Prevalence of HPV cervical infections among imprisoned women in Barcelona, Spain

EDITOR.—The penitentiary centres in Spain harbour inmates in whom the combination of HIV infection, history of injecting drug use, and prostitution is common. Extensive protocols to detect sexually transmitted diseases and tuberculosis are implemented in these centres; however, human papillomavirus (HPV) infections and related lesions are not routinely searched for. Although Spain is characterised by a very low incidence of cervical cancer, a high rate of cervical cancer has been reported recently among the AIDS female population in Catalonia. We carried out a study aiming to characterise HPV cervical infection and related cervical lesions among women with many potential risk factors for cervical neoplasia. The study was done in the only institution in Barcelona where women are imprisoned. The population consisted of 157 women attending the medical office of the prison between February and December 1996 and represented 90% of all women staying in prison for more than 3 days. Women who agreed to participate underwent a gynaecological examination, collection of cervical cells, a structured interview by a trained nurse, determination of HIV, hepatitis B and C serostatus, and detection of HPV DNA in the cervical cells by means of PCR. L1 consensus primers MY09/MY11 were used with modifications described by Hildesheim et al.1 HPV DNA was detected in 48% of the women. The prevalence of cervical abnormalities was 29.9%; 19 women had a atypical squamous cells of undetermined significance (ASCUS) and 28 women were diagnosed with squamous intraepithelial lesion (SIL), which increased with age (table 1). No association between HPV detection was found with other reproductive and sexual characteristics. In addition, HIV positive women had an increased risk to develop SIL compared with HIV negative women (POR=5.02, 95% CI=1.69–14.89). As previously reported, the risk for SIL increased with low CD4 T cell counts, although POR did not reach statistical significance.3 Data from an ongoing study in a nearby area indicate that the prevalence of cervical abnormalities in the general population is around 4% (manuscript in preparation). This is the first time that we have documented in Spain a group of women with a very high rate of HPV infection linked to injecting drug use and with a rate of pre-neoplastic cervical lesions about seven times higher than that observed in the general population.

While in prison these women were appropriately treated for HIV infection and for SIL. When out of prison or in jail, a gynaecological screening every 6–12 months should be organised and recommended.

Financial support: This work has been partially supported by the Spanish Ministry of Health, FIS No 98/0646.

We thank Mrs Anna Coma for her assistance with data managing and analysis.

SILVIA DE SANJOSÉ FRANCESC XAVIER BOSCH Servicio de Epidemiología y Registro del Cancer, Institut Català d’Oncologia, Gran Via sn Km 2, 7E-08907, Spain

IMMA VALLS Centro Penitenciario de Mujeres de Barcelona Mª PAZ CANADAS Departamento de Biologia Molecular, General Lab, Barcelona

BELEN LLOVERAS Departamento de Anatomia Patologica, General Lab, Barcelona

XAVIER CASTELLSAGÜÉ Servicio de Epidemiología y Registro del Cancer, Institut Català d’Oncologia, Gran Via sn Km 2, 7E-08907, Spain

KEERTI V SHAH Department of Molecular Microbiology and Immunology, Johns Hopkins School of Public Health, Baltimore, USA

Correspondence to: Dr Sanjose

Table 1 Age adjusted prevalence odds ratios for human papillomavirus infection (HPV DNA) in the cervical cells by different characteristics

<table>
<thead>
<tr>
<th></th>
<th>HPV DNA Negative</th>
<th>HPV DNA positive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>HIV Negative</td>
<td>54</td>
<td>63.5</td>
</tr>
<tr>
<td>HIV Positive</td>
<td>31</td>
<td>36.5</td>
</tr>
<tr>
<td>Prostitution</td>
<td>59</td>
<td>69.4</td>
</tr>
<tr>
<td>No</td>
<td>26</td>
<td>30.6</td>
</tr>
<tr>
<td>Yes</td>
<td>44</td>
<td>51.8</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>Yes</td>
<td>41</td>
</tr>
<tr>
<td>Length of use:</td>
<td>0–9 years</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>≥10 years</td>
<td>17</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>49</td>
<td>59.8</td>
</tr>
</tbody>
</table>

PORc = age adjusted.

