Secondly, a travel history is important. The cases identified in the reports from Manchester and Liverpool were associated with travel to countries where chancroid is endemic. If lessons are to be learnt from recent experience in the United States where there was a significant association between outbreaks of syphilis, chancroid, and the use of crack cocaine, a high index of suspicion for chancroid is justified for genital ulcers in Afro-Caribbean given their connection in the Bristol syphilis outbreak and the known endemicity of both syphilis and chancroid in the Caribbean. Also, travellers or recent immigrants with genital ulcers from southern African countries, where the United Kingdom still has close Commonwealth ties, should be considered to be at risk of chancroid, particularly if there is a history of unprotected commercial sex.

Because of its importance in facilitating heterosexual HIV transmission, opportunities to improve surveillance for chancroid should be sought. The KC 60 coding system is due to undergo revision soon and it would surely not be a retrograde step to revert to the pre-1989 system whereby chancroid was reported under the C1 coding, LGV as C2, and donovonosis as C3.

Ideally, patients with chancroid and their sexual contacts are best treated at their first attendance. Currently the most cost effective options are either a single dose of ciprofloxacin 500 mg or erythromycin 500 mg three times daily for 7 days. However, if it is thought prudent to try and confirm the diagnosis of chancroid by culture, it may be necessary to bring patients back when suitable culture media are available.

NIGEL O’FARRELL

Jefferson Wng, St Mary’s Hospital, Praed Street, London W2 1NY

ofarrell@postmaster.co.uk


10 Communicable Diseases Surveillance Centre. GUM clinic returns on forms SBH 60 1971–1988 (Qr 1) and KC 60 (1988 (Qr 2) to 1998. New diagnoses, selected conditions by sex.


The COPE Report 1999

Hitherto, there has been a lack of a coordinated approach by editors of scientific and medical journals to breaches of research and publication ethics. The publication in this issue of the guidelines on good publication practice developed by the Committee on Publication Ethics (COPE) is therefore most welcome. Consensus has been reached on what constitutes good research and the guidelines on study design, ethical approval, and data analysis are sensible and clear. In any case, all researchers should already follow these principles. For many years, there has been controversy on authorship, and guidance is given on avoidance of conflict over this issue. The duty of all authors to take public responsibility for the content of their paper is rightly emphasised. Conflicts of interest are not confined to the authors of papers, and editors and reviewers must ensure that any relevant conflict of interest is disclosed; again sound guidance is given in the report. Guidelines are also available on peer review and greater transparency by journals of their review, selection, and appeal processes is suggested. Ultimately, this can only benefit authors. Plagiarism and redundant publication are issues with which editors are only too familiar and, in some cases, these unethical practices can be difficult to identify. Advice to authors on how to avoid possible misconduct is given in the report. Most editors are well aware of their duties, but it is good to see these defined here. The mass media are becoming much more concerned with biomedical research, and the guidelines on media relations are timely.

Unfortunately, breaches of research and publication ethics occur, and there have been several recent, celebrated cases. It is clear that the authors of the report have given much thought to some of the thorny issues surrounding the investigation of suspected breaches, and their guidance to editors is very clear. The mechanism for implementation of the guidelines for dealing with serious misconduct, however, is not entirely clear. For example, there does not appear to be a forum for the author(s) suspected of misconduct to rescind the allegations. With the possible grave consequences of an investigation of this nature, future refinements to the guidelines may be required.

As a former editor of the journal, I would have greatly appreciated access to guidelines such as these when considering difficult issues, and I feel that all editors should endorse this report.

ALEXANDRA Mc MILLAN

Journal ombudsman
Committee on Publication Ethics: the COPE Report 1999

Guidelines on good publication practice

Why the guidelines were developed
COPE was founded in 1997 to address breaches of research and publication ethics. A voluntary body providing a discussion forum and advice for scientific editors, it aims to find practical ways of dealing with the issues, and to develop good practice.

