instructed to apply the gel three times a week to the respective lesions without any adverse effects. Thereafter, the patient was treated on an outpatient basis at 1.5% cidofovir in a viscous gel.

Successful treatment of recalcitrant condyloma with topical cidofovir

Editor,—Despite the high prevalence of condylomata acuminata, their treatment remains unsatisfactory for both patients and physicians. Epidemiological studies estimated the prevalence of genital warts between 1–31% with a peak occurring in young adults. As a consequence, the economic burden of human papillomavirus (HPV) infection in the United States is estimated to exceed $8.5 billion per year. Current treatments rely on the ablation of warts (cryotherapy, laser vaporisation, electrodessication, or trichloroacetic acid) or the interruption of cell division (podophyllotoxin, intralesional or systemic interferon, and 5-fluorouracil). Recently, imiquimod has been successfully used as a topical immune response modifier for the treatment of external anogenital warts. However, there remains a substantial number of patients who fail to respond to traditional and newer drugs. We report on such a patient with recalcitrant condylomata acuminata on the glans and shaft of the penis who was successfully treated using the novel virustatic cidofovir as a 1.5% gel.

A 48 year old man with a 2 1⁄2 year history of condylomata acuminata had received laser treatment, podophylox, and imiquimod. The treatment of condylomata acuminata had received laser treatment, podophylox, and imiquimod. The patient presented to the Oxford genitourinary medicine department at High Wycombe (5500 new attendances per annum) between 1991 and 1998; the fifth patient who was referred to the genitourinary medicine department at High Wycombe was diagnosed (at that time there were 5–10 white cells/high power field (×1000) on a urethral swab, and a chlamydia ELISA test and cultures for Neisseria gonorrhoeae were negative; no haematuria was detected). Both patients were subsequently noted to have neoplastic infiltration in the bladder neck area and prostatic urethra.

In all five cases a degree of persistent microscopic haematuria was noted at presentation; in patient 4 this was never greater than a trace on dipstick testing. Patient 1 reported intermittent painless macroscopic haematuria at presentation; he was referred by his general practitioner with suspected haematuria. The condition may occur at younger ages. Men with bladder carcinoma typically present in later life (median age 65 years), but the condition may occur at younger ages. A subgroup of patients develop frequency, urgency, and dysuria—symptoms usually associated with bladder infection. Rarely, penile and perineal pain mimicking prostatitis may be a presenting feature, as in patients 3 and 4, who have been described in more detail elsewhere.

Non-specific urethritis (NSU) is diagnosed commonly in genitourinary medicine clinics in men of all ages. In this series, patient 2 was referred with presumed NSU, and patient 4 had attended previously with a diagnosis of NSU. 2 years before the bladder cancer was diagnosed (at that time there were 5–10 white cells/high power field (×1000) on a urethral smear, and a chlamydia ELISA test and cultures for Neisseria gonorrhoeae were negative; no haematuria was detected). Both patients were subsequently noted to have neoplastic infiltration in the bladder neck area and prostatic urethra.

Figure 1 Condylomata acuminata with some lesions in the coronary sulcus having a more verruciform appearance.

SUCCESSFUL TREATMENT OF RECALKITANT CONDYLOMA WITH TOPICAL CIDOFOVIR

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Table 1 Patient details

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Age (years)</th>
<th>Smoker</th>
<th>Referral source</th>
<th>Referral diagnosis</th>
<th>Presenting features</th>
<th>Urine dipstick</th>
<th>Urine cytology</th>
<th>Diagnosis and treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>26</td>
<td>NR</td>
<td>GP</td>
<td>Infection</td>
<td>3 months intermittent painless haematuria, 6 weeks frequency, dysuria</td>
<td>Blood +ve (trace)</td>
<td>ND</td>
<td>Well differentiated bladder papillary TCC; non-invasive; rescinded</td>
</tr>
<tr>
<td>2</td>
<td>34</td>
<td>Yes</td>
<td>GP</td>
<td>Urethritis</td>
<td>6 weeks frequency, dysuria</td>
<td>Blood +ve ND</td>
<td>ND</td>
<td>Poorly differentiated adenocarcinoma; bladder calculi also present; tumour ressection, chemotherapy, and radiotherapy</td>
</tr>
<tr>
<td>3</td>
<td>53</td>
<td>No</td>
<td>GP</td>
<td>Recurrent prostatitis</td>
<td>1 year periurethral and suprapubic pain, frequency, dysuria</td>
<td>Blood +ve Malignant</td>
<td>Blood +ve Malignant</td>
<td>Extensive transitional cell carcinoma in situ, involving prostatic urethra; cystoprostatectomy</td>
</tr>
<tr>
<td>4</td>
<td>42</td>
<td>No</td>
<td>GP</td>
<td>Sterile pyuria</td>
<td>1 year periurethral and suprapubic pain, frequency, dysuria</td>
<td>Blood +ve Malignant</td>
<td>Blood +ve Malignant</td>
<td>Extensive TCC plus carcinoma in situ, involving prostatic urethra, cystoprostatectomy</td>
</tr>
<tr>
<td>5</td>
<td>50</td>
<td>Yes</td>
<td>GP</td>
<td>Infection</td>
<td>6 weeks frequency, urgency, dysuria</td>
<td>Blood +ve Suspicious</td>
<td>Blood +ve Suspicious</td>
<td>Poorly differentiated TCC at bladder neck; muscle invasion; cystoprostatectomy, and chemotherapy</td>
</tr>
</tbody>
</table>

NR = not recorded; ND = not done; TCC = transitional cell carcinoma.

The patient was diagnosed with asymptomatic HIV infection in February 1987 when she was aged 50 years. Her CD4 count was $690 \times 10^6$ at this time. HIV infection was acquired by a bisexual male partner. In December 1990 the CD4 lymphocyte count had fallen to $190 \times 10^6$ and zidovudine monotherapy was started. This was continued until 1996 when she was prescribed a combination regimen.

