LETTERS TO THE EDITOR

Successful treatment of recalcitrant condylomata 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 1–3% 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, electrodissection, or trichloroacetic acid) or the interruption of cell division (podophylox, 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 patient’s history was remarkable for diabetes mellitus. He presented with numerous, flesh coloured, flat topped papules in a circular manner on the outer preputium and the glans, which led to the diagnosis of invasive condylomata acuminata in the coronary sulcus had a more verruciform appearance (fig 1). Thereafter, the patient was treated with podophylox, and imiquimod. The patient presented to the Oxford genitourinary medicine department (9000 new attendances per year) on a urethral discharge. Both patients were negative for Chlamydia trachomatis, Neisseria gonorrhoeae, and genital human papillomavirus. The patient’s urine was negative for human papillomavirus DNA as determined by PCR analysis of urethral cell DNA. Despite these results the patient presented weekly to the genitourinary medicine clinic for podophylox and imiquimod treatment, which resulted in remission of the lesions.

Cidofovir was evaluated in the indicator phase study for the treatment of external anogenital warts. The metabolism of cidofovir is negligible, and its principal mechanism of action is cell cycle arrest through inhibition of viral DNA polymerase. Cidofovir was also reported as effective in the treatment of molluscum contagiosum in children. Cidofovir was not well tolerated in this study, but it did result in remission of the lesions.

Cidofovir is a nucleotide analogue of deoxyctydine monophosphate (dCMP). Analogous to the metabolism of dCMP to dCTP, cidofovir is converted to the active cidofovir diphosphate that inhibits viral DNA polymerase when it is incorporated into DNA. Since the majority (>80%) is recovered unchanged in the urine, the principal systemic toxicity (nephrotoxicity) can be avoided by topical application. The 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.

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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 suggestive of infection or inflammation of the genitourinary tract. Although bladder neoplasms typically cause painless haematuria, in a subgroup of patients they cause other urinary symptoms that may produce diagnostic confusion. 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 these patients presented to the genitourinary medicine department at High Wycombe (5000 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 develop frequency, urgency, and dysuria—symptoms usually associated with bladder infection. Rarely, penile and perineal pain mimicking prostatic or static 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

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Figure 1 Condylomata acuminata with some lesions in the coronary sulcus having a more verruciform appearance.
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 through anal intercourse with a bisexual male partner. In December 1990 the CD4 lymphocyte count had fallen to 190 ×10^6/l and zidovudine monotherapy was started. This continued until 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 she 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 an 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. This was continued until 1996 when she was prescribed a combination regimen.

In a parallel prospective study of 256 consecutive heterosexual female patients attending the same department, 55 (21%) were diagnosed as having BV. Of 111 women who practised receptive cunnilingus in the previous 4 weeks, 67% had BV. By contrast, no BV was present in all eight women who did not practise oral sex (table 1).

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 cunnilingus 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).
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 cumminus, a not uncommon practice among lesbians.

Cumannus 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.

<table>
<thead>
<tr>
<th>Table 1 BV prevalence results</th>
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<tbody>
<tr>
<td>Lesbians</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Practised receptive cunnilingus in previous 4 weeks</td>
</tr>
<tr>
<td>Did not practise receptive cunnilingus</td>
</tr>
<tr>
<td>Heterosexual women</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Practised receptive cunnilingus in previous 4 weeks</td>
</tr>
<tr>
<td>Did not practise receptive cunnilingus in past 4 weeks</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.

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Sexual partner reduction and HIV infection

EDITOR,—We recently conducted a national urban random sample survey of 1400 men of sexually active males in the Democratic 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 54.8% of a national random sample of Democratic 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.1 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.2 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 Democratic 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 flexible programmes that promote and provide condoms.

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Is partner notification in the public interest?

EDITOR,—This ethical debate3 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 any 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 observed. As such, contact tracing is called for in the contact tracing process.

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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 1995–99 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 period. A decrease in frequency 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 \times 10^9/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 noted to increase (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 pneumocystosis, Campbellia neoptophasitis, neurotoxoplasmosis, and Kaposi’s sarcoma was observed (table 1). However, while pneumocystosis, Campbellia neoptophasitis, cryptococcosis, and HIV encephalopathy were included in the most frequent AIDS related events in both study periods, cytomegalovirus, HIV encephalopathy, cryptosporidiosis, and mycobacteriosis (which ranked fifth to eighth in


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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 number of patients with increased mean CD4+ count was found during the HAART era for all AIDS related illnesses considered, except non-Hodgkin’s lymphoma or primary CNS lymphoma. Table 1 shows a slightly increased frequency during the pre-HAART era), extrapulmonary cryptococcosis, mycobacteriosis, and wasting syndrome.