We thought it essential to attempt to define best practice in the ethics of scientific publishing. These guidelines should be useful for authors, editors, editorial board members, readers, owners of journals, and publishers.

Intellectual honesty should be actively encouraged in all medical and scientific courses of study, and used to inform publication ethics and prevent misconduct. It is with that in mind that these guidelines have been produced.

Details of other guidelines on the ethics of research and published codes of conduct are listed in the Appendix.

How the guidelines were developed
The guidelines were developed from a preliminary version drafted by individual members of the committee, which was then submitted to extensive consultation. They address: study design and ethical approval, data analysis, authorship, conflict of interests, the peer review process, redundant publication, plagiarism, duties of editors, media relations, advertising, and how to deal with misconduct.

What they aim to do
These guidelines are intended to be advisory rather than prescriptive, and to evolve over time. We hope that they will be disseminated widely, endorsed by editors, and refined by those who use them.

1 Study design and ethical approval
2 Data analysis
3 Authorship
4 Conflicts of interest
5 Peer review
6 Redundant publication
7 Plagiarism
8 Duties of editors
9 Media relations
10 Advertising
11 Dealing with misconduct

Appendix

Acknowledgement
The following are gratefully acknowledged for their contribution to the drafting of these guidelines: Philip Fulford (Coordinator), Professor Michael Doherty, Ms Jane Smith, Dr Richard Smith, Dr Fiona Godlee, Dr Peter Wilmshurst, Dr Richard Horton, Professor Michael Farthing, Other members of COPE, Delegates to the meeting on April 27 1999, other corresponding editors.

1 Study design and ethical approval
Definition
Good research should be well justified, well planned, appropriately designed, and ethically approved. To conduct research to a lower standard may constitute misconduct.

Action
1 Laboratory and clinical research should be driven by protocol; pilot studies should have a written rationale.
2 Research protocols should seek to answer specific questions, rather than just collect data.
3 Protocols must be carefully agreed by all contributors and collaborators, including, if appropriate, the participants.
4 The final protocol should form part of the research record.
5 Early agreement on the precise roles of the contributors and collaborators, and on matters of authorship and publication, is advised.
6 Statistical issues should be considered early in study design, including power calculations, to ensure there are neither too few nor too many participants.
7 Formal and documented ethical approval from an appropriately constituted research ethics committee is required for all studies involving people, medical records, and anonymised human tissues.
8 Use of human tissues in research should conform to the highest ethical standards, such as those recommended by the Nuffield Council on Bioethics.
9 Fully informed consent should always be sought. It may not always be possible, however, and in such circumstances, an appropriately constituted research ethics committee should decide if this is ethically acceptable.
10 When participants are unable to give fully informed consent, research should follow international guidelines, such as those of the Council for International Organisations of Medical Sciences (CIOMS).
11 Animal experiments require full compliance with local, national, ethical, and regulatory principles, and local licensing arrangements. International standards vary.
12 Formal supervision, usually the responsibility of the principal investigator, should be provided for all research projects: this must include quality control, and the frequent review and long term retention (may be up to 15 years) of all records and primary outputs.

2 Data analysis
Definition
Data should be appropriately analysed, but inappropriate analysis does not necessarily amount to misconduct. Fabrication and falsification of data do constitute misconduct.

Action
1 All sources and methods used to obtain and analyse data, including any electronic pre-processing, should be fully disclosed; detailed explanations should be provided for any exclusions.
2 Methods of analysis must be explained in detail, and referenced, if they are not in common use.
3 The post hoc analysis of subgroups is acceptable, as long as this is disclosed. Failure to disclose that the analysis was post hoc is unacceptable.
4 The discussion section of a paper should mention any issues of bias which have been considered, and explain how they have been dealt with in the design and interpretation of the study.