In September 1995 the patient experienced a syncopal episode. An echocardiogram revealed a mass in the left atrium consistent with a left atrial myxoma. A coronary angiogram showed normal coronary arteries. Surgical resection of the myxoma was recommended.

In December 1995 the patient's CD4 count was $64 \times 10^6$, but apart from oral candidiasis there had been no HIV-related problems since diagnosis. Two leading UK HIV physicians were asked if they considered surgery to be advisable. They estimated the patient's likely survival from HIV disease to be 1–4 years. The risks of major heart surgery had to be balanced against the likelihood of recurrent symptoms from the myxoma in the next 1–4 years. The patient and her physician agreed to proceed with surgery.

On 4 December 1995 the patient underwent surgical resection of a pedunculated left atrial mass. Histological examination confirmed a benign atrial myxoma. The procedure was uncompleted and she was discharged from hospital 4 days later. Annual cardiac review including an echocardiogram has shown no evidence of recurrence up to the present time. She remains free from cardiovascular symptoms. Her HIV disease is managed with combination therapy that consists of stavudine, lamivudine, and efavirenz. Curative benefits of HAART (highly active antiretroviral therapy) have made it unacceptable to delay major surgical interventions to individuals with HIV.

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The association between receptive compulsive and viral vaginosis

Editor,—We are puzzled by the surprisingly little, if any, serious work done to explain the epidemiological enigma of high prevalence of bacterial vaginosia (BV) in lesbians,1 and the oft observed, but as yet unconfirmed association between BV and receptive vulvovaginitis in women in general.

In a detailed study of 17 consecutive lesbians attending the department of genitourinary medicine at the Royal Sussex County Hospital in Brighton, bacterial vaginosis was found in six women (35%). Of nine lesbians who practised receptive vaginal sex in the previous 4 weeks, six (67%) had BV. By contrast, no BV was present in all eight women who did not practise oral sex (table 1).

In a parallel prospective study of 256 consecutively heterosexual female patients attending the same department, 55 (21%) were diagnosed as having BV. Of 111 women who practised receptive vulvovaginitis in the previous 4 weeks, 41 (37%) had BV. Of 145 women who did not have oral sex, only 14 (10%) had BV (table 1). In both groups there was no association between BV and age, or age in years of sexual penetration.

The evidence associating bacterial vagino-

The mouth is full of Gram positive and Gram negative organisms including Bacteroides oralis and, albeit in much smaller quantities, lactobacilli. These organisms are part of normal flora in the mouth, but are they normal to the vagina? Might the tiny amount of lactobacilli be enough to act as a phage which destroys the
Is partner notification in the public interest?

EDITOR,— This ethical debate calls for comment. Why did the clinicians only suspect AIDS? Surely at the second attendance the diagnosis was clinically obvious. As well as continuing treatment of candidiasis and starting prophylaxis of Pneumocystis carinii pneumonia, was not treatment for AIDS indicated? For fear of court proceedings a specimen of blood untested or surplus to routine haematological tests could have been stored to confirm, if necessary, the clinical diagnosis. A perspicacious defence lawyer could make much of this in terms of doctor thoroughness, cautiousness, and thoughtfulness—on behalf of his client.

In terms of contact tracing the word “disclosure” occurs repeatedly. Surely the first thing an index case is told when his/her cooperation is sought is that under no circumstances will their name be divulged. The contacts, when attending, will be refused any information regarding who has named them and immediately assured that the same confidentiality will be maintained if their cooperation is called for in the contact tracing process.

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Letters, Book reviews, CD-Rom reviews, Notices, Correction, Current publications


Sexual partner reduction and HIV infection

EDITOR,— We recently conducted a national urban random sample survey of 1400 men of sexually active age in the Dominican Republic to measure possible change in sexual behaviour. This sexual behaviour change (SBC) survey was prompted by results from the 1996 demographic and health survey, which found that 84.8% of a random sample of Dominican men claimed that they had changed their behaviour in some way because of their fear of, or concern about, AIDS. The proportion of respondents reporting behaviour change such as becoming monogamous or reducing their number of sexual partners was about triple the proportion reporting condom adoption. In our SBC survey, 79% of respondents claimed to have changed behaviour because of concern about AIDS. A majority (52.2%) said they had become monogamous or reduced their number of sexual partners. This was followed by condom adoption (14.6%); only having sexual relations with a person they know (13.9%); avoiding relations with “prostitutes” (9.0%); or becoming abstinent (1.6%). A small proportion (2.8%) had not yet begun to have sexual relations. As with the Dominican DHS findings, we see that most answers are classifiable as behaviour change, as distinct from condom adoption. This follows a pattern found in recent studies in countries such as Uganda and Zambia. A recent review of findings from behavioural change surveys in 16 countries in Africa, Latin America, and the Caribbean shows that partner reduction is more often reported than condom adoption. If sizeable numbers of men reduce their number of sexual partners, can this have significant impact on HIV infection rates? Urban HIV seroprevalence among the general or low risk Dominican population seems to have stabilised at the 1.0–2.0% level since 1995, according to the US Census Bureau. Recent studies that have modelled the impact of different interventions on HIV infection rates in east Africa suggest that reduction in number of partners can have a great impact on averting HIV infections, in fact greater than either condom use or treatment of STDs.1 Of course, impact of partner reduction on HIV infection rates would be especially strong where there is relatively high HIV seroprevalence among potential partners. In view of these modelling studies as well as population based surveys such as the two cited from the Dominican Republic, perhaps there ought to be greater equity in resource allocation between HIV/AIDS prevention programmes promoting behaviour change—such as monogamy/fidelity or at least reduction of number and frequency of change of sex partners—and far more familiar programmes that promote and provide condoms.

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Features of AIDS and AIDS defining diseases during the highly active antiretroviral therapy (HAART) era, compared with the pre-HAART period: a case-control study

EDITOR,— To assess the features of AIDS defining illnesses during the HAART era versus those observed before the introduction of HAART, the characteristics of 72 consecutive patients diagnosed in 1995, compared with those of 144 subjects randomly selected from the 436 patients diagnosed from 1985 to 1995, in a case-control study.

