I would suggest that women with cytological evidence of HSV infection be advised of their diagnosis and urged to inform their obstetrician of the same. It is possible that ulceration has gone unnoticed in the past and an opportunity to corroborate the cytological diagnosis by viral culture may present itself to the vigilant medical attendant. Alternatively, infection may be truly confined to the cervix, in which case the obstetrician will have no external clinical indicator of recurrence. Virological screening in the latter stages of pregnancy may have a particular place in the management of this selected group of patients, although its routine use in all those with a history of genital herpes is disputed.4 At the very least, these women should be advised to attend early in labour so that a full genital examination, including speculum examination of the cervix might be performed.

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Dr Radcliffe and Dr Mindel reply:
We agree with Dr Stack that women with herpes detected by cytology alone should be offered the opportunity of careful monitoring during subsequent pregnancies.

Labial adhesions after genital herpes infection – authors reply
Haran and colleagues' appear to have missed the point of our case report1 on labial adhesions after genital herpes infection, since it was not so much the occurrence of the adhesions per se but rather their persistence and related consequences which were important. We have little doubt that the majority of physicians, like ourselves, who see patients with florid primary herpes have seen varying degrees of adhesion formation. These adhesions generally require little more than gentle digital separation and other simple measures because of their flimsy nature.

Our case report served to show how relatively quickly, since it was less than three weeks from the onset of her attack to our first seeing her, the adhesions had become so fixed, rendering simple digital separation impossible. The consequence of this was that the patient was to have a general anaesthetic and laser separation, and although this was in our case not ultimately required, as the majority of the adhesions had resolved spontaneously, in a similar case report2 the patient was not so fortunate.

To our knowledge this persistence in adhesions is relatively rare, the rarity undoubtedly being attributed to the diligent management by physicians of the primary stages of the infection. Our case report hopefully served to highlight that such diligence is necessary in order to avoid long-term complications leading to unnecessary surgical procedures under general anaesthesia.

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(Ed: This correspondence is now closed.)

Yersinia pseudotuberculosis infection as a cause of reactive arthritis as seen in a genitourinary clinic: case report

The recent case report of reactive arthritis associated with Yersinia pseudotuberculosis infection3 highlights a growing problem. Statistical returns from genitourinary medicine (GUM) clinics in England indicate that the number of cases of non-specific genital infection NSGI with arthritis has been increasing steadily since 1984 although the total number of cases of NSGI dropped in 1987.2 Because of the nature of reactive arthritis, it is likely that many cases will be referred to a GUM clinic, with, or without evidence of urethritis, rather than attend spontaneously.

It is important that genitourinary physicians are aware of the full differential diagnosis and are familiar with the tests which are required to elucidate the underlying cause of the condition.

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Holey prepuce following genital ulceration

I read with interest the letter from Drs Maiti and Haye1 describing a patient with a circular hole in the foreskin following treatment with podophyllin. A similar case but with a larger hole seen recently in a patient who had not received podophyllin is described.

A 27 year old Zulu man attending the STD clinic at King Edward VIII hospital, Durban with a urethral discharge was found to have a large defect in the dorsal aspect of the foreskin through which the glans penis protruded (fig). On further questioning the patient described an episode of sub-preputial genital ulceration 6 months previously involving the coronal sulcus which had penetrated through the foreskin. Antibiotics were prescribed by a local doctor and healing had occurred slowly. He did not appear concerned about the resultant
anatomical abnormality which had not been present on his last clinic attendance twelve months previously when treated for gonorrhoea. He denied trauma or attempted circumcision and accepted a surgical referral for definitive circumcision.

Many sub-preputial ulcers involving the coronal sulcus are seen in uncircumcised Zulu men and healing may follow a protracted course despite corrective treatment. In this case serological testing for syphilis was negative and granuloma inguinale or chancroid were the most likely infections. Tissue contraction during healing and trauma from subsequent intercourse probably accounted for the appearances found. The potential risk of HIV transmission to such patients might be reduced by making circumcision more readily available, thereby improving hygiene and facilitating speedier healing of ulcers. This patient declined a test for HIV antibodies.

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The third section is the real strength of the book, where the major opportunistic infections seen in AIDS are grouped by aetiological agent. (It is interesting that Pneumocystis carinii is still included as a protozoa despite recent claims that phylogenetically it is actually a fungus). Some of the more unusual clinical problems are included here such as the endemic mycoses (Histoplasma capsulatum, Blastomyces dermatitidis, Coccidioides immitis and Candida albicans). Each chapter is not only a very complete review of the literature to the present time, well and clearly referenced, but provides sound clinical advice, indicating where more research needs to be done and in which areas this is progressing.

The fourth and last section of the book covers the optimal use of diagnostic laboratories for the evaluation of patients with AIDS, including a useful brief review of the various methods of detecting and confirming the presence of HIV itself.

Any physician who cares for AIDS patients, especially one who does not have the time to plough through the innumerable publications on the subject, will find this an accurate informative up-to-date reference book. Its only drawback, for those not fortunate enough to be asked to review it, is its cost ($107). The text is, however, clearly and luxuriously printed on high quality paper with clear diagrams and both colour and black and white prints (some particularly good colour prints of the oral manifestations of HIV infection).

I would recommend that you reserve a copy at your nearest library!

SM FORSTER


Dr Mindel states in the preface to this book that it is written from a clinical perspective and that consequently clinical sections dominate whilst those dealing with virology, immunology, epidemiology, pathology and pathogenesis are “relatively brief”. The aim of the book he tells us, is to bring together all these various aspects of herpetic disease. In this he succeeds brilliantly.

The book is a model of readability and brevity (attributes not often possessed by medical authors) whilst...