3 Authorship
Definition
There is no universally agreed definition of authorship, although attempts have been made (see Appendix). As a minimum, authors should take responsibility for a particular section of the study.
Action
1 The award of authorship should balance intellectual contributions to the conception, design, analysis and writing of the study against the collection of data and other routine work. If there is no task that can reasonably be attributed to a particular individual, then that individual should not be credited with authorship.
2 To avoid disputes over attribution of academic credit, it is helpful to decide early on in the planning of a research project who will be credited as authors, as contributors, and who will be acknowledged.
3 All authors must take public responsibility for the content of their paper. The multidisciplinary nature of much research can make this difficult, but this can be resolved by the disclosure of individual contributions.
4 Careful reading of the target journal’s “Advice to authors” is advised, in the light of current uncertainties.

4 Conflicts of interest
Definition
Conflicts of interest comprise those which may not be fully apparent and which may influence the judgment of author, reviewers, and editors.

They have been described as those which, when revealed later, would make a reasonable reader feel misled or deceived.
They may be personal, commercial, political, academic or financial.
“Financial” interests may include employment, research funding, stock or share ownership, payment for lectures or travel, consultancies and company support for staff.

Action
1 Such interests, where relevant, must be declared to editors by researchers, authors, and reviewers.
2 Editors should also disclose relevant conflicts of interest to their readers. If in doubt, disclose. Sometimes editors may need to withdraw from the review and selection process for the relevant submission.

5 Peer review
Definition
Peer reviewers are external experts chosen by editors to provide written opinions, with the aim of improving the study.
Working methods vary from journal to journal, but some use open procedures in which the name of the reviewer is disclosed, together with the full or “edited” report.

Action
1 Suggestions from authors as to who might act as reviewers are often useful, but there should be no obligation on editors to use those suggested.
2 The duty of confidentiality in the assessment of a manuscript must be maintained by expert reviewers, and this extends to reviewers’ colleagues who may be asked (with the editor’s permission) to give opinions on specific sections.
3 The submitted manuscript should not be retained or copied.
4 Reviewers and editors should not make any use of the data, arguments, or interpretations, unless they have the authors’ permission.
5 Reviewers should provide speedy, accurate, courteous, unbiased and justifiable reports.
6 If reviewers suspect misconduct, they should write in confidence to the editor.
7 Journals should publish accurate descriptions of their peer review, selection, and appeals processes.
8 Journals should also provide regular audits of their acceptance rates and publication times.

6 Redundant publication
Definition
Redundant publication occurs when two or more papers, without full cross reference, share the same hypothesis, data, discussion points, or conclusions.

Action
1 Published studies do not need to be repeated unless further confirmation is required.
2 Previous publication of an abstract during the proceedings of meetings does not preclude subsequent submission for publication, but full disclosure should be made at the time of submission.
3 Re-publication of a paper in another language is acceptable, provided that there is full and prominent disclosure of its original source at the time of submission.
4 At the time of submission, authors should disclose details of related papers, even if in a different language, and similar papers in press.

7 Plagiarism
Definition
Plagiarism ranges from the unreferenced use of others’ published and unpublished ideas, including research grant applications to submission under “new” authorship of a complete paper, sometimes in a different language.
It may occur at any stage of planning, research, writing, or publication: it applies to print and electronic versions.

Action
1 All sources should be disclosed, and if large amounts of other people’s written or illustrative material is to be used, permission must be sought.

8 Duties of editors
Definition
Editors are the stewards of journals. They usually take over their journal from the previous editor(s) and always want to hand over the journal in good shape.
Most editors provide direction for the journal and build a strong management team. They must consider and balance the interests of many constituents, including readers, authors, staff, owners, editorial board members, advertisers and the media.

Action
1 Editors’ decisions to accept or reject a paper for publication should be based only on the paper’s importance, originality, and clarity, and the study’s relevance to the remit of the journal.
2 Studies that challenge previous work published in the journal should be given an especially sympathetic hearing.
3 Studies reporting negative results should not be excluded.
4 All original studies should be peer reviewed before publication, taking into full account possible bias due to related or conflicting interests.
5 Editors must treat all submitted papers as confidential.
6 When a published paper is subsequently found to contain major flaws, editors must accept responsibility for correcting the record promptly and promptly.