An impressive drop in AIDS diagnosis was seen shortly after the introduction of HAART, with only 38, 21, and 13 cases per 1000 patient years observed in 1997, 1998, and 1999 respectively, versus a mean frequency >60 cases per 1000 patient years, demonstrated during the pre-HAART era. This trend towards an increased incidence of female sex was shown in 1997–9 compared with 1985–95 (33.3% versus 27.1%), together with a rise of mean CD4+ lymphocyte count (86.8 (SD 99.4) versus 72.1 (93.7) cells × 1010/l), while an increase in the mean patient age was highly significant (39.8 (8.3) versus 34.6 (7.7) years; p<0.0001). When considering the exposure to HIV infection, drug abuse became significantly less important in the HAART era (p<0.05), while heterosexual transmission was notably increased (34.7% versus 13.2% of cases; p<0.0003). The distribution of AIDS defining disorders during the HAART era showed an tendency towards a reduction in cytomegalovirus, cryptocoCCOSIS, mycobacteriosis, cryptosporidiosis, and HIV encephalopathy, while a relative increase in pneumocystis/ATROPOPHAGEAL candidiasis, wasting syndrome, tuberculosis, and non-Hodgkin’s lymphoma was found; neurotoxoplasmosis and Kaposi’s sarcoma were stable (table 1). However, while pneumocytosis, Candida esophagitis, neurotoxoplasmosis, and Kaposi’s sarcoma represented the four most frequent AIDS related events in both study periods, cytomegalovirus, HIV encephalopathy, cryptocoCCOSIS, and mycobacteriosis (which ranked fifth to eighth in

endogenous healthy vaginal lactobacillus? In an interesting hypothesis, Blackwell described the possible effect of biochemical and microbial abnormalities in the vagina on BV recurrence. She also quoted Berger’s description of concordant vaginal floras in lesbian couples, suggestive of a mechanical transfer of an infectious agent. Is it not possible for mouth organisms or hostile salivary enzymes to induce biochemical and microbial abnormalities in the vagina?

Furthermore, mechanical transfer of infectious agents in lesbian couples is most likely to occur via cummings, a not uncommon practice among lesbians.

Cummings is a common fact of sexual life. The dynamics of this practice vary considerably. If association between BV and oral sex is ever confirmed, would the degree of tongue penetration be a factor and should it be incorporated in the aetiology equation? Further and more extensive studies are certainly indicated.

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Letters, Book reviews, CD-Rom reviews, Notices, Correction, Current publications

Table 1 BV prevalence results

<table>
<thead>
<tr>
<th></th>
<th>No of women</th>
<th>BV diagnosed</th>
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<tbody>
<tr>
<td>Total</td>
<td>17</td>
<td>6 (35%)</td>
</tr>
<tr>
<td>Practised receptive cunnilingus in previous 4 weeks</td>
<td>9</td>
<td>6 (67%)</td>
</tr>
<tr>
<td>Did not practise receptive cunnilingus</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

Lesbians

<table>
<thead>
<tr>
<th></th>
<th>No of women</th>
<th>BV diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>256</td>
<td>55 (21%)</td>
</tr>
<tr>
<td>Practised receptive cunnilingus in previous 4 weeks</td>
<td>111</td>
<td>41 (37%)</td>
</tr>
<tr>
<td>Did not practise receptive cunnilingus in past 4 weeks</td>
<td>145</td>
<td>10 (6.9%)</td>
</tr>
</tbody>
</table>

Heterosexual women


Features of AIDS and AIDS defining diseases during the highly active antiretroviral therapy (HAART) era, compared with the pre-HAART period: a case-control study

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frequency during the pre-HAART era), virtually disappeared after the introduction of HAART (28 versus four overall cases; p<0.007), together with cryptosporidiosis. Neoplasms and HIV related disorders (encephalopathy and wasting syndrome) showed a slightly increased frequency during the HAART era (16.8% and 9.2% during 1997–9, versus 13.2% and 7.9% respectively, during the pre-HAART period). A considerable increase in mean CD4+ count was found during the HAART era for all AIDS related illnesses considered, except neurotoxoplasmosis. However, this increase in CD4+ count was significant only for Candida esophagitis (p<0.04), wasting syndrome (p<0.03), and tuberculosis (p<0.03), probably because of small patient samples. Only seven of the 72 patients who developed AIDS since 1997 (9.7%), were effectively treated with HAART for more than 3 months before diagnosis; in the remaining 65 cases HIV infection was detected concurrently with an AIDS defining event in subjects who were unaware of their condition (40 cases), or refused HAART or carried out it with poor adherence (25 patients). Although a sharp decline in the incidence of multiple AIDS defining events was demonstrated after the introduction of HAART, the distribution of primary AIDS associated diseases showed limited modifications.1,3 An increased incidence of women, a higher patient age, a greater role for heterosexual transmission compared with injecting drug addiction, and a rise in CD4+ count were disclosed by us in the HAART era compared with the pre-HAART period. Appreciable modifications of the spectrum of AIDS associated illnesses were also observed during the HAART era (a drop of cytomegalovirusis, cryptococcosis, mycobacteriosis, cryptosporidiosis, and HIV encephalopathy, with a parallel increase in pneumocystosis, oesophageal candidiasis, wasting syndrome, tuberculosis, and non-Hodgkin’s lymphoma), together with a considerable trend towards an increased mean CD4+ count at diagnosis, as previously noted.1,3 Disorders which are directly or indirectly associated with HIV damage itself, AIDS related neoplasms, and opportunistic diseases occurring with a less profound immunodeficiency, show a substantially stable or even increasing incidence among newly diagnosed cases of AIDS.1,3 However, opportunistic diseases related to a severe immunodeficiency are still frequent among AIDS defining events, since the majority of cases identified during the pre-HAART era occur in patients who are not aware of their disease, or fail HAART. Only early detection and aggressive treatment of HIV infection may definitively improve the epidemiology of AIDS; a continued surveillance of AIDS related disorders remains critical for the implementation of therapeutic and prophylactic strategies.

