significant improvement in the sensitivity of endocervical smears adopting a similar approach.

Re-reading original slides in "slide negative" but culture positive cases is essential as these often represent the most difficult slides to interpret. Dr Evans' letter demonstrated that re-reading of "negative" slides by an experienced microscopist in a non-clinic setting showed 64% were wrongly reported initially. This means storage facilities should be available to keep all patient slides for at least a week. Good communication between doctors and microbiologists is essential to highlight which slides are most likely to be positive to allow more time for selective slide-reading.

It is well recognised that the performance of any microbiological test decreases when the prevalence rate of the corresponding disease diminishes. The decreasing prevalence of gonorrhoea in the UK places even greater difficulty in ensuring that accuracy in slide-reading is kept at acceptable levels. A combination of continual staff training, regular audit of microscopy and collaboration between microbiology and GUM clinic staff with checking of presumptive negative and positive smears and culture results if mandatory if a high diagnostic standard is to be achieved.

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Kaposi sarcoma in Germany

Albrecht et al's report of cases of Kaposi's sarcoma (KS) in HIV-infected women provides further substantial evidence, from the western hemisphere, for a putative sexually transmissible aetiological agent of KS.

Unlike previous reports which were based on data from homosexual men, their's suggests that the agent could be transmitted heterosexualy and, therefore, lends itself to comparison with experience from some parts of Africa where KS and HIV infection are both common in heterosexuals, separately and concurrently. Moreover, they imply that two of their patients, who were of African origin and had recently come from there, could have acquired the KS agent from Africa.

One of us has previously pointed out that the epidemiology of KS in Africa is not consistent with a sexually transmissible aetiology as suggested by Albrecht et al and other studies from western countries. However, the evidence for sexually transmissible aetiology generated from Western data is quite compelling; and the disparity with African data very intriguing. It has been suggested that the fact that the African countries with a high incidence of HIV infection generally also have high incidence of KS; and that patients with AIDS-related KS and those with non-AIDS KS have comparable high risk factors for sexually transmitted infections, argues for a putative sexually transmissible aetiology for KS.

We find the evidence for sexually transmissible aetiology to be more compelling than recent reports on Kaposi's sarcoma in Uganda and Zambian cohorts suggest for sexual transmission. A report of 10 cases and review of the literature. Genitourin Med 1994;70:394-8.


Beral V, Bull D, Jaffe H et al. Is risk of Kaposi's sarcoma in AIDS patients in Britain increased if sexually exposed cases from United States or Africa? BMJ 1991;302:624-5.