9 Media relations
Definition
Medical research findings are of increasing interest to the print and broadcast media.
Journalists may attend scientific meetings at which preliminary research findings are presented, leading to their premature publication in the mass media.
**Action**

1. Authors approached by the media should give as balanced an account of their work as possible, ensuring that they point out where evidence ends and speculation begins.
2. Simultaneous publication in the mass media and a peer reviewed journal is advised, as this usually means that enough evidence and data have been provided to satisfy informed and critical readers.
3. Where this is not possible, authors should help journalists to produce accurate reports, but refrain from supplying additional data.
4. All efforts should be made to ensure that patients who have helped with the research should be informed of the results by the authors before the mass media, especially if there are clinical implications.
5. Authors should be advised by the organisers if journalists are to attend scientific meetings.
6. It may be helpful to authors to be advised of any media policies operated by the journal in which their work is to be published.

**10 Advertising**

**Definition**

Many scientific journals and meetings derive significant income from advertising. Reprints may also be lucrative.

**Action**

1. Editorial decisions must not be influenced by advertising revenue or reprint potential: editorial and advertising administration must be clearly separated.
2. Advertisements that mislead must be refused, and editors must be willing to publish criticisms, according to the same criteria used for material in the rest of the journal.
3. Reprints should be published as they appear in the journal unless a correction is to be added.

**Dealing with misconduct**

1. **Principles**
   1. The general principle confirming misconduct is intention to cause others to regard as true that which is not true.
   2. The examination of misconduct must therefore focus, not only on the particular act or omission, but also on the intention of the researcher, author, editor, reviewer or publisher involved.
   3. Deception may be by intention, by reckless disregard of possible consequences, or by negligence. It is implicit, therefore, that “best practice” requires complete honesty, with full disclosure.
   4. Codes of practice may raise awareness, but can never be exhaustive.

2. **Investigating misconduct**
   1. Editors should not simply reject papers that raise questions of misconduct. They are ethically obliged to pursue the case. However, knowing how to investigate and respond to possible cases of misconduct is difficult.
   2. COPE is always willing to advise, but for legal reasons, can only advise on anonymised cases.
   3. It is for the editor to decide what action to take.

3. **Serious misconduct**
   1. Editors must take all allegations and suspicions of misconduct seriously, but they must recognise that they do not usually have either the legal legitimacy or the means to conduct investigations into serious cases.

2. The editor must decide when to alert the employers of the accused author(s).
3. Some evidence is required, but if employers have a process for investigating accusations—as they are increasingly required to do—then editors do not need to assemble a complete case. Indeed, it may be ethically unsound for editors to do so, because such action usually means consulting experts, so spreading abroad serious questions about the author(s).
4. If editors are presented with convincing evidence—perhaps by reviewers—of serious misconduct, they should immediately pass this on to the employers, notifying the author(s) that they are doing so.
5. If accusations of serious misconduct are not accompanied by convincing evidence, then editors should confidentially seek expert advice.
6. If the experts raise serious questions about the research, then editors should notify the employers.
7. If the experts find no evidence of misconduct, the editorial processes should proceed in the normal way.
8. If presented with convincing evidence of serious misconduct, where there is no employer to whom this can be referred, and the author(s) are registered doctors, cases can be referred to the General Medical Council.
9. If, however, there is no organisation with the legitimacy and the means to conduct an investigation, then the editor may decide that the case is sufficiently important to warrant publishing something in the journal. Legal advice will then be essential.
10. If editors are convinced that an employer has not conducted an adequate investigation of a serious accusation, they may feel that publication of a notice in the journal is warranted. Legal advice will be essential.
11. Authors should be given the opportunity to respond to accusations of serious misconduct.