**BOOK REVIEW**

**Hustling for Health. Developing Services for Sex Workers in Europe.** Pp 83; Price 10 euros. The European Network for HIV/STD Prevention in Prostitution (EUROPAP/TAMPEP), 1999. Contact Judith Kelvington/Helen Ward, Coordinating Centre, European Network for HIV/STD Prevention in Prostitution, Department of Epidemiology and Public Health, Imperial College School of Medicine, London W2 1PG (tel: 0207 594 3318; fax: 0207 402 2150; email: europap@ic.ac.uk). (Also available in nine other European languages (Danish, Finnish, Flemish, French, German, Greek, Italian, Portuguese, Spanish), and the full text (without illustrations) can be found online on the website (http://www.med.ic.ac.uk/dflhm/europap/hustling/press.htm).

How do you begin to address the sexual health needs of commercial sex workers (CSWs)? Here you will find (most of) the answers. This immensely practical book is essential for those setting up an outreach service, or simply wishing to know more about commercial sex work. It is the outcome of a series of projects and workshops, written by workers providing services to CSWs throughout Europe, and draws from the lessons learnt by these pioneering workers and clients. It is written with great clarity and frankness. The A4 layout is bold, imaginative, and attractive, with illustrations of promotional literature. Its European inclusiveness means that sadly it cannot be specific regarding, for example, the law as it applies to commercial sex. It does, however, give the broad framework within which providers must acquaint themselves wherever they work. It takes us through the steps; sources of funding, the scope of the service, useful contacts, where to make contact with CSWs, and so on. Importantly, in the current climate there are sections on evaluation and monitoring of the service, the legal and political context of the work, and dealing with the media. It stresses the heterogeneous nature of commercial sex workers whether male, female, or transsex, and the spectrum of commercial sex venues. Peer educator programmes are covered in some detail. There are fascinating pieces of practical advice—for example, cooperate with police, but don’t be identified too closely with law enforcement. Advising police of your outreach vehicle’s registration number may prevent you being stopped for kerb crawling! You can set up a flawless screening service and find only a few CSWs attend. The book reminds us middle class, health aware professionals that, for many, sexual health is not a priority. We are perplexed when faced with “indifference, hostility and self destructive behaviour”; that her next fix, a roof over her head, or the desire to have a baby might be more important to the CSW than the nebulous risk of HIV. Address some of these needs and you have the carrot to attract attention to and confidence in your service. The spin off is that clients can then benefit from STD screening and safer sex advice. Simply providing toilets and somewhere to sit from STD screening and safer sex advice. Simply providing toilets and somewhere to sit from

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The 13,000 bodies providing CAMHS spending £15 million (sic) of public money annually in England and Wales. The Commission’s team of seven have met with external advisers with a view to shaping the audit, its comments, and guidance. The aim is to achieve economy with efficiency and effectiveness. The report is in five chapters and five helpful appendices. It lists 71 references and has an index.

Under the heading “The changing context” it is revealed that one in five children and adolescents (alas, not defined) (both males and females) suffer from a wide range of mental health problems of variable degrees of severity from social ineptitude through psychological to severe psychiatric disorder. Strong links are noted with juvenile crime, alcohol and drug abuse, eating disorders, and of course self harm.

The key components of the CAMHS are viewed as four “tiers”: (a) Those providing primary intervention, eg, GPs, health visitors, residential social workers, juvenile justice workers, school nurses, and teachers. (b) Professional providers of services, eg, clinical and educational psychologists, paediatricians, child psychiatric nurses in the community, and child psychiatrists. (c) High grade specialist services for severe, complex and persistent disorders, eg, child psychiatrists, community psychiatric nurses, psychotherapists, occupational therapists and art, music, and drama therapists. (d) Consists of hospital services especially unnamed “highly specialised outpatient teams”. This clearly applies to accident and emergency departments, obstetric and gynaecology departments, and genitourinary medicine departments. These deal very adequately with self poisoning episodes, premartial abortions, and sexually acquired infection, but fail to see the underlying behaviour as but one manifestation of an ongoing complex of maternal social pathology. Clearly, services for the care of our adolescents, unlike paediatrics and geriatrics, are seriously fractionated. What follows should help the holistically minded hospital doctor to increase his awareness and skills and so make more regular and early use of referral routes and emergency cover arrangements provided by developing CAMHS.

It is clear that in many areas there is an urgent need to plan how best to meet unmet needs, including appropriate monitoring. The final chapter of this book purports to cover arrangements provided by developing CAMHS.


“Venerable diseases are like the fine arts—it is pointless to ask who invented them.” (Voltaire, Dictionaire philosophique). Sexually transmitted diseases (STDs) now rank among the top ten diseases for which adults in developing countries seek health care. The economic burden of STDs on both developed and developing countries is enormous. Infection with conventional STDs is a risk factor for transmission of infection with HIV, and therefore for the development and spread of the AIDS epidemic. It is important that laboratory services are available to guide the clinician to the correct diagnosis and treatment of these conditions, and to give an accurate epidemiological picture of their prevalence in a particular community but also to keep track of relevant populations and ensure optimal and economic use of available resources. Yet, the availability of both funds and technology varies widely between different settings.

This manual sets out to give comprehensive guidance on tests available and applicable to the level of expertise and funding available.

Nine chapters cover the major STDs, encompassing bacterial and viral infections, and under the umbrella of vaginitis in adults; trichomoniasis, candidiasis, and bacterial vaginosis. Each chapter begins with a brief description of the microbiology of the infective agent and the clinical spectrum of disease. The detail given is not consistent, being comprehensive for chancroid and granuloma inguinale, and surprisingly brief for HIV and chlamydia by way of contrast. Then follows a description of collection and transport requirements, and of techniques for diagnosis. The emphasis is on tests that are possible in a reasonably well equipped laboratory, and those of reference facilities. Tests that are suitable for use in the field are highlighted. An evaluation of sensitivity and specificity is also given. Other tests available in central or reference laboratories are mentioned in brief, usually with supporting references.

