Successful treatment of recalcitrant condyloma with topical cidofovir

Editor,—Despite the high prevalence of condyloma 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 therapy. Antiviral agents (phosphonylmethylether nucleosides) are a new class of antiviral agents (phosphonylmethylether nucleotide analogues). It shows potent activity against a broad spectrum of herpesviruses, including human cytomegalovirus (CMV), HSV-1 and HSV-2, and adenoviruses. Recent in vitro and in vivo studies have demonstrated activity against papillomavirus and poxvirus.

Cidofovir is a nucleotide analogue of deoxyadenosine monophosphate (dCMP). Analogous to the metabolism of dCMP to dCTP, cidofovir is converted to the active cidofovir diphosphate that inhibits viral DNA polymerase. The drug is slowly metabolised in vivo; cells are killed, but the intracellular half-life of the various metabolites is between 6 and 87 hours, thus allowing frequent dosing. Compared with the general mechanism of activation of cidofovir, which requires phosphorylation by the virus encoded UL97 gene, cidofovir does not depend on viral infection for its phosphorylation and can therefore prime cells to an antiviral state (prophylaxis).

The metabolism of cidofovir is negligible, since the majority (>80%) is recovered unchanged in the urine. The principal systemic toxicity (nephrotoxicity) can be avoided by topical application. This initial case report suggests that topical cidofovir may represent a valuable addition to the armamentarium of hard to treat condyloma. However, a careful evaluation of the dose and frequency of cidofovir application is warranted.

U R HENGGE
Department of Dermatology and Venereology, University of Essen, Hufelandstrasse 55, 45122 Essen, Germany

G YETTZE
Hospital Pharmacy, University of Essen, Hufelandstrasse 55, 45122 Essen, Germany

Correspondence to: U R Hengge
dermatology@uni-essen.de


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Bladder carcinoma presenting to genitourinary medicine departments

Editor,—Large numbers of patients are seen in departments of genitourinary medicine with symptoms suggesting infection and inflammation of the genitourinary tract. Although bladder neoplasms typically cause painless haematuria, in a subgroup of patients they cause other urinary symptoms that may precede diagnostic confirmation. We identified five patients who were referred to the genitourinary medicine service, and who were found to have bladder carcinoma (see table 1). Four of the patients presented to the genitourinary medicine department at High Wycombe (5500 new attendances per annum) between 1991 and 1998; the fifth patient presented to the Oxford genitourinary medicine department (9000 new attendances per annum) in 1997. None of the patients had an occupational history that placed them at higher risk for bladder cancer.

Men with bladder carcinoma typically present in later life (median age 70 years), but the condition may occur at younger ages. A subgroup of patients develops 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.

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 at presentation; he was referred by his general practitioner with suspected haematuria.
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</td>
<td>ND</td>
<td>Well differentiated bladder papillary TCC; non-invasive; recurred</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</td>
<td>ND</td>
<td>Poorly differentiated adenocarcinoma; bladder calculus also present; tumour resection, 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 penile and suprapubic pain; frequency, dysuria</td>
<td>Blood +ve</td>
<td>Malignant</td>
<td>Extensive transitional cell carcinoma in situ, involving prostatic urethra; prostatic adenocarcinoma</td>
</tr>
<tr>
<td>4</td>
<td>42</td>
<td>No</td>
<td>GP</td>
<td>Sterile pyuria ?case</td>
<td>1 year penile and perineal pain; frequency, dysuria</td>
<td>Blood +ve</td>
<td>Malignant</td>
<td>Extensive TCC plus carcinoma in situ, involving prostatic urethra; prostatic adenocarcinoma</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</td>
<td>Suspicious</td>
<td>Poorly differentiated TCC at bladder neck; muscle invasion; prostatic adenocarcinoma, and chemotherapy</td>
</tr>
</tbody>
</table>

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

Atrial myxoma and HIV infection

Editor,—Atrial myxoma has not previously been reported in HIV infection. We describe a patient with advanced HIV disease who underwent surgery for this condition.