4. **Less serious misconduct**
   1. Editors may judge that it is not necessary to involve employers in less serious cases of misconduct, such as redundant publication, deception over authorship, or failure to declare conflict of interest. Sometimes the evidence may speak for itself, although it may be wise to appoint an independent expert.
   2. Editors should remember that accusations of even minor misconduct may have serious implications for the author(s), and it may then be necessary to ask the employers to investigate.
   3. Authors should be given the opportunity to respond to any charge of minor misconduct.
   4. If convinced of wrongdoing, editors may wish to adopt some of the sanctions outlined below.

5. **Sanctions**
   Sanctions may be applied separately or combined. The following are ranked in approximate order of severity:
   1. A letter of explanation (and education) to the authors, where there appears to be a genuine misunderstanding of principles.
   2. A letter of reprimand and warning as to future conduct.
   3. A formal letter to the relevant head of institution or funding body.
   4. Publication of a notice of redundant publication or plagiarism.
   5. An editorial giving full details of the misconduct.
   6. Refusal to accept future submissions from the individual, unit, or institution responsible for the misconduct, for a stated period.
   7. Formal withdrawal or retraction of the paper from the scientific literature, informing other editors and the indexing authorities.
8 Reporting the case to the General Medical Council, or other such authority or organisation which can investigate and act with due process.

Appendix


ABPI fact sheets and guidance notes:
Guidelines for phase IV clinical trials, September 1993.
Relationship between the medical profession and the pharmaceutical industry, June 1994.
Patient information and consents for clinical trials, May 1997.
Guidelines on the structure of a formal agreement to conduct sponsored clinical research, July 1998.


General Medical Council. Good medical practice guidelines series:
Consent, February 1999.
Confidentiality, October 1995.
LETTERS TO THE EDITOR

Carbamazepine in Reiter's syndrome

EDITOR,—A psoriatic spectrum with Reiter's syndrome. We report a case of carbamazepine-induced Reiter's syndrome in an HIV infected patient.

A 30 year old married man presented with erythematous papules and plaques of 2 months' duration covered with hard limpet-like scales on face, body, and both extremities (Fig 1). Palms and soles showed keratoderma blenorrhagica and subungual hyperkeratosis with distal onycholysis. Both knees and wrists had painful swelling with restriction of movements. With this clinical presentation Reiter's syndrome was inferred. All routine investigations were normal except a raised erythrocyte sedimentation rate of 100 mm in the first hour. x Rays of the affected joints were normal. ELISA for HIV-1 and HIV-2 was positive with two kits (Immunocomb, Tri-dot) and confirmed with western blotting technique (Speciality Ranbaxy Limited). The absolute helper T lymphocyte count was 435 cells x10^9/l. Human leucocyte antigen B27 and rheumatoid factor were negative. The patient was commenced on prednisolone by mouth 60 mg daily and indomethacin by mouth 25 mg three times daily without any concomitant antimicrobial therapy. New erythematous papules and plaques appeared with no relief in joint pain and swelling.

In seeking an effective treatment, we serendipitously came across the efficacy of carbamazepine in an HIV infected patient with psoriatic erythroderma. We started carbamazepine 200 mg daily in two divided doses in addition to above. The erythema cleared rapidly within 7 days. To confirm the effect of carbamazepine, it was stopped. New lesions similar to the old ones appeared within 3–4 days. Carbamazepine was then reintroduced in the same dose. Erythema cleared again within 7 days followed by scaling and joint swelling and pain. New lesions stopped appearing. Prednisolone was then tapered off rapidly and analgesics were stopped. Carbamazepine was continued in the same dose for 6 months. On follow up at 1 year, the patient showed no recurrence of skin lesions and synovitis, no change in liver and renal function tests, with no further deterioration in his overall health and no opportunistic infections.

