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.

Advice to authors Papers for publication, which will be accepted on the understanding that they have not been and will not be published elsewhere and are subject to editorial revision, should be sent in duplicate to Dr A McMillan, Department of Genitourinary Medicine, Royal Infirmary, Lauriston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) *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.

(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 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 2¾" or 5¾" wide, maximum 5¾" × 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.

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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.

Genitourin Med 1985; **61**: 348-53

List of current publications

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

Syphilis and other treponematoses

Diagnosis of liver involvement in early syphilis: a critical review
M VEERAVAHU (Birmingham, England). *Arch Intern Med* 1985; **145**: 132-4.

Lumbar puncture in asymptomatic late syphilis: an analysis of the benefits and risks
J WIESEL, DN ROSE, AL SILVER, HS SACKS, AND RH BERNSTEIN (New York, USA). *Arch Intern Med* 1985; **145**: 465-8.

Serological response to syphilis treatment: a new analysis of old data
ST BROWN, A ZAIDI, SA LARSEN, AND GH REYNOLDS (Atlanta, USA). *JAMA* 1985; **253**: 1296-9.

Evaluation of an enzyme-linked immunosorbent assay for treponemal antibody
RW STEVENS AND ME SCHMITT (Albany, USA). *J Clin Microbiol* 1985; **21**: 399-402.

Four-step enzyme-linked immunosorbent assay for detection of *Treponema pallidum* antibody
CE FARSHY, EF HUNTER, LO HELSEL, AND SA LARSEN (Atlanta, USA). *J Clin Microbiol* 1985; **21**: 387-9.

Pretest temperature effects on CAP syphilis serology survey samples
JH RIPPEY AND P HOOD (Stokie, USA). *Arch Pathol Lab Med* 1985; **109**: 17-8.

Antigens of *Treponema pallidum* recognized by IgG and IgM antibodies during syphilis in humans
SA BAKER-ZANDER, EW HOOK, P BONIN, HH HANDSFIELD, AND SA LUKEHART (Seattle, USA). *J Infect Dis* 1985; **151**: 264-72.

Reinfection of chancre-immune rabbits with *Treponema pallidum*: I. Light and immunofluorescence studies
S SELL, J SALMAN, AND SJ NORRIS (Houston, USA). *Am J Pathol* 1985; **118**: 248-55.

Oxygen toxicity in *Treponema pallidum*: deoxyribonucleic acid single-stranded breakage induced by low doses of hydrogen peroxide
BM STEINER, GHW WONG, P SUTRAVE, AND S GRAVES (Prahran, Australia). *Can J Microbiol* 1984; **30**: 1467-75.

Gonorrhoea

A new β-lactamase plasmid in *Neisseria gonorrhoeae*
JDA van EMBDEN, M DESSENS-KROON, AND B van KLINGEREN (Bilthoven, The Netherlands). *J Antimicrob Chemother* 1985; **15**: 247-50.

Association of resistance of *Neisseria gonorrhoeae* to killing by human phagocytes with outer-membrane proteins of about 20 kilodaltons
NJ PARSONS, AAA KWAASI, PV PATEL, PMV MARTIN, AND H SMITH (Birmingham, England). *J Gen Microbiol* 1985; **131**: 601-10.

Lack of utility of *Limulus* amoebocyte lysate assay in the diagnosis of urethral discharges in men
FN JUDSON, BA WERNESS, AND MR SHAHAN (Denver, USA). *J Clin Microbiol* 1985; **21**: 152-4.

Comparative study of ceftriaxone and spectinomycin for treatment of pharyngeal and anorectal gonorrhea
FN JUDSON, JM EHRET, AND HH HANDSFIELD (Denver, USA). *JAMA* 1985; **253**: 1417-9.

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

Genital infections with *Chlamydia trachomatis* in women attending an antenatal clinic
PL WOOD, D HOBSON, AND E REES (Liverpool, England). *Br J Obstet Gynaecol* 1984; **91**: 1171-6.