The patient was diagnosed with asymptomatic HIV infection in February 1987 when she was aged 50 years. Her CD4 count was 690 ×10^6/l at this time. HIV infection was acquired as a result of a commercial sexual bisexual male partner. In December 1990 the CD4 lymphocyte count had fallen to 190 ×10^6/l and zidovudine monotherapy was started. This was followed in 1996 when she was prescribed a combination regimen. Co-trimoxazole was given for Pneumocystis carinii prophylaxis, but the patient deferred starting this until December 1992.

In February 1990 the patient was admitted to another hospital with an acute myocardial infarction which was successfully thrombolysed. Fasting lipids were within the normal range. There were no cardiac risk factors apart from smoking.

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 ×10^6/l, 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 uncomplicated 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. Current CD4 count is 564 ×10^6/l and viral load less than 30 copies/ml (Chiron bDNA v3.0).

Atrial myxoma is a rare tumour that is considered to be benign unless recurrence and metastases have been described.1 The myocardial infarction suffered by our patient may have been an embolic manifestation of the myxoma, and the normal serum lipids and normal coronary angiogram almost 4 years later would support this.

In 1995 expert opinion provided a very guarded prognosis for someone with a CD4 count of 60 ×10^6/l who had been exposed to a single antiretroviral agent, zidovudine. Today there would be less debate over the merits of such a surgical procedure in this scenario, and this case demonstrates the excellent outcome that can be achieved with major surgery despite profound immunosuppression. The proved benefits of HAART (highly active antiretroviral therapy) have made it unacceptable to deny major surgical interventions to individuals with HIV.

Andrew J Shaw
Ken A McLean

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 biological and microbial abnormalities in the vagina? Furthermore, mechanical transfer of infectious agents in lesbian couples is most likely to occur via culcos, a not uncommon practice among lesbians.

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 biological and microbial abnormalities in the vagina? Furthermore, mechanical transfer of infectious agents in lesbian couples is most likely to occur via culcos, a not uncommon practice among lesbians.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>BV prevalence results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lesbians</td>
</tr>
<tr>
<td></td>
<td>No of women</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
</tr>
<tr>
<td>Practised receptive culcos in previous 4 weeks</td>
<td>9</td>
</tr>
<tr>
<td>Did not practise receptive culcos</td>
<td>8</td>
</tr>
<tr>
<td>Heterosexual women</td>
<td>256</td>
</tr>
<tr>
<td>Practised receptive culcos in previous 4 weeks</td>
<td>111</td>
</tr>
<tr>
<td>Did not practise receptive culcos in past 4 years</td>
<td>145</td>
</tr>
</tbody>
</table>

Only when it becomes widely known in a clinic that such confidentiality is thoroughly pursued will counterproductive fears be eliminated. With understanding and cooperation it can be done.

SAKINA RASHID
Department of Genito-Urinary Medicine, Sunderland Royal Hospital, Kayll Road, Sunderland SR4 7TP


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 national 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 much more often reported than condom adoption.1 If sizeable numbers of men reduce their number of sexual partners, can this have significant impact on HIV infection rates? Urban HIV serorelevance among the general or low risk Dominican population seems to have stabilised at the 1.9–2.0% 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 condom use in number of partners can have a great impact on averting HIV infections, in fact greater than either condom use or treatment of STDs.2 Of course, impact of partner reduction on HIV infection rates would be especially strong where there is relatively high HIV serorelevance 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.

EDWARD C GREEN
ALDO CONDE
2807 38th Street, NW, Washington, DC 20007, USA
Correspondence to: Dr Green


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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 1997 were 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. The tendency 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) × 109/L, while an increase in the mean patient age was highly significant (39.8 (8.3) versus 34.6 (7.7) years; p<0.001). 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 to a reduction in cytomegalovirus, cryptococcosis, mycobacteriosis, cryptocapsorindosis, and HIV encephalopathy, while a relative increase in pneumocystosis, toxoplasmosis, 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...
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, wasting, 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 neurotoxoplasmplasia. However, this increase in CD4+ count was significant only for Candida infection (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 following the introduction of HAART, the distribution of primary AIDS associated diseases showed limited modifications.13 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, cryptosporidiosis, mycobacteriosis, cryptocoeciosis, 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.13 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.13,14 However, opportunistic diseases related to a severe immunodeficiency are still frequent among AIDS defining events, since the majority of cases identified during the 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.