It has been proposed that in genetically predisposed people, the release of neuropeptides like substance P, calcitonin gene related peptide, vasoactive intestinal peptide, and the inflammatory leucotriene B4 from cutaneous sensory nerves causes local inflammatory responses that trigger psoriasis. Stimulated mast cells secrete a number of proinflammatory cytokines and proteases that act similarly. Carbamazepine significantly inhibits the uptake of substance P, calcitonin gene related peptide, and blocks a cyclic AMP mediated calcium influx that is associated with neuropeptide release and control of a slow potassium current.

The rapid clearing of erythema, secondary to raised levels of neuropeptides, with carbamazepine may have been mediated through inhibition of these neuropeptides and by inhibition of uptake of noradrenaline. The exacerbation and consequent resolution of lesions on withdrawal and re-institution of carbamazepine respectively proves its efficacy in our patient. Also, the clinical remission maintained for 1 year after stopping carbamazepine may suggest a therapeutic role in Reiter's syndrome. The therapeutic response seen in our patient conforms to that seen in the HIV-1 positive patient of Smith et al.

This apparent success adds carbamazepine to the armamentarium against Reiter's syndrome in an HIV infected patient. This is the first reported case and an evaluation of long term carbamazepine therapy is warranted.

N N GOYAL
R S DHURAT
H R JERAJANI
Department of Dermatology, LTM Medical College and LTM General Hospital, Nain, Mumbai - 400066, India

Correspondence to: Dr N N Goyal, 14 Vinay, Prayas Sadan, Chheda nagar, Chembur, Mumbai - 400089, India

madhunil@hotmail.com


Accepted for publication 20 March 2000

Condoms and warts

EDITOR,—Wen et al1 should be applauded for their attempt to address the key question of whether or not condoms protect people from genital warts. However, some of the major study variables need clarification, as they did not match up with my knowledge of the Sydney Sexual Health Centre (SSHC) database. The article discussed the issue of “acquisition of genital warts” and was presented as an incidence study. Cases were defined as: “All patients with a new diagnosis of macroscopic genital warts who attended SSHC [in] 1996.” However, many of these patients had been previously diagnosed with genital warts elsewhere while others had recurrent lesions. In Australia, most genital warts are managed by general practitioners.2 Consequently, the experience of specialist services is biased towards recurrent and difficult cases. “New diagnosis” in this situation means new to the clinic but not necessarily new to the patient. This means that the main outcome measure was a mixture of incident, prevalent, and recurrent cases, with the possibility that the warts may have affected the behaviour of many of the study subjects.

The SSHC database does document whether a person has previously been diagnosed with HPV infection. To me, the study would have had more validity if patients with a past history had been excluded.

The diagnostic grouping for warts at SSHC does not distinguish between genital and anal lesions. The readers of the journal need to know that many of these male “genital wart” cases would have been homosexually active men with anal warts. This is important as risk factors for penile and anal warts may differ, potentially confusing the results of the present study.

Finally, the referent group in the table describing condom use deemed as “Not applicable, no sex” should have been more accurately described as “No vaginal or anal sex in the previous 3 months.” Many of these people would have practised oral sex or other sexual acts during those 3 months. Others may have ceased practising vaginal or anal intercourse up to 3 months earlier because of their persistent or recurrent warts.

Large relational quality assured clinical databases can be powerful tools for health care evaluation, surveillance, and the generation of research questions. It may be prudent for researchers to engage the people responsible for designing and maintaining those databases to minimise errors of interpretation.

LINDA DAYAN
Sydney Sexual Health Centre and Sexual Health Services, Northern Sydney Health, Sydney, Australia

LDayan@doh.health.nsw.gov.au


Reply

EDITOR,—We are grateful to Dr Dayan for her helpful and constructive comments. The major criticism of our paper relates to the selection of cases, and the possible inclusion...
Editor,—The non-nucleoside reverse transcriptase inhibitor (NNRTI) efavirenz is a recent addition to the armamentarium available to physicians in the treatment of human immunodeficiency virus (HIV) infection. However, at present the known side effect profile of this new agent is still in its infancy. We would like to report a case of photosensitivity associated with efavirenz.