Two annexes cover media, reagents and stains, and details of equipment required to diagnose each condition. A third annex is an interesting table of which tests should be available at “peripheral,” “intermediate,” and “central” laboratories.

Overall, this manual is to be welcomed as an educational and reference source for medical microbiologists, technologists, and clinicians. However, I would recommend that the authors “road test” the manual to discover omissions in technical detail that would prevent the sole use of the manual in the field.

Indifferent colour reproduction detracts from the quality of the text—for example, blue reactions appearing as red in the figure. For the next edition, a chapter on basic microscopical techniques and another on the general principles and interpretation of laboratory tests would provide useful introductions to an otherwise excellent publication.

R S MORTON

Facing HIV: A Resource for Primary Healthcare. Contributors: Annalisa Rossi, Margaret Allen, Sirrka-Liisa Nurkkala, Begona Gros, Cristina Martinez-Bueno. £29.38. East Lancashire Health Authority, South Lancashire Health Authority, University of Central Lancashire, The Faculty of Health, and The Centre for Learning Technologies at the University of Central Lancashire.

This is an interesting CD Rom which gives a very personal guide to issues surrounding HIV—covering the experience of the patient, carer and healthcare professional.

Four main sections cover the following areas: Living with HIV, Is HIV different? Loss, grieving and bereavement, Supporting people affected by HIV.

These areas are illustrated by short video clips and backed up by further information. Basic information is given about HIV treatment, the impact of diagnosis and of illness, and other related topics. Unfortunately the information about drug treatment is already outdated and there is no search facility.

The strength of this CD Rom is the way it gives the emotional responses to HIV and the strategies for coping with the infection from the viewpoint of those involved. The academic content is limited but it is worth a look for the patient perspectives.

SARAH EDWARDS

Department of GU Medicine, West Suffolk Hospital, Bury St Edmunds, Suffolk, IP32 9GZ

CD-ROM REVIEWS


This is a superb CD Rom covering various aspects of HIV and AIDS by means of interactive tutorials. It is clear, concise, and up to date and has tutorials under the following headings: Overview, Biology of HIV, Natural history, Infections and malignancies, Epidemiology, Transmission and risk factors, Prevention, Diagnosis and monitoring, Women and children, Management, Social and psychological issues.

Each tutorial is self contained (which does lead to some duplication) and has self assessment questions—usually with click and drag matching of statements or true/false boxes. The information itself is well illustrated and contains animations and a video clip, together with further information/announcements in pop up boxes. At the end of each section there is a set of summary points, a reading list, and further activities such as internet sites.

There is a searchable picture index which allows you to search, view, and save sets of images for reference and lectures (although copyright does apply), and a glossary of terms. Overall this is an excellent CD Rom providing good information, presented in an attractive and usable way, with a wealth of illustrations. I would strongly recommend it.

SARAH EDWARDS

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Letters, Book reviews, CD-ROM reviews, Notices, Correction, Current publications
NOTICES

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: sisbox@aol.com)

Sexually Transmitted Diseases in a Changing Europe, 14–15 April 2000, Rotterdam, The Netherlands

Further details: Mediscon, Organisation for Medical Congresses, PO Box 113, 5660 AC Geldrop, Netherlands (tel: +31-(0)40-2852212; fax: +31-(0)40-2851966; email: MEDISCON@IAEh.nl)

20th Scientific Conference of Venereological Section of the Polish Society of Dermatologists, Bielystok, 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, 15-679 Bielystok, Poland (tel/fax: (085) 7422778; email: bozchod@amb.ac.bialystok.pl)

Joint meeting of the MSSVD and the ASTD, 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@bbam.ac.uk)

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Advanced Course in Fetal Medicine, 22–24 May 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: symprog@ic.ac.uk)

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Advanced Course for Obstetricians and Gynaecologists, 19–23 June 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: symprog@ic.ac.uk)

Australasian Sexual Health Conference, Ven Troppro, 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)

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Caring for Sexuality in Health and Illness (for healthcare professionals and nurses), jointly with Association of Psychosexual Nursing 27 June 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: symprog@ic.ac.uk)

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Advanced Course in Fetal Medicine, 22–24 May 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: symprog@ic.ac.uk)

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Advances in Obstetric Medicine: International Meeting of Obstetric Medicine Societies (satellite to ISSHP, Paris, 6–7 July 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: symprog@ic.ac.uk)

XIII International AIDS Conference, 9–14 July 2000, Durban, South Africa

Further details: Congrex Sweden AB, PO Box 5619, Linnegatan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 661 91 25; email: aids2000@congrex.se)


Further details: Congrex Sweden AB, PO Box 5619, Linnegatan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 661 91 25; email: aids2000@congrex.se)

An error occurred in an original article by Hughes et al that appeared in the February issue of the journal (2000;76:18–24). In the participants section under West Midlands, “Dr Wade, Coventry and Warwickshire Hospital” should read “Dr Wade and Dr Allan, Coventry and Warwickshire Hospital.”

CORRECTION

CURRENT PUBLICATIONS

Selected titles form recent reports published worldwide are arranged in the following sections:

- Gonorrhoea
- Chlamydia
- Cervical dysplasia
- Cervical intraepithelial neoplasia
- Bacterial vaginosis
- Trichomoniasis
- Syphilis and other treponematoses
- Pelvic inflammatory disease
- Human papillomavirus infection
- Herpes
- Other sexually transmitted infections
- Microbiology and immunology
- Dermatology
- Miscellaneous
Gonorrhoea

*Neisseria gonorrhoeae* infections in girls younger than 12 years of age are seen for vaginitis.


Opa expression correlates with elevated transformation rates in *Neisseria gonorrhoeae*.