ROBERTO MANFREDI
FRANCESCO CHIODO
Department of Clinical and Experimental Medicine, Division of Infectious Diseases, University of Bologna, Bologna, Italy

Correspondence to: Dr Roberto Manfredi, Department of Clinical and Experimental Medicine, Division of Infectious Diseases, University of Bologna, S Orsola Hospital, Via Massarenti, 1, I-40138 Bologna, Italy

5 Lee MG, De Winder L, McDonald A, Cooper DA, Kaldor JM. AIDS diagnoses at higher CD4 counts in Australia following the introduction of highly active antiretroviral treatment. AIDS 1999;13:263-9.

Accepted for publication 25 February 2000

BOOK REVIEWS

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 Kedgworth/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 3315; 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/dfhm/europap/hustling.pdf.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 people that, for many, sexual health is not a priority. We are perplexed when faced with...

“Venerable diseases are like the fine arts—it is pointless to ask who invented them.” (Voltaire, Dictionary of philosophy). 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 for females and males) suffer from a wide range of mental health problems of variable degrees of severity from social ineptitude through to 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, premarital 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 fractionalised.

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 accident and emergency departments, obstetric and gynaecology departments, and genitourinary medicine departments. These deal very adequately with self poisoning episodes, premarital 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 fractionalised.

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.

Thus, we see the need for a book which gives of the emotional responses to HIV and AIDS and provides good information, presented in an attractive and usable way, with a wealth of illustrations. I would strongly recommend it.

SARAH EDWARDS
Department of GU Medicine, West Suffolk Hospital, Bury St Edmunds, Suffolk, IP32 9QZ

Facing HIV: A Resource for Primary Healthcare. Contributors: Annalisa Rossi, Margaret Allen, Sirrka-Lisa Nurtkkala, 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 ill health, 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 view it gives of 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 9QZ
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: isidbox@aol.com).

Sexually Transmitted Diseases in a Changing Europe, 14–15 April 2000, Rotterdam, The Netherlands
Further details: Medison, Organisation for Medical Congresses, PO Box 113, 5560 AC Geldrop, Netherlands (tel: +31-(0)40-2852212; fax: +31-(0)40-2851966; email: MEDISON@IAEvh.nl).

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

Joint meeting of the MSSVD and the ASTDA, 3–7 May 2000, Baltimore Marriott 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 Troppo, Carlton Hotel, Darwin, Northern Territory, 21–24 June 2000
Further details: Shirley Conley, 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).

Sexual Health and HIV Conference: Facing the Millennium, Portsmouth Marriott Hotel, Portsmouth, 28 June 2000
Further details: Rebecca Mitchell (tel: 023 9286 6796; fax: 023 9286 6769).

6th ESC Congress on Contraception in the Third Millennium: a (R)Evolution in Reproductive and Sexual Health, Lubjijana, Slovenia, 28 June–1 July 2000
Further details: Orga-Med Congress Office, Mr Peter Erard, Eissenstraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 19; email: orgamed@village.uynet.be).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, New Horizons in Recurrent Pregnancy Loss, 29 June–1 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).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Bereavement, 5 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).

CorreCTION
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.”

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

Gonorrhoea
Chlamydia
Candidiasis
Bacterial vaginosis
Trichomoniasis
Pelvic inflammatory disease
Syphilis and other treponematoses
Hepatitis
Herpes
Human papillomavirus infection
Cervical cytology and colposcopy
Other sexually transmitted infections
Public health and social aspects
Microbiology and immunology
Dermatology
Miscellaneous
Gonorrhea

Neisseria gonorrhoeae infections in girls younger than 12 years of age evaluated for vaginitis.
RA SHAPIRO, CJ SCHYBERT, RM SIEGEL. Pediatrics 1999;104:721–30

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 ANTILA, T BJORK et al. Int J Cancer 2000;85:35–9

Screening for Chlamydia trachomatis in subfertile women.
S MACMILLAN, 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.
S PAIL, J RANGEL, EM PETERSON, LM DELAMAZA. Vaccine 1999;18:752–63

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 type-1 is required for rapid activation of CD4+ T helper type 1 lymphocytes that control early acute phase of genital chlamydial infection in mice.
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