A study was carried out to assess the incidence of infection with *Chlamydia trachomatis* in 252 unselected 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 innoculated 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 chlamydiae 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 chlamydia 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 chlamydia 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
RC BUMP (Columbus, USA). *Obstet Gynecol* 1985;**65**:384-8.

Illnesses in infants born to women with _Chlamydia trachomatis_ infection: a prospective study
C SCHAEFER, R HARRISON, WT BOYCE, AND M LEWIS (Atlanta, USA). *Am J Dis Child* 1985;**139**:127-33.

Evidence of chlamydial infection in infertile women with and without fallopian tube obstruction
JL KANE, RM WOODLAND, T FORSEY, S DAROUGAR, AND MG ELDER (London, England). *Fert Steril* 1984;**42**:843-8.

Serological evidence that chlamydiae and mycoplasmas are involved in infertility in women
BR MØLLER, D TAYLOR-ROBINSON, PM FURR, B TOFT, AND J ALLEN (Harrow, England). *J Reprod Fert* 1985;**73**:237-40.

Serological evidence for chlamydial infections in patients with acute diarrhoea
T BUTLER, M BENNISH, J SCHACHTER, AND BJ STOLL (Dhaka-2, Bangladesh). *Trans R Soc Trop Med Hyg* 1985;**79**:42-3.

Chlamydial endocervical infections and cytologic findings in sexually active female adolescents
M-A SHAFER, KL CHEW, LK KROMHOUT, *ET AL* (San Francisco, USA). *Am J Obstet Gynecol* 1985;**151**:765-71.

Cytologic manifestations of cervical and vaginal infections: II. Confirmation of _Chlamydia trachomatis_ infection by direct immunofluorescence using monoclonal antibodies
NB KIVIAT, 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
MJ THORNLEY, SE ZAMZE, MD BYRNE, M LUSHER, AND RT EVANS (Cambridge, England). *J Gen Microbiol* 1985;**131**:7-15.

Interferon-induced inhibition of _Chlamydia trachomatis:_ dissociation from antiviral and antiproliferative effects
LM de la MAZA, EM PETERSON, JM GOEBEL, CW FENNIE, AND CW CZARNIECKI (San Francisco, USA). *Infect Immun* 1985;**47**:719-22.

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

Urethral infection in male chimpanzees produced experimentally by _Mycoplasma genitalium_
D TAYLOR-ROBINSON, JG TULLY, AND MF BARILE (Harrow, England). *Br J Exp Path* 1985;**66**:95-101.

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
BR MØLLER, AS JØRGENSEN, E FROM, AND A STENDERUP (Aarhus, Denmark). *Acta Obstet Gynecol Scand* 1985;**64**:145-9.

Use of Kova-slide II with grid and uncentrifuged segmented urine specimens in the diagnosis of nongonococcal urethritis: a quantitative technique
SAB PERERA (Manchester, England). *Sex Transm Dis* 1985;**12**:14-8.

Pelvic inflammatory disease

Endometritis and acute salpingitis associated with _Chlamydia trachomatis_ and herpes simplex virus type two
J PAAVONEN, K TEISALA, PK HEINONEN, *ET AL* (Tampere, Finland). *Obstet Gynecol* 1985;**65**:288-91.

***Haemophilus influenzae* causes purulent salpingitis**
J PAAVONEN, M LEHTINEN, K TEISALA, *ET AL* (Tampere, Finland). *Am J Obstet Gynecol* 1985;**151**:338-9.

Tubal infertility and the intrauterine device
DW CRAMER, I SCHIFF, SC SCHOENBAUM, *ET AL* (Boston, USA). *N Engl J Med* 1985;**312**:941-7.

Oral contraceptives, _Chlamydia trachomatis_ infection and pelvic inflammatory disease: a word of caution about protection
AE WASHINGTON, S GOVE, J SCHACHTER, AND RL SWEET (Atlanta, USA). *JAMA* 1985;**253**:2246-50.