PORa = adjusted for age and the other variables in the table.
The discrepancy in total is due to the presence of more than one STD in some patients.  

We thank Lic D Guzman, Lic Y Gutierrez, and O Gutierrez for their technical support during this study and Dr A Llop for her revision.  

We accept for publication 5 November 1999.

Rising HIV prevalence in STD clinic attenders at Chandigarh (north India)—a relatively low prevalence area

EDITOR.—The patients attending the STD clinics are at risk of having concurrent HIV infection. The trends of HIV infection in these patients may reflect the trends of HIV epidemic in the community. We have analysed the HIV status of 981 patients (824 males, 157 females) who attended our STD clinic from January 1993 to July 1999 (about 6½ years). The screening for HIV was done by ELISA. Those who were found positive were tested by repeat ELISA utilising another blood sample and considered HIV seropositive only, if both samples were found positive. The STDs were diagnosed by appropriate laboratory tests. The majority of the attenders had STDs; however, a small but significant proportion of patients had psychosexual disorders and other non-sexually transmitted genital diseases. Four per cent of the 981 patients—that is, 40 patients (26 males, 14 females) were found to be seropositive for HIV. The annual prevalence showed a rising trend (1993, 0.56%; 1994, 4.4%; 1995, 2.4%; 1996, 4.7%; 1997, 4.4%; 1998, 5.7%; and January to July 1999, 8.7%). The prevalence of HIV seropositivity in different STDs is shown in table 1. Large proportions of seropositive patients were truckers (15/40, 37.5%) and housewives (12/40, 30%). Among 12 housewives, four were wives of truckers. All of the 26 seropositive male patients confessed to at least one sexual contact with commercial sex workers (CSWs). Twenty eight (70%) seropositive patients had one STD, while the remaining 12 (30%) patients had more than one STD; 18 (45%) seropositive patients had STDs with either atypical morphologies or unusual severity, the remaining 22 (55%) presented with usual morphologies. India is a country with a wide variation in geographical, cultural, and behavioural patterns. This is also reflected in the trends of current HIV epidemic in the various regions of the country. We believe that no other country has such a high variation in HIV epidemic status. Our data on HIV prevalence with STD clinics of different regions of the country highlights this difference. The high HIV prevalence zones of the country include western and southern zones, where HIV prevalence among STD clinic attenders varies from 15% to 33%. On the other hand, in eastern and northern zones, it is still low and varies from 0.2 to 4%. In our study we found that a high proportion of HIV positive patients were truckers, who generally acquired infection from CSWs from the highways to Bombay or Chennai, two metropolitan cities of the western and southern zones respectively. These long distance truckers have a high risk sexual behaviour and contribute in the spread of HIV infection throughout the country in a short time. Even though the present figures for HIV seropositivity in STD clinic attenders are not very high, the HIV epidemic in this region is now progressing at an alarming rate. In our study, the prevalence in our STD clinic increased from 0.56% in 1993 to 8.7% in 1999 (July). This indicates that northern India is entering from a low level epidemic (HIV prevalence less than 5% in STD patients) to a concentrated epidemic. This calls for an immediate vigorous intervention programme to be introduced in this region.

BHUHAN KUMAR
SOMESHE GUPTA
Department of Dermatology, Venereology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh-160 012, India

Correspondence to: Bhushan Kumar


Table 1 Frequency of HIV seropositivity in different sexually transmitted diseases