A 27 year old white homosexual man was commenced on combivir (zidovudine/lamivudine) therapy in March of 1999. One month later he reported that he was well and had no major side effects associated with his new combination. However, 4 weeks further into treatment he represented with an itchy rash affecting his arms and hands. On examination there was a maculopapular rash over the affected area but there was no oral ulceration, conjunctivitis, or fever. A drug reaction was diagnosed and he was prescribed antihistamines and asked to continue into treatment. He represented with an exacerbation of the rash a week later. Rash had settled, he then commenced combivir and efavirenz.

Photosensitivity in the context of HIV has been reported as a presenting sign of underlying HIV infection in a number of cases. In addition to this porphyria cutanea tarda (PCT) has been reported in the context of HIV infection and has been associated with concomitant hepatitis C infection; however, screening for both these conditions was negative. Switching from nevirapine to efavirenz in this context has been regarded as unwise; however, of 19 patients who have been intolerant of nevirapine secondary to the development of rash, who have switched to efavirenz only nine have developed a mild to moderate rash, of which only two needed to discontinue treatment. Photosensitivity in the context of HIV infection may not only be a presenting condition but also secondary to concomitant treatment.

A NEWELL
C AVILA
M R RODGERS
Dope GUM, Mayday Hospital, Thornton Heath,
GR7 7VE
Tony.Newell@mhc-tr.shanes.nhs.uk

1 Pappert A, Grossman M, DeLeo V. Photosensi-
tivity as the presenting symptom in four patients with human immunodeficiency viral infection. Arch Dermatol 1994;130:618–23.
5 DuPont Pharmaceuticals Company Research Laboratories. Wilmington, DE. In-house data 1980s.

Accepted for publication 20 March 2000

HIV associated cytomegalovirus retinitis in Melbourne, Australia

Editor,—We report the results of a 12 year review of human immunodeficiency virus (HIV) associated cytomegalovirus (CMV) retinitis in Melbourne, Australia.

We conducted a retrospective review of all HIV infected patients diagnosed with CMV retinitis at Fairfield Hospital and the Alfred Hospital between 1984 and 1996, aiming to identify factors at diagnosis of CMV retinitis which were predictive of outcome. Both hospitals had the same protocol for the treatment of CMV retinitis and employed 3 monthly ophthalmological screening of all HIV infected patients with CD4 counts of less than 50 ×10⁹/l.

The study outcomes were visual loss and death. Moderate visual loss was defined as a visual acuity of less than 6/12 in the better eye, and severe visual loss as visual acuity of less than 6/60 in the better eye (this is legal blindness in Australia).

CMV retinitis was diagnosed in 212 of 1281 patients (16.5%) with AIDS over the study period. As of June 1998, 193 (93%) had died, at a median time of 36 weeks (range 2–192) from CMV diagnosis. Seventy four patients (35%) developed moderate visual loss at a median time of 23 weeks (range 0–163) and 30 patients (14%) developed severe visual loss at a median time of 35 weeks (range 0–120) from diagnosis of CMV retinitis.

The presence of visual symptoms at diagnosis of CMV retinitis was predictive of the development of moderate visual loss (relative risk 2.1, 95% confidence interval 1.4–2.5). Fifty eight of 138 patients (42%) with visual symptoms at diagnosis developed moderate visual loss, compared with 16 of 64 patients (25%) who were asymptomatic at diagnosis (p=0.02). The presence of visual symptoms at diagnosis was not predictive of the development of severe visual loss, or early death (p=0.2). Other factors measured at diagnosis of CMV retinitis included the patients’ age, CD4 count, weight, visual acuity, and the presence of any previous AIDS defining condition. None of these was associated with the development of visual loss or early death (p>0.1).