Chlamydia

*Chlamydia trachomatis* infection as a risk factor for invasive cervical cancer.

P. Koskela, T. Anttila, T. Björk et al. *Int J Cancer* 2000;85:35–9

Screening for *Chlamydia trachomatis* in subfertile women.

S. Macmellan, A. Templeton. *Hum Reprod* 1999;14:3009–12

Analysis of *Chlamydia trachomatis* serovars in endocervical specimens derived from pregnant Japanese women.


Molecular epidemiology of genital *Chlamydia trachomatis* infection in high-risk women in Senegal, West Africa.


Evaluation of a rapid assay for detection of *Chlamydia trachomatis* infections in outpatient clinics in South Kalimantan, Indonesia.


Seroactivity to *Chlamydia trachomatis* Hsp10 correlates with severity of human genital tract disease.


Immunogenic and protective ability of the two developmental forms of *Chlamydia* in a mouse model of infertility.


Subclinical chlamydial infection of the female mouse genital tract generates a potent protective immune response: implications for development of live attenuated chlamydial vaccine strains.


Isolates of *Chlamydia trachomatis* that occupy nonfusogenic inclusions lack IncA, a protein localized to the inclusion membrane.


The intercellular adhesion molecule 1 is required for rapid activation of T helper type 1 lymphocytes that control early acute phase of genital chlamydial infection in mice.


Candidiasis

Species and genotypic diversities and similarities of pathogenic yeasts colonizing women.


Isolated candidal prostatitis.

A. Elet, R. Vandenbroeck, R. Nusser et al. *J Urol* 2000;163:244

Multilocus genotypes and DNA fingerprints do not predict variation in azole resistance within clinical isolates of *Candida albicans*.


Bacterial vaginosis

Prevalence of bacterial vaginosis and correlation of clinical to gram stain diagnostic criteria in low risk pregnant women.


Direct or referral microscopy of vaginal wet smear for bacterial vaginosis: experience from an STD clinic.


Trichomoniasis

Improved diagnosis of *Trichomonas vaginalis* infection by PCR using vaginal swabs and urine specimens compared to diagnosis by wet mount microscopy, culture and fluorescent staining.


Use of spun urine to enhance detection of *Trichomonas vaginalis* in adolescent women.


Identification of *Trichomonas vaginalis* α-actin as the most common immunogen recognized by sera of women exposed to the parasite.


Pelvic inflammatory disease


Patterns of diagnosis and referral in women consulting for chronic pelvic pain in UK primary care.


Syphilis and other treponematoses

Response to standard syphilis treatment in patients infected with the human immunodeficiency virus.


Identification of *Treponema pallidum* subspecies *pallidum* in a 200-year-old skeleton specimen.


Validation of the INNO-LIA syphilis kit as a confirmatory assay for *Treponema pallidum* antibodies.


Hepatitis

Low risk of vertical transmission of hepatitis C virus by breast milk.


Urine from chronic hepatitis B virus carriers: implications for infectivity.


Herpes

Prevalence and incidence of herpes simplex virus type 2 infection among male Zimbabwean factory workers.


Relation between herpes simplex viruses and human immunodeficiency virus infections.

Persistent stress as a predictor of genital herpes recurrence.

Rapid detection of HSV from cytologic specimens collected into ThinPrep fixative.

Treatment of primary herpes simplex virus infection in guinea pigs by imiquimod.

Protective immune correlates can segregate by vaccine type in a murine herpes model system.

Cellulose acetate phthalate (CAP): an ‘inactive’ pharmaceutical excipient with antiviral activity in the mouse model of genital herpesvirus infection.

Co-infection of acyclovir-resistant and acyclovir-sensitive herpes simplex type 2 virus strains in BS-C-1 cells.
K KEVYAN, E KATZ. Intervirology 1999;42:247–51

Immune responses and protection against vaginal infection after nasal or vaginal immunization with attenuated herpes simplex virus type-2.
EL PARR, MB PARR. Immunology 1999;98:639–45

Immunity induced by DNA immunization with herpes simplex virus type 2 glycoproteins B and C.
JC MESTER, TA TWOMEY, ET TEPE, DI BERNSTEIN. Vaccine 1999;18:875–83

Persistence of infectious herpes simplex virus type 2 in the nervous system in mice after antiviral chemotherapy.

Repression of viral transcription during herpes simplex virus latency.

The major neutralizing antigenic site on herpes simplex virus glycoprotein D overlaps a receptor-binding domain.

Herpes simplex virus type 2 glycoprotein G-negative clinical isolates are generated by single frame shift mutations.

Potential role for luman, the cellular homologue of herpes simplex virus VPA16 (a gene trans-inducing factor) in herpesvirus latency.

Granzyme A, a noncytotoxic component of CD8(+) cell granules, restricts the spread of herpes simplex virus in the peripheral nervous systems of experimentally infected mice.

Intracellular localization of the UL31 protein of herpes simplex virus type 2.

Human papillomavirus infection

Pernicious papillomavirus infection.
RB BURK. N Engl J Med 1999;341:1687

Type-specific persistence of human papillomavirus DNA before the development of invasive cervical cancer.

Epidemiology of acquisition and clearance of cervical human papillomavirus infection in women from a high-risk area for cervical cancer.

HPV transmission—still feeling the way.
A MINDEL, RS TIDEHOLM. Lancet 1999;354:2097

HPV DNA testing of self-collected vaginal samples compared with cytologic screening to detect cervical cancer.
TC WRIGHT, L DEJNY, L KOHN et al. JAMA 2000;283:81–6

HPV DNA testing in cervical cancer screening: results from women in a high-risk area for cervical cancer.
EL FRANCO, LL VILLA, JF SORRINHO et al. JAMA 2000;283:87–93

Human papillomavirus testing for primary cervical cancer screening.

HPV-based cervical cancer screening in a population at high risk for HIV infection.
SD WOZACK, ZH CHEN, B GAFFIN et al. Int J Cancer 2000;85:206–10

Screening for cervical neoplasia by self-assessment for human papillomavirus DNA.