<table>
<thead>
<tr>
<th>STDs</th>
<th>No screened</th>
<th>HIV seropositive</th>
<th>Seropositivity rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcerative STDs</td>
<td>188</td>
<td>19</td>
<td>10.1</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>107</td>
<td>6</td>
<td>5.6</td>
</tr>
<tr>
<td>Syphilis</td>
<td>21</td>
<td>1</td>
<td>4.76</td>
</tr>
<tr>
<td>Chancroid</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Donovanosis</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>LGV</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All ulcerative STDs</td>
<td>322</td>
<td>25</td>
<td>7.6</td>
</tr>
<tr>
<td>Non-ulcerative STDs</td>
<td>184</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Condylomata acuminata</td>
<td>75</td>
<td>2</td>
<td>2.66</td>
</tr>
<tr>
<td>Genital warts</td>
<td>35</td>
<td>1</td>
<td>2.86</td>
</tr>
<tr>
<td>Molluscum contagiosum</td>
<td>27</td>
<td>3</td>
<td>11.1</td>
</tr>
<tr>
<td>Non-gonococcal urethritis</td>
<td>27</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vaginosis</td>
<td>23</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>All non-ulcerative STDs</td>
<td>368</td>
<td>18</td>
<td>4.9</td>
</tr>
<tr>
<td>All STD clinic attenders</td>
<td>981</td>
<td>40</td>
<td>4</td>
</tr>
</tbody>
</table>

*The discrepancy in total is due to the presence of more than one STD in some patients.


Correspondence to: Dr Rafael Llanes Caballero


Accepted for publication 5 November 1999.
positive for HIV antibody. This was highly significant (p<0.001, Fisher’s exact test). Presence of HIV antibody was associated with genital ulcer in 23.5% women, followed by genitourinary tract infection/AIDS case in India (1986–1999). Ministry of Health and Family Welfare, Govt of India, New Delhi.

**Table 1** Details of patients undergoing serological test for syphilis

<table>
<thead>
<tr>
<th>Clinical diagnosis</th>
<th>No of samples (%)</th>
<th>Positive for syphilis serology</th>
<th>Positive for HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous pregnancy loss*</td>
<td>89/281 (31.6)</td>
<td>16/89 (17.9%)</td>
<td>0/16 (0%)</td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td>101/281 (55.8)</td>
<td>9/101 (8.9%)</td>
<td>1/9 (11.1%)</td>
</tr>
<tr>
<td>Genital growth</td>
<td>49/281 (17.4)</td>
<td>4/49 (12.2%)</td>
<td>1/6 (16.6%)</td>
</tr>
<tr>
<td>Genital ulcer</td>
<td>42/281 (14.9)</td>
<td>17/42 (40.47%)</td>
<td>4/17 (23.5%)</td>
</tr>
</tbody>
</table>

*Intrauterine death, still birth, repeated abortions.

Immune reconstitution CMV pneumonia

EDITORS,—A 41 year old white homosexual man presented in late July 1999 with a 5 day history of exertional dyspnoea, non-productive cough, fever with sweats, and anorexia. An empirical course of broad spectrum antibiotics did not improve his symptoms and SaO₂ remained 98% on air at rest. The chest radiograph showed non-specific abnormalities. He had been found to be HIV-1 antibody positive in August 1991; cutaneous Kaposi’s sarcoma defined AIDS in June 1992. In May 1995 biopsy of lymph node showed cytomegalovirus (CMV) viremia and colitis were treated with intravenous ganciclovir for 2 weeks; no maintenance therapy was given. At this time the CD4 count was 130 cells x 10⁹/l. In October 1996 the patient had non-thymoma adenocarcinoma urogenitalis. He had a complex antiretroviral history, having taken combinations of reverse transcriptase inhibitors and protease inhibitors. He had discontinued all antiretroviral therapy in January 1999 as the viral load had failed to maintain CD4 counts and HIV viral load had risen: co-trimoxazole prophylaxis had been continued. In early June 1999 HIV viral load had risen to 223 000 copies/ml and CD4 count had fallen to 70 cells x 10⁹/l. Two weeks before the onset of respiratory symptoms the patient had recommenced antiretroviral therapy with d4T, 3TC, and amphenic/in saquinavir. Four weeks after starting antiretroviral therapy viral load had fallen to 1500 copies/ml and CD4 had risen to 170 cells x 10⁹/l. At this time 50 copies/ml and CD4 x 10⁹/l. A computed tomography (CT) scan of the thorax 4 weeks after the onset of respiratory symptoms and 6 weeks after starting antiretroviral therapy showed focal areas of ground glass shadowing, largely in the left upper lobe but also involving other lobes; in addition, chronic interstitial changes resulting from the previous episode of pneumonia were noted, including multifocal fibroitic change with thickened interlobular septae, cystic air spaces, and minor bronchiectasis involving all lobes. Repeat viral load at this time 200 copies/ml and CD4 x 10⁹/l. At bronchoscopy, performed after 8 weeks of antiretroviral therapy, the endobronchial appearances were normal. Bronchoalveolar lavage (BAL) was performed from the left upper lobe. Analysis of BAL fluid revealed a lymphocytic reaction; many cells had intranuclear/cytoplasmic inclusions typical of CMV infection. In situ hybridisation for CMV was positive. Post-mortem histological and culture for bacteria, mycobacteria, P carinii and other fungi were negative. Intravenous ganciclovir 10 mg/kg per day was given for 21 days, in addition, antiretroviral therapy and co-trimoxazole were continued. With this regimen there was a rapid defervesence of fever, a reduction in exudational dyspnoea and improvement in SaO₂ to 98% on air. Repeat CT of the thorax after 3 weeks of intravenous ganciclovir showed an improvement in ground glass shadowing and persistence of the chronic changes. The patient was subsequently maintained on oral ganciclovir.