**Table 1 AIDS defining events and mean CD4+ lymphocyte count at disease occurrence, in the two considered time periods**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Years 1985–95</th>
<th>Years 1997–9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(144 patients, 151 diseases)</td>
<td>(72 patients, 76 diseases)</td>
</tr>
<tr>
<td></td>
<td>No of cases (%)</td>
<td>Mean CD4+ count (cells ×10³/l (SD))</td>
</tr>
<tr>
<td>Oesophageal candidiasis</td>
<td>21 (33.3)</td>
<td>71.3 (98.1)</td>
</tr>
<tr>
<td>Kaposis’s sarcoma</td>
<td>5 (4.2)</td>
<td>48.0 (29.8)</td>
</tr>
<tr>
<td>Cryptococcosis</td>
<td>6 (4.0)</td>
<td>25.2 (19.4)</td>
</tr>
<tr>
<td>Extrapulmonary cryptococcosis</td>
<td>5 (3.3)</td>
<td>62.4 (41.1)</td>
</tr>
<tr>
<td>Wasting syndrome</td>
<td>5 (3.3)</td>
<td>38.4 (41.1)</td>
</tr>
<tr>
<td>Non-Hodgkin’s lymphoma</td>
<td>3 (2.0)</td>
<td>148.2 (51.4)</td>
</tr>
</tbody>
</table>
| Isolation pneumonia in patients 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. An increased incidence of women, 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, crypto- sporidiosis, and HIV encephalopathy, with a parallel increase in pneumocystosis, oesophageal candidiasis, wasting syndrome, tuberculosis, non-Hodgkin’s lymphoma), together with a considerable trend towards an increased mean CD4+ count at diagnosis, as previously noted. 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. 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 surveil- lance of AIDS related disorders remains critical for the implementation of therapeutic and prophylactic strategies.
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/annotations 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.

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Department of GU Medicine, West Suffolk Hospital, Bury St Edmunds, Suffolk, IP32 0QZ.

Facing HIV: A Resource for Primary Healthcare. Contributors: Annalisa Rossi, Margaret Allen, Sirrka-Lisa Nuutkkala, Begona Gros, Cristina Martinez-Bueno. £29.98. 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.

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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, 5660 AC Geldrop, Netherlands (tel: +31-(0)40-2852212; fax: +31-(0)40-2851966; email: MEDISON@IAEihv.nl).

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, MSSFV (tel: +44(0)121-237 5729; email: k.w.radcliffe@bham.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: symprop@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: symprop@ic.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.net.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: symprop@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, Ljubljana, 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.uneet.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: symprop@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: symprop@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: symprop@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: symprop@ic.ac.uk).

XIII International AIDS Conference, 9–14 July 2000, Durban, South Africa
Further details: Congrex Sweden AB, PO Box 5619, Linneagatan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 661 91 25; email: aids2000@congress.se).

Further details: Dr Wade and Dr Allan, Bromsgrove Stakis Hotel, 23–24 September 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.net.au).

National NCCG Uptake Meeting, Bromsgrove Stakis Hotel, 23–24 September 2000
Further details: Kathy Taylor (tel: 01384 235207; email: palmtranining@tesco.net).

Corrigendum
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:

Genorrhoea
Chlamydia
Candidiasis
Bacterial vaginosis
Trichomoniasis
Pelvic inflammatory disease
Syrphils 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 SCHUBERT, RM SIEGEL. Pediatrics 1999;104:E721–30


Chlamydia


Screening for Chlamydia trachomatis in subfertile women. S MACMILLAN, A TEMPLETON. Hum Reprod 1999;14:3009–12


Immunogenic and protective ability of the two developmental forms of Chlamydia in a mouse model of infertility. S PAL, J RANGEL, EM PETERSON, LM DELAMAZA. Vaccine 1999;18:752–63


The intercellular adhesion molecule type-I is required for rapid activation of T helper type 1 lymphocytes that control early acute phase of genital chlamydial infection in mice. JU GIETSEMIE, GA ANANBA, J BOLIER et al. Immunology 1999;98:510–8

Candidiasis


Isolated candidal prostatitis. A ELEKT, B VONKOBLOCH, R NUSSER et al. J Urol 2000;163:244


Bacterial vaginosis


Direct or referral microscopy of vaginal wet smear for bacterial vaginosis: experience from an STD clinic. CS PETERSEN, AG DANIELSEN, J RENNEBERG. Acta Dermato-Venereol 1999;79:473–4

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. C VANDERSCHIE, A VANBELKUM, L ZWIGERS et al. J Clin Microbiol 1999;37:4127–34

Use of spun urine to enhance detection of Trichomonas vaginalis in adolescent women. DR CLARK, A RUGGIO, A JOFFE. Arch Pediat Adolesc Med 1999;153:1222–5

Identification of Trichomonas vaginalis α-actinin as the most common immunogen recognized by sera of women exposed to the parasite. MF ADSON, P RAPPELLI, AMP DEANBRAD et al. J Infect Dis 1999;180:1727–30

Pelvic inflammatory disease


Syphilis and other treponematoses


Hepatitis


Herpes


Relation between herpes simplex viruses and human immunodeficiency virus infections. JL SEVERSON, SK TYRING. Arch Dermatol 1999;135:1393–7
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.

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

Human papillomavirus infection

Pernicious papillomavirus infection.

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, J RIDEHALL. Lancet 1999;354:2097

HPV DNA testing of self-collected vaginal samples compared with cytologic screening to detect cervical cancer.

HPV DNA testing in cervical cancer screening: results from women in a high-risk province of Costa Rica.
M SCHIFFMAN, H HERRERO, A HILDESHEIM et al. JAMA 2000;283:87–93

Human papillomavirus testing for primary cervical cancer screening.

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