Spontaneous evolution of human papillomavirus infection in the uterine cervix—a prospective observational study.

Seroreactivity to human papillomavirus type 16, 18, 31 and 45 virus-like particles in a case-control study of cervical squamous intraepithelial lesions.

Anal intraepithelial neoplasia.

A randomized, controlled, safety study using imiquimod for the topical treatment of anogenital warts in HIV-infected patients.

Human papillomavirus type 16 E6 variants in cervical carcinomas: relationship to host genetic factors and clinical parameters.

Favorable clinical outcome of cervical cancers infected with human papilloma virus type 58 and related types.
HC LAG, CA SUN, MY YU et al. Int J Cancer 1999;84:535–7


Improved amplification of genital human papillomaviruses.

Additional human papillomavirus types detected by the hybrid capture tube test among samples from women with cytological and colposcopical atypia.

PCR-RFLP-detected human papilloma virus infection in a group of Senegalese women attending an STD clinic and identification of a new HPV-68 subtype. 

Detection of human papilloma virus genomes by the primed in situ (PRINS) labelling technique.

DNA vaccination of mice with plasmid expressing human papillomavirus 6 major capsid protein L1 elicits type-specific antibodies neutralizing pseudovirions constructed in vitro.

Capture ELISA and in vitro cell binding assay for the detection of antibodies to human papillomavirus type 6b virus-like particles in patients with anogenital warts.
SW PENG, YM QI, NC CHRISTENSEN et al. Pathology 1999;31:418–24

Detection of high-risk cervical intraepithelial neoplasia and cervical cancer by amplification of transcription derived from integrated papillomavirus oncoproteins.
Antibodies against oncoproteins E6 and E7 of human papillomavirus types 16 and 18 in cervical-carcinoma patients from Russia.

HPV 16 E6 blocks TNF-mediated apoptosis in mouse fibroblasts LM cells.
P J DUERKSEN-HUGHES, J YANG, SB SCHWARTZ. Virology 1999;264:55–65

CD4(+) tumor-infiltrating lymphocytes in cervical cancer recognize HLA-DR-restricted peptides provided by human papillomavirus-E7.

The E6 protein of human papillomavirus type 16 binds to and inhibits co-activation by CBP and p50.
D PATEL, SM HUANG, LA BAGLIA, DJ MCCANCE. EMBO J 1999;18:5061–72

The human papillomavirus type 16 E5 protein modulates phospholipase C-γ-1 activity and phospatidyl inositol turnover in mouse fibroblasts.
K CRUSIOS, M KASZKIN, V KINZEL, A ALONSO. Oncogene 1999;18:6714–8

Interaction between the HPV-16 E2 transcriptional activator and p53.
P MASSIMI, D PIM, C BERTOLI et al. Oncogene 1999;18:7748–54

The E8/E2C protein, a negative regulator of viral transcription and replication, is required for extrachromosomal maintenance of human papillomavirus type 31 in keratinocytes.

The differentiation-specific factor CDP/C can repress transcription and replication of human papillomaviruses through a conserved silencing element.

Cervical cytology and colposcopy

Cervical cytology after 2000: where to go?

Comparative evaluation of seven cell collection devices for cervical smears.

Efficacy of cervical smear collection devices: a systematic review and meta-analysis.
P MARTINSHERSCH, R LIFORD, G JARVIS, HC KITCHENER. Lancet 1999;354:1763–70

Detection of false-negative Papanicolaou smears by rapid rescreening in a large routine cervical cytology laboratory.
BG WRIGHT, JA HALFORD, DJ DITCHMAN. Pathology 1999;31:379–81

Determining the cost-effectiveness of mass screening for cervical cancer using common analytic models.

A prototype computer image-based Panpanicolaou smear proficiency test.

The diagnostic value of computer-assisted primary cervical smear screening: a longitudinal cohort study.
H DOORENBLOAARD, YT VANDELSOCH, Y VANDERGAFT et al. Mod Pathol 1999;12:995–1000

Detection of human herpesvirus 8 in cervical cells of Chinese women with abnormal Papanicolaou smears.

A study of the follow up patterns of women treated for CIN 2 and 3 before and after the introduction of the 1992 guidelines.
CH MANN, S KEOH, A BROWN, CM LUESSE. Br J Obstet Gynaecol 1999;106:1126–9

Cidofovir, a new approach for the treatment of cervix intraepithelial neoplasia grade III (CIN III).

Effects of chemotherapy and tamoxifen on cervical and vaginal smears in bone marrow transplant recipients.

Serum carotenoids and vitamins and risk of cervical dysplasia from a case-control study in Japan.

Vaginal 5-fluorouracil for high-grade cervical dysplasia in human immunodeficiency virus infection: a randomized trial.

Preclinical feasibility study of NMP179, a nuclear matrix protein marker for cervical dysplasia.

Fhit alterations in cancerous and non-cancerous cervical epithelium.

Other sexually transmitted infections

A randomized, double-blind, placebo-controlled trial of single-dose ciprofloxacin versus erythromycin for the treatment of chancroid in Nairobi, Kenya.
IM MALONZA, MW TYNDALL, JO INOYAYACHO et al. J Infect Dis 1999;180:18693

Cytoreductive distorting toxin of Haemophilus ducreyi induces apoptotic death of Jurkat T cells.

Public health and social aspects

Encouraging use of coupons to stimulate condom purchase.

Microbiology and immunology

Human herpesvirus 8 cellular immune responses in homosexual men.

Correlation of behaviours with microbiological changes in vaginal flora.
JR SCHWERKE, CM RICHET, HL WEISS. J Infect Dis 1999;180:1632–6

The identification of vaginal Lactobacillus species and the demographic and microbiologic characteristics of women colonized by these species.
MAJ ANTONIO, SE HARLES, ML HILLER. J Infect Dis 1999;180:1950–6

Common mucosal immunity: a novel hypothesis.
FA MOORE. Ann Surg 2000;231:9–10

Immunoglobulin concentrations and antigen-specific antibody levels in cervico-vaginal lavages of rhesus macaques are influenced by the stage of the menstrual cycle.