The diagnosis of CMV pneumonitis was made by identifying CMV as the sole pathogen in BAL fluid and the improvement in symptoms, SaO₂, and CT appearances with ganciclovir as monotherapy. This diagnosis was made in the context of a rapidly falling viral load and an increase in CD4 count indicating partial immune reconstitution. Partial restoration of cell mediated immunity induced by antiretroviral therapy, as shown by recovery of part of CD4 T cell reactivity to memory antigens, may cause development of sufficient inflammatory responses to produce symptoms and signs in patients latently infected with opportunistic infections. Reactivation mycobacterial lymphadenitis, cryptococcal meningoitis, and CMV retinitis have been described. The current case described here suggests CMV pneumonitis should be added to the list of immune reconstitution phenomena.

R F MILLER
P J SHAW
G L INGLIS
Department of Sexually Transmitted Diseases, Royal Free and University College Medical School, Mortimer Market Centre, Mortimer Market, Edgware Road, London W1B 6AU

1 Autran B, Garavel G, Li TS et al. Positive effects of combined antiretroviral therapy on CD4+ T cell homeostasis and function in advanced HIV disease. Science 1997;277:112–16.

Accepted for publication 26 November 1999

**BOOK REVIEWS**


A book with a title such as this one makes it difficult for the author to decide what to exclude. This book certainly fulfills its major objective of providing an easy reference manual for the diagnosis and management of common gynaecological conditions. It deals with almost all the gynaecological conditions that could be encountered in the community and the common gynaecological problems in hospital medicine. Overall, the topics covered are well presented with special points highlighted.
The use of pictures relating to almost all the conditions dealt with by the book breaks up what would otherwise be a book of lists. The use of two different views of the same woman exercising on a treadmill certainly made me smile. The first picture tells us she is an intensively training sportswoman who may develop amenorrhoea and osteoporosis with stress fractures while the second picture, on a page dealing with advice to women who do not want HRT, reveals she is a grandmother taking regular exercise.

From a genitourinary medicine trainee point of view, I would have liked to see a more comprehensive chapter on pelvic infections and sexually transmitted diseases (this is the second smallest chapter in the book), and would have preferred this chapter to follow the one on vaginal and vulval problems. I am, however, glad to see that the role of the genitourinary clinic in the management of pelvic infections is emphasised.

ADE APOOLA

Department of GU Medicine, Whittall Street Clinic, Whittall Street, Birmingham B4 6DH