Cefotaxime treatment for women with community-acquired pelvic abscesses
DL HEMSELL, R SANTOS-RAMOS, FG CUNNINGHAM, BJ NOBLES, AND PG HEMSELL (Dallas, USA). *Am J Obstet Gynecol* 1985;**151**:771-7.

Trichomoniasis

Effect of culture medium iron content on the biochemical composition and metabolism of *Trichomonas vaginalis*
TE GORRELL (New York, USA). *J Bacteriol* 1985;**161**:1228-30.

Use of a time-kill technique for susceptibility testing of *Trichomonas vaginalis*
JN KRIEGER, CS DICKINS, AND MF REIN (Charlottesville, USA). *Antimicrob Agents Chemother* 1985;**27**:332-6.

Reduction of nitroimidazole derivatives by hydrogenosomal extracts of *Trichomonas vaginalis*
N YARLETT, TE GORRELL, R MARCZAK, AND M MÜLLER (New York, USA). *Mol Biochem Parasitol* 1985;**14**:29-40.

Candidosis

Management of recurrent vulvovaginal candidiasis with intermittent ketoconazole prophylaxis
JD SOBEL (Philadelphia, USA). *Obstet Gynecol* 1985;**65**:435-40.

Genital herpes

Fulminant hepatic failure caused by genital herpes in a healthy person
MH RUBIN, DM WARD, AND J PAINTER (Winston-Salem, USA). *JAMA* 1985;**253**:1299-301.

Genital herpes: a pervasive psychosocial disorder
ED LUBY AND V KLINGE (Detroit, USA). *Arch Dermatol* 1985;**121**:494-7.

A prospective study of herpes simplex virus infection in a defined population in Houston, Texas
K ALDER-STORTHZ, GR DREESMAN, RH KAUFMAN, JL MELNICK, AND E ADAM (Houston, USA). *Am J Obstet Gynecol* 1985;**151**:582-6.

Frequency of acquisition of first-episode genital infection with herpes simplex virus from symptomatic and asymptomatic source contacts
GJ MERTZ, O SCHMIDT, JL JOURDEN, *ET AL* (Albuquerque, USA). *Sex Transm Dis* 1985;**12**:33-9.

Evaluation of a commercial enzyme-linked immunosorbent assay for the detection of herpes simplex virus
DL SEWELL AND SA HORN (Portland, USA). *J Clin Microbiol* 1985;**21**:457-8.

Experimental model for activation of genital herpes simplex virus
H WRZOS AND F RAPP (Hershey, USA). *J Infect Dis* 1985;**151**:349-54.

Role of antibody in primary and recurrent herpes simplex virus infection
A SIMMONS AND AA NASH (Cambridge, England). *J Virol* 1985;**53**:944-8.

Systemic acyclovir in pregnancy: a case report
L GROVER, J KANE, J KRAVITZ, AND A CRUZ (Gainesville, USA). *Obstet Gynecol* 1985;**65**:284-7.

The effect of prostaglandin E_2 on the initial immune response of herpes simplex virus infection
DA BAKER AND J THOMAS (Stony Brook, USA). *Am J Obstet Gynecol* 1985;**151**:586-90.

Protection from genital herpes simplex virus type 2 infection by vaccination with cloned type 1 glycoprotein D
PW BERMAN, T GREGORY, D CRASE, AND LA LASKY (San Francisco, USA). *Science* 1985;**227**:1490-2.

Genital warts

Condyloma acuminatum of the bladder and ureter: case report and review of the literature
MA KEATING, RH YOUNG, CP CARR, N NIKRUI, AND NM HENEY (Boston, USA). *J Urol* 1985;**133**:465-7.

Increased risk of cervical neoplasia in consorts of men with penile condylomata acuminata
MJ CAMPION, A SINGER, PK CLARKSON, AND DJ McCANCE (London, England). *Lancet* 1985;i:943-6.