Evaluation of the bacterial flora of the prostate using a 16s rRNA gene based polymerase chain reaction.

Dermatology

Incidence of preputial lichen sclerosus in adults: histologic study of circumcision specimens.

Penile cancer among patients with genital lichen sclerosus.
Vulvar lichen sclerosus: an immunologic study.
F SCRRMN, S RUSTIA, R RARILLO et al. Obstet
Gynecol 2000;95:147–50

Guidelines for management of Bowen's
disease.
NH COX, DJ SEIDT, GA MORTON. Br J Dermatol
1999;141:633–41

Vulvar melanoma, biologically different
from other cutaneous melanomas.
CJ DUNTON, DBERD. Lancet 1999;354:2013

Cytomegalovirus balanitis in a renal
transplant recipient.
A RODRIGUEZ, B HILL, RGOPOLAN, GN SKLAR. J
Urol 1999;162:2086

The imidazolesquinoines, imiquimod and
R-48 induce functional but not pheno-
typic systemic vasculitis.
RF BURNS, BFEBEL, MMH TONAI. J Med
1999;354:2013

Miscellaneous

The staying power of sexually transmitted
diseases.
W CATES, G DALLABETTA. Lancet 1999;354:62

Breaking the silence surrounding rape.
S RAMSAY. Lancet 1999;354:2018

Seasonal variations in sexual activity and
their implications for sexual health
promotion.
K WILLING, WMACDOWALL, MCATCHPOLS, J
GOODRICH. J Roy Soc Med 1999;92:60–4

Future change in sexual behaviour?

Symptoms of reproductive-tract
infection—not all that they seem to be.
K TROLLOPEKUMAR. Lancet 1999;354:1745

Reproductive-tract infections in women in
low-income, low prevalence situation: assessment of
syndromic management in
Matlab, Bangladesh.
S HAWES, LMORISON, SFOSTER et al. Lancet
1999;354:1776–81

High prevalence and incidence of sexu-
ally transmitted diseases in urban ado-
lescent females despite moderate risk behaviors.
RE BUNNELL, LHALHBERG, RBOLPS et al. J Infect
Dis 1999;180:1624–31

Sexual and reproductive health: what
about boys and men: Education and
service provision are the keys to increas-
ing involvement.
G VAMEY. BMJ 1999;319:1315

Male adolescents and physician sex pref-
erence.
CJ VANNESS, DALYNCH. Arch Pediat Adolesc Med
2000;154:49–54

Repeated school-based screening for
sexually transmitted diseases: a feasible
strategy for reaching adolescents.
DA COHEN, MNSUAMI, DH MARTIN, TA FARLEY. Pediatrics
1999;104:1281–5

Lesbians' sexual history with men: im-
plications for taking a sexual history.
AL DIAMANT, MASCHESTER, MMCGURAN, J
LEVER. Arch Intern Med 1999;159:2730–8

Hysterectomy and sexual function.
JG RHODES, KEJRULFF, BKANGENBERG, GM
GUZINSKI. JAMA 1999;282:1934–41

Perineal anatomy and urine-voiding
characteristics of women with and
without recurrent urinary tract infec-
tions.
TM HUTTON, AE STAPLETON, PL ROBERTS et al. Clin Infect Dis
1999;29:1600–1

Prophylactic antibiotics for intrauterine
device insertion: a metaanalysis of the
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DGRIEMES, RF SCHULZ. Contraception
1999;60:57–64

Genital pain without urogenital pathol-
y: the koro-like syndrome.
JCABALLEDO, AVILA, XCARDONA et al. J Urol
2000;163:243

Neurochemical characterization of the
vestibular nerves in women with vulvar
vestibulitis syndrome.
NLINDSTARR, MHILLEGIES, CFALCONER, ER
BYLANDER. Gynecol Obstet Invest 1999;48:
270–5

Acupuncture for vulvodynia.
1999;92:579–81

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avid bicycling.
VSRICHTU, CAAHAS, ADSFETEL et al. J Urol
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Prostate histopathology and the chronic
prostatitis/chronic pelvic pain syn-
drome: a prospective biopsy study.
LDTRUE, JBERGER, RROTHMAN et al. J Urol
1999;162:2014–8

Asthma and epididymitis: the calm be-
fore the storm.
GHMGEORGE, JAXFORD. Ann Rheum Dis
1999;58:731–6

Male impotence.
AMORENTALER. Lancet 1999;354:1713–8

Lack of diagnostic tools to prove erectile
dysfunction: consequences for reim-
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KLEHMANN, RECHLISBERGER, TCASSER. J Urol
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Treatment of intracorporeal injection
nonresponse with sildenafil alone or in
combination with triple agent intracor-
pororeal injection therapy.
CMACKNHON, RSAMALI, HJOHNSON. J Urol
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ment of Peyronie's disease.
CTELKEN, EHRHODEN, TMGrazzitien et al. J

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nie's disease.
CRIEDEL, PFLAS, PENGELHARDET et al. J Urol
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approach to clinical care.
AFWHALLETT, GTHURRAIAN, JHAMBURGER et al. Q J Med
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Is there a place for large vessel disease in
the diagnostic criteria of Behcet's dis-
ease?
M SCHIRMER, KTCALAMA, JODUFFY. J Rheumatol
1999;26:2511–2

Secondary inflammation of the appendix
via the vagina.
SABUTRMANUEN, PTOWNSEND. J Roy Soc Med
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Two forms of reactive arthritis?
P TOVANEN, PTOVANEN. Ann Rheum Dis
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Reactive or infectious arthritis.
JKKULPERA, HKOHBER, HZEDKLER. Ann Rheum Dis
1999;58:661–4

Beaver fever—a rare cause of reactive
arthritis.
MTINCHONG, ASIMOR, CDEWAR. J Rheumatol
1999;26:2701–2