These two books provide histories of STDs and HIV in nine sub-Saharan African countries and another 11 countries in the Asia-Pacific region. The contributors are mostly historians or social scientists and the historical accounts take the reader up to 1995. Each volume is divided up into well referenced scholarly monographs on individual countries and individual chapters will be of considerable interest to anyone with an interest in sexual health in the countries studied. The number of readers of this journal who will want to read both books throughout is likely to be much less, given that these books are fairly specialist medical historical studies written mainly by historians for historians. The decision of the editors to treat each country separately has led inevitably to much repetition of certain themes. Many chapters rehearse the familiar story of how governments have responded to public pressure to regulate prostitution and the difficulties of demonstrating whether such efforts have had any real impact on STD transmission. The most interesting example in this context is the account of the attempts to eradicate prostitution and STDs in China, a subject where particularly detailed research has been carried out. China is not treated in the Latin American book which is more focused on more recent developments. The account of the campaign to control it. The main problem for more clinically oriented readers is the wealth of innovative approaches to STD and HIV control that have been explored in these countries since 1995 and which are too recent for inclusion in these volumes. The accounts of HIV go little further than the difficulties experienced in galvanising governments and communities into denouncing and acting. For detailed accounts of the Tanzanian and Rakai trials and their impact on policy and for the discussion of more topical controversies such as the possible role of polio vaccine development in the Congo in triggering the HIV pandemic we will have to look to future historians.

JOHN RICHENS

Department of Sexually Transmitted Diseases, Martineer Street Centre, Martineer Market, off Copper Street, London WC1E 6DU


This is a terrific read and should be read cover to cover by all practising genitourinary medicine physicians and trainees. Generally the quality of the writing is excellent. Genitourinary medicine is a rapidly advancing field so read the book now before it becomes out of date. Indeed the majority of the text shows in places. Some statistics relate to 1992 where 1997 figures are available. Some statements are also slightly out of date.

In a book of this size the referencing provides a challenge. If one references every statement (and considers all the conflicting evidence) the handbook turns into a weighty and unmanageable tome. Mostly, the authors have managed a sensible compromise. Statements that are controversial or old hats are not referenced. Occasionally more controversial statements remain un referenced. This may present a problem for the trainee. There are also some surprising omissions. I could find no description of desquamative vaginitis or focal vulvitis. However, I believe that this handbook could serve as an excellent basis for discussions between trainer and trainee and stimulate further reading around these topics.

Get this book. You will enjoy it. A number of chapters are absolute gems.

CHRIS CARNE

Genitourinary Medicine, Clinic IA, Addenbrooke’s Hospital, Hills Road, Cambridge CB2 2QQ

NOTICES

1st Annual Teesside Sexual Health Conference, 11 March 2000
Further details: Mandy Bruce (tel: 01642 854809).

9th International Congress on Infectious Diseases, 9–12 April 2000, Buenos Aires, Argentina
Further details: International Society for Infectious Diseases, 181 Longwood Avenue, Boston, MA 02115, USA (tel: (617) 277-0551; fax: (617) 731-1541; email: isidbos@aol.com).

Sexually Transmitted Diseases in a Changing Europe, 14–15 April 2000, Rotterdam, The Netherlands
Further details: Medicson, Organisation for Medical Congresses, PO Box 113, 5600 AC Geldrop, Netherlands (tel: +31-(0)40-2852212; fax: +31-(0)40-2851966; email: MEDICON@IAEhv.nl).

20th Scientific Conference of Venereological Section of the Polish Society of Dermatologists, Białystok, 28–30 April 2000
The conference will be on epidemiological and clinical aspects of sexually transmitted infections. Further details: Dept Dermatology and Venereology, Sw Rocha 3, 15-879 Białystok, Poland (tel/fax: (085) 7422778; email: bozchod@amb.ac.bialystok.pl).

Joint meeting of the MSSVd and the ASTDA, 3–7 May 2000, Baltimore Marriot Inner Harbor Hotel, Baltimore, Maryland, USA
Further details: Dr Keith Radcliffe, honorary assistant secretary, MSSVd (fax: +44(0) 121-237 5729; email: k.w.radcliffe@bham.ac.uk).

Australasian Sexual Health Conference, Ven Troppo, Carlton Hotel, Darwin, Northern Territory, 21–24 June 2000
Further details: Shirley Corley, Conference manager, Dart Associates, PO Box 781, Lane Cove, 2066 NSW, Australia (tel: 02 9418 9396/97; fax: 02 9418 9398; email: dartconv@mpx.com.au).

6th ESC Congress on Contraception in the Third Millennium: a (R)Evolution in Reproductive and Sexual Health, Ljubljana, Slovenia, 28 June–1 July 2000
Further details: Orga-Med Congress Office, Mr Peter Erad, Essenestraat 77, B-1740 Tempel, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@villaage.unet.be).
Increase in oral sex and pharyngeal gonorrhoea: an unintended effect of a successful condom promotion programme for vaginal sex.