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
M VÄYRYNEN, K SYRJÄNEN, O CASTRÉN, S SAARIKOSKI, AND R MÄNTYJÄRVI (Kuopio, Finland). *Obstet Gynecol* 1985;**65**:409-15.

Prevalence of papillomavirus infection in colposcopically directed cervical biopsy specimens in 1972 and 1982
SG BERNSTEIN, RL VOET, DS GUZICK, *ET AL* (Dallas, USA). *Am J Obstet Gynecol* 1985;**151**:577-81.

Spontaneous resolution of cervical warty atypia: the relevance of clinical and nuclear DNA features: a prospective study
AS EVANS AND JM MONAGHAN (Gateshead, England). *Br J Obstet Gynaecol* 1985;**92:** 165-9.

Human fibroblast interferon in cervical and vulvar intraepithelial neoplasia associated with papilloma virus infection
G De PALO, B STEFANON, F RILKE, S PILOTTI, AND M GHIONE (Milan, Italy). *Int J Tiss React* 1984;**6:**523-7.

Acquired immune deficiency syndrome

Special report. The AIDS epidemic
SH LANDESMAN, HM GINZBURG, AND SH WEISS (New York, USA). *N Engl J Med* 1985; **312:**521-5.

Acute AIDS retrovirus infection: definition of a clinical illness associated with seroconversion
DA COOPER, J GOLD, P MACLEAN, *ET AL* (Sydney, Australia). *Lancet* 1985;i:537-40.

During 1984 1000 homosexual men living in Sydney were enrolled in a prospective immunoepidemiological 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 lymphadenoapthy, erythematous rash, and thrombocytopaenia. 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
LA VANDERMOLEN, KM FEHIR, AND L RICE (Houston, USA). *Arch Intern Med* 1985; **145:**745-6.

Epstein-Barr virus infections in homosexual men with chronic, persistent, generalised lymphadenopathy
RS CHANG, H THOMPSON, AND S POMERANTZ (Davis, USA). *J Infect Dis* 1985;**151:** 459-63.

Spectrum of pulmonary diseases associated with the acquired immune deficiency syndrome
DE STOVER, DA WHITE, PA ROMANO, RA GELLENE, AND WA ROBESON (New York, USA). *Am J Med* 1985;**78:**429-37.

Actinomycetales infection in the acquired immunodeficiency syndrome
HA HOLTZ, DP LAVERY, AND R KAPILA (Newark, USA). *Ann Intern Med* 1985; **102:**203-5.

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
GM SHAW, ME HARPER, BH HAHN, *ET AL* (Bethesda, USA). *Science* 1985;**227:** 177-81.

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
L GOLDSTICK, TI MANDYBUR, AND R BODE (Cincinnati, USA). *Neurology* 1985;**35:** 103-6.

Disseminated talc granulomatosis: an unusual finding in a patient with acquired immunodeficiency syndrome and fatal cytomegalovirus infection
JH LEWIS, JT SUNDEEN, GL SIMON, *ET AL* (Washington, USA). *Arch Pathol Lab Med* 1985; **109**: 147-50.

Hyperalgesic pseudothrombophlebitis: new syndrome in male homosexuals
SB ABRAMSON, CM ODAJNYK, AJ GRIECO, G WEISSMANN, AND E ROSENSTEIN (New York, USA). *Am J Med* 1985; **78**: 317-20.

The authors describe a syndrome of unknown aetiology, which resembles deep vein thrombosis and affects patients with acquired immune deficiency syndrome. Four men with Kaposi's sarcoma and one man with lymphopenia and chronic giardiasis presented with calf swelling, erythema, and a pronounced tenderness of the overlying skin. Although tender, erythematous, indurated cords could be felt in the position of superficial veins, no obstruction was shown on venography. Four patients had temperatures over 39°C. Non-steroidal anti-inflammatory drugs provided only partial relief, and the swelling and erythema persisted for up to one month. Cutaneous hyperalgesia, a most unusual feature, seems to remain despite the resolution of swelling and erythema.
P C Schober

Differential diagnosis of Kaposi's sarcoma
W BLUMENFELD, BM EGBERT, AND RW SAGEBIEL (San Francisco, USA). *Arch Pathol Lab Med* 1985; **109**: 123-7.

