. The illness was of sudden onset, lasted three to 14 (mean 8.1) days, and had features including fever, sweats, malaise, lethargy, anorexia, nausea, myalgia, arthralgia, headaches, sore throat, diarrhoea, generalised lymphadenopathy, erythematous rash, and thrombocytopenia. In three patients the time to seroconversion was 19, 32, and 56 days after the onset of the acute illness. In these three patients, titres of antibody to Epstein-Barr virus and cytomegalovirus (CMV) did not change during the course of the illness. In the other patients these antibodies were not measured.

In some of these cases, therefore, the mononucleosis like illness was possibly due to a recurrence of CMV infection, perhaps as a result of immunosuppression after infection with ARV. Whatever the mechanism, however, infection with ARV should now be considered in the differential diagnosis of mononucleosis like illness in groups at high risk of developing AIDS.

G R Scott

Multiple myeloma in a homosexual man with chronic lymphadenopathy

Epstein-Barr virus infections in homosexual men with chronic, persistent, generalised lymphadenopathy

Spectrum of pulmonary diseases associated with the acquired immune deficiency syndrome

Actinomycetales infection in the acquired immunodeficiency syndrome

Testicular cancer in homosexual men with cellular immune deficiency: report of 2 cases
CJ LOGOTHETIS, GR NEWELL, AND M SAMUELS (Houston, USA). J Urol 1985; 133:484-6.

HTLV-III infection in brains of children and adults with AIDS encephalopathy

Up to 40% of patients with the acquired immune deficiency syndrome (AIDS) develop a debilitating dementia known as AIDS encephalopathy. This condition is characterised by variable onset of global loss of higher cerebral function (loss of short and long term memory, loss of cerebration, personality change, generalised seizures) and marked cerebral atrophy on computerised tomography scanning of the brain. This condition has not been associated with any known opportunist agent.

The authors took brain tissue from 15 patients with clinical evidence of AIDS encephalopathy. Four were children of infected mothers, nine were homosexual men, one an abuser of intravenous drugs, and one a female sexual partner of a patient with AIDS. The brain tissue was analysed by the Southern blot hybridisation technique with a human T cell lymphotropic virus type III (HTLV-III) specific probe for evidence of HTLV-III DNA sequences. Five of the 15 patients had evidence of HTLV-III DNA in the brain. Comparison of relative abundance of HTLV-III DNA sequences in other tissues (spleen, lymph node, liver, and lung) in one patient showed at least as much viral DNA in brain tissue as in lymph node tissue or peripheral blood lymphocytes, and considerably more than in liver or lung tissue. Further examination of frozen sections of brain tissue was performed by in situ hybridisation for viral specific RNA. Four of five specimens positive by Southern blot were also positive by in situ hybridisation. This indicated that the HTLV-III genome was being expressed in these tissues. It is highly improbable that these results reflected the presence of infected lymphocytes in the brain. The authors conclude that direct infection of brain tissue may be a consequence of HTLV-III infection, and that these findings may explain the aetiology of AIDS encephalopathy. The homology between HTLV-III and the Visna virus, a neurotropic lentivirus of sheep, is commented on. Visna causes a chronic degenerative neurological disease, and may infect both brain tissue and lymphocytes, but without causing immune deficiency. HTLV-III is probably more closely related to Visna than to other members of the HTLV family.

This paper is a landmark. Until now HTLV-III has been viewed as an infection of T helper lymphocytes, leading to immunosuppression. This report shows that large quantities of replicating virus are present in brain tissue. Direct CNS infection may be the cause of AIDS encephalopathy. The report, however, contains no appropriate control group of patients infected with HTLV-III but without evidence of encephalopathy. The role of CNS infection with HTLV-III therefore needs to be studied more fully.

J Weber

Spinal cord degeneration in AIDS
Disseminated talc granulomatosis: an unusual finding in a patient with acquired immunodeficiency syndrome and fatal cytomegalovirus infection

Frequent transmission of HTLV-III among spouses of patients with AIDS-related complex and AIDS

Postnatal transmission of AIDS-associated retrovirus from mother to infant

Pathologic appraisal of the thymus gland in acquired immunodeficiency syndrome in children: a study of four cases and a review of the literature

Cerebral toxoplasmosis in AIDS: a simple laboratory technique for diagnosis

Acquired immunodeficiency syndrome: distinctive features of bone marrow biopsies

Lymphocyte subsets in lymph nodes of homosexual men with generalized unexplained lymphadenopathy: correlation with morphology and blood changes

Decreased population of Leu-7+ natural killer cells in lymph nodes of homosexual men with AIDS-related persistent lymphadenopathy

Precipitable immune complexes in healthy homosexual men, acquired immune deficiency syndrome and the related lymphadenopathy syndrome

Hepatitis B vaccination: when is a booster injection needed?

Over 10,000 high risk people in the Zurich area have been vaccinated against hepatitis B with three initial injections of 20 μg H-B-Vax. The question arises as to whether, and if so when, booster injections should be given. Concentrations and persistence of the protective anti-HBs antibodies in 158
Genitourinary bacteriology

Gynaecological infection caused by Haemophilus influenzae

Hemophilus influenzae epididymo-orchitis
TR WEBER (St Louis, USA). J Urol 1985; 133:487.

Is group B streptococcal screening during pregnancy justified?

Characterization of Micrococcaceae strains isolated from the human urogenital tract by the conventional scheme and a micromethod

A screen for Clostridium difficile in the vagina: an out-patient study using and comparing selective media

Use of a sodium polyanetholesulfonate disk for the identification of Gardnerella vaginalis

Antimicrobial susceptibilities of anaerobic bacteria isolated from female genital tract infections

Miscellaneous

Diagnosis of Behçet’s syndrome

Therapy of Behçet’s syndrome

Epithelioid haemangioma of the penis: a rare and distinctive vascular lesion

Vulvar sweat gland carcinomas

Problems with rectal foreign bodies