Cervical wet mount as a negative predictor for Neisseria gonorrhoeae- and Chlamydia trachomatis-induced cervicitis in a gravid population.


Experimental transmission of Neisseria gonorrhoeae from pregnant rat to fetus.


Comparison of direct inoculation and copan transport systems for isolation of Neisseria gonorrhoeae from endocervical specimens.


T lymphocyte response to Neisseria gonorrhoeae porin in individuals with mucosal gonococcal infections.

SD SIMPSON, Y HO, PA RICE, LM WETZLER. J Infect Dis 1999;180:762–73 38

Decreased azithromycin susceptibility of Neisseria gonorrhoeae due to mtrR mutations.


The farAB-encoded efflux pump mediates resistance of gonococci to long-chained antibacterial fatty acids.

EH LEE, WM SHAFER. Mol Microbiol 1999;33:839–45 40

Chlamydia

Partner notification for chlamydial infections among private sector clinicians in Seattle-King County: a clinician and patient survey.


Patterns of Chlamydia trachomatis testing and follow-up at a university hospital medical center.

LH BACHMANN, CM RICHIE, K WAITES et al. Sex Transm Dis 1999;26:496–9

Completeness of and duration of time before treatment after screening women for Chlamydia trachomatis infections.

G FOGLIA, P RHOADES, M GOLDBERG, ME STLOUIS. Sex Transm Dis 1999;26:421–5

Control of Chlamydia trachomatis infections in female army recruits: cost-effectiveness screening and treatment in training cohorts to prevent pelvic inflammatory disease.

MR HOWELL, JC GATDOL, KT MCKEE et al. Sex Transm Dis 1999;26:519–26

Lack of association between serum antibodies to Chlamydia trachomatis and a history of recurrent pregnancy loss.


How adequate is adequate for the collection of endocervical specimens for Chlamydia trachomatis testing?

IL REEVE, KA GERSHMAN, JK KELLEY et al. Sex Transm Dis 1999;26:579–83

The impact on accuracy and cost of ligase chain reaction testing by pooling urine specimens for the diagnosis of Chlamydia trachomatis infections.

JR KEPEL, JP TAYLOR, A SPRY. Sex Transm Dis 1999;26:504–7

Ability of the Digene Hybrid Capture II test to identify Chlamydia trachomatis and Neisseria gonorrhoeae in cervical specimens.


Impact of reference standard sensitivity on accuracy of rapid antigen detection assays and a leukocyte esterase dipstick for diagnosis of Chlamydia trachomatis infection in first-void urine specimens from men.


Antimicrobial susceptibility testing of Chlamydia trachomatis using a reverse transcriptase PCR-based method.


Detection of Chlamydia trachomatis endocervical infections by ligase chain reaction versus ACCESS Chlamydia antigen assay.


Antibody response to the chlamydial heat-shock protein 60 in an experimental model of chronic pelvic inflammatory disease in monkeys (Macaca nemestrina).

BW FEELING, DL PATTON, YTC SNEYNEY et al. Infect Dis 1999;180:774–9

Role of gamma interferon in controlling murine chlamydial genital tract infection.


Lower prevalence of Chlamydia pneumoniae DNA compared with Chlamydia trachomatis DNA in synovial tissue of arthritis patients.


Lack of cell wall peptidoglycan versus penicillin sensitivity: new insights into the chlamydial anomaly.


The effect of doxycycline treatment and the development of protective immunity in a murine model of chlamydial genital infection.

Pelvic inflammatory disease

The association of interleukin 6 with clinical and laboratory parameters of acute pelvic inflammatory disease.


Syphilis and other treponematoses

Incident syphilis among women with multiple admissions to jail in New York City.


Enzyme-linked immunospot assay for the diagnosis of active Treponema pallidum infection during the various stages of syphilis.


The use of Western blotting as the confirmatory test for syphilis in patients with rheumatic disease.