Lymphadenopathy in patients at risk for acquired immunodeficiency syndrome: histopathology and histochemistry
M RAPHAEL, P POULETTY, M CAVAILLE-COLL, *ET AL* (Paris, France). *Arch Pathol Lab Med* 1985; **109**: 128-32.

Isolation of lymphadenopathy-associated virus (LAV) and detection of LAV antibodies from US patients with AIDS
F BARRÉ-SINOUSSI, U MATHUR-WAGH, F REY, *ET AL* (Paris, France). *JAMA* 1985; **253**: 1737-9.

Seroepidemiology of HTLV-III antibodies in a remote population of eastern Zaire
RJ BIGGAR, M MELBYE, L KESTENS, *ET AL* (Bethesda, USA). *Br Med J* 1985; **290**: 808-10.

Frequent transmission of HTLV-III among spouses of patients with AIDS-related complex and AIDS
RR REDFIELD, PD MARKHAM, SZ SALAHUDDIN, *ET AL* (Bethesda, USA). *JAMA* 1985; **253**: 1571-3.

Postnatal transmission of AIDS-associated retrovirus from mother to infant
JB SIEGLER, DA COOPER, RO JOHNSON, AND J GOLD (Sydney, Australia). *Lancet* 1985; i: 896-8.

Pathologic appraisal of the thymus gland in acquired immunodeficiency syndrome in children: a study of four cases and a review of the literature
V JOSHI AND JM OLESKE (Newark, USA). *Arch Pathol Lab Med* 1985; **109**: 142-6.

Cerebral toxoplasmosis in AIDS: a simple laboratory technique for diagnosis
A DATRY, G LECSO, W ROZENBAUM, M DANIS, AND M GENTILINI (Paris, France). *Trans R Soc Trop Med Hyg* 1984; **78**: 679-80.

Acquired immunodeficiency syndrome: distinctive features of bone marrow biopsies
SA GELLER, R MULLER, ML GREENBERG, AND FP SIEGAL (Los Angeles, USA). *Arch Pathol Lab Med* 1985; **109**: 138-41.

Lymphocyte subsets in lymph nodes of homosexual men with generalized unexplained lymphadenopathy: correlation with morphology and blood changes
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Hepatitis B vaccination: when is a booster injection needed?
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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

successfully vaccinated people (medical staff and patients on haemodialysis or with renal transplants) were analysed. The anti-HBs behaved typically in most people, reaching maximum concentrations in the seventh month (one month after the third vaccine injection) and then falling gradually, more rapidly in the next following month than later. Persistence of antibodies depended on the maximum anti-HBs concentration reached initially.

Three years after the first vaccine injection, anti-HBs concentrations had fallen below 10 IU/l in all healthy people who had had initial concentrations between 10 and 99 IU/l, in 44% of vaccinees who had had initial titres between 100 and 499 IU/l, in 17% of people who had had initial anti-HBs between 500 and 1499 IU/l, but in none of the vaccinees whose antibody concentrations had originally been higher than 1500 mIU/l. Anti-HBs were undetectable in 6% of all medical staff members, in 30% of hemodialysis patients, and in 59% of patients with renal transplants.

Several policies for booster injections are discussed. One possible approach is to measure anti-HBs in all vaccinees after completion of the initial immunisation, a further booster injection being recommended individually on the basis of the calculated time when anti-HBs fall lower than, for example, 10 IU/l depending on the initial anti-HBs concentration. According to this scheme, about 20% of healthy people need to have booster injections less than three years after the start of active immunisation.

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