PT Murphy, R. George, K. Kubota et al. J Rheumatol 1999;26:2448–53

T-cell responses to Treponema pallidum subsp pallidum antigens during the course of experimental syphilis infection.


Immunization with Treponema pallidum outer membrane vesicles induces high-titer complement-dependent treponemal activity and aggregation of T-pallidum rare outer membrane proteins (TROMPS).


Hepatitis

Cost-effectiveness analysis of hepatitis A vaccination strategies for adults.


The Denver school-based adolescent hepatitis B vaccination program: a cost analysis with risk simulation.


Pathogenesis of chronic hepatitis C: immunological features of hepatic injury and viral persistence.


Herpes

A prospective study of new infections with herpes simplex virus type 1 and type 2.


Is sexual transmission an important pattern for herpes simplex type 2 virus seroconversion in the Spanish general population?


Quality of life and use of health care among people with genital herpes in France.


The differential impact of training stress and final examination stress on herpes virus latency at the United States Military Academy of West Point.


College students’ attitudes regarding vaccination to prevent genital herpes.


Ecthyma secondary to herpes simplex virus infection.


Acquired lymphedema of the hand due to herpes simplex virus type 2.


Whole cell lysate enzyme immunoassays vs recombinant glycoprotein G2-based immunoassays for HSV-2 seroprevalence studies.


A double-blind, randomized study assessing the equivalence of valacyclovir 1000 mg once daily versus 500 mg twice daily in the episodic treatment of recurrent genital herpes.


Foscarnet treatment of genital infection due to acyclovir-resistant herpes simplex virus 2 in a pregnant patient with AIDS: case report.


The comparative effects of famciclovir and valacyclovir on herpes simplex virus type 1 infection, latency and reactivation in mice.

Antiviral properties of isoborneol, a potent inhibitor of herpes simplex virus type 1.

Antitherpetic activity and mode of action of natural carrageenans of diverse structural types.

Civamide (cis-capsaicin) treatment of primary or recurrent experimental genital herpes.

γ6 T cell response induced by vaginal herpes simplex 2 infection.

Humoral response to herpes simplex virus is complement-dependent.

LAT expression during an acute HSV infection in the mouse.
RG JARMAN, WK WAGNER, DC BLOOM. Virology 1999;262:384–97

Inhibition of dendritic cell maturation by herpes simplex virus.

Human papillomavirus infection

Assessing gains in diagnostic utility when human papillomavirus testing is used as an adjunct to Papanicolaou smear in the triage of women with cervical cytologic abnormalities.
EL FRANCO, A FERENCZY. Am J Obstet Gynecol 1999;181:382–6

HPV testing in primary screening of older women.

Do HPV-negative cervical carcinomas exist—revisited.
CS HERRINGTON. J Pathol 1999;189:1–3

Human papillomavirus is a necessary cause of invasive cervical cancer worldwide.
JMM WALBOOMERS, MV JACOBS, MM MANOS et al. J Pathol 1999;189:12–9

Has the use of Pap smears reduced the risk of invasive cervical cancer in Guatemala, Mexico?
M JIMENEZPEREZ, DB THOMAS. Int J Cancer 1999;82:804–9

Familial risks in cervical cancer: is there a hereditary component?
K HEMMNEL, CH DONG, P VAITTINEN. Int J Cancer 1999;82:775–81

Human papillomavirus infection, cervical dysplasia and invasive cervical cancer in Honduras: a case-control study.

Human papillomavirus-associated penile squamous cell carcinoma in HIV-positive patients.

Enhancement of the innate and cellular immune response in patients with genital warts treated with topical imiquimod cream 5%.

Intralesional or topical cidofovir for the treatment of recurrent genital warts.

Histologic and immunologic associations of an HPV16 variant in low-grade smears.

Seroprevalence of human papillomavirus type 16 in pregnant women.

Serum antibodies to human papillomavirus 16 proteins in women from Brazil with invasive cervical carcinoma.

Serological evidence for human papillomavirus type 6 infection against HPV type 16 cervical carcinogenesis.

The integration of HPV-18 DNA in cervical carcinoma.

High prevalence of human papillomavirus type 18 in Chinese women with cervical cancer and precancerous lesions.


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