The advent of highly active antiretroviral therapy (HAART) has resulted in a reduction in the incidence of new diagnoses of opportunistic infections. Prolonged survival times with CMV retinitis have been demonstrated in patients who achieve immunological recovery with HAART. The ability to predict those patients who are at highest risk of visual loss may assist in advising those who may reasonably cease maintenance therapy for CMV retinitis following immune restoration. An understanding of the natural history of CMV retinitis in the pre-HAART years remains important in managing patients who are failing HIV therapy.

The only factor measurable at diagnosis of CMV retinitis that was predictive of outcome was the presence of visual symptoms. The use of routine ophthalmological screening in HIV infected individuals with low CD4 counts aims to detect CMV retinitis before visual symptoms occur. It is possible that visual loss may be prevented by detecting disease before retinal damage occurs. A prospective evaluation is needed to confirm this finding.

C L CHERRY
M A MJICH
F HOY
Department of Infectious Diseases,
The Alfred Hospital, Victoria, Australia

A J H HALL
Department of Ophthalmology, The Alfred Hospital
M E HELLARD
Department of Infectious Diseases,
The Alfred Hospital, Victoria, Australia
M BRYANT
B DEGRAAFF
Department of Infectious Diseases,
The Alfred Hospital, Victoria, Australia
C K FAIRLEY
Department of Infectious Diseases,
The Alfred Hospital, Victoria, Australia

Correspondence to Catherine Cherry, The Alfred Hospital, Commercial Rd, Prahran 3181, Victoria, Australia
catherine@netspace.net.au


Accepted for publication 20 April 2000
Azithromycin vs oxytetracycline for the treatment of non-specific urethritis

EDITOR,—Single dose azithromycin 1 g rather than multidose tetracyclines or erythromycin over several days for the treatment of chlamydial urethritis is becoming more widespread as patient acceptability and improved compliance outweigh cost considerations. However, in men, treatment is often initiated on the basis of microscopic evidence of urethritis before the chlamydial result is available. Recently, several studies report the efficacy of azithromycin in the treatment of non-gonococcal non-chlamydial urethritis (NSU), but recently published evidence-based guidelines for the management of NSU recommend either doxycycline 100 mg twice daily for 7 days or azithromycin 1 g immediately.

In this genitourinary medicine clinic azithromycin became first line treatment for all proved or suspected chlamydial infections from 1 April 1998. This retrospective study assessed the efficacy of azithromycin for the treatment of NSU compared with oxytetracycline 250 mg four times daily for 7 days, the previous first line treatment regimen for men with microscopic urethritis in whom no Gram negative diplococci were evident.

NSU was defined as the presence of at least five polymorphonuclear leucocytes (PMN) in five or more fields on microscopy of a urethral smear. Suspected NSU was defined between 1 April 1998 and 30 September 1997 (treated with oxytetracycline). The outcome of all men with NSU diagnosed between 1 April 1998 and 30 September 1998 (treated with azithromycin) was compared with those diagnosed between 1 April 1997 and 30 September 1997 (treated with oxytetracycline).

NSU was defined as the presence of at least five polymorphonuclear leucocytes (PMN) in five or more fields on microscopy of a urethral smear. Suspected NSU was defined between 1 April 1998 and 30 September 1997 (treated with oxytetracycline). The outcome of all men with NSU diagnosed between 1 April 1998 and 30 September 1998 (treated with azithromycin) was compared with those diagnosed between 1 April 1997 and 30 September 1997 (treated with oxytetracycline).

Table 1 Comparative age, symptoms, and response to treatment of the two groups

<table>
<thead>
<tr>
<th></th>
<th>1997, oxazitromycin</th>
<th>1998, oxytetracycline</th>
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</thead>
<tbody>
<tr>
<td>Number treated</td>
<td>76</td>
<td>52</td>
</tr>
<tr>
<td>Median age (range)</td>
<td>28 (16–63)</td>
<td>25 (16–54)</td>
</tr>
<tr>
<td>No with symptoms (%)</td>
<td>35 (46)</td>
<td>25 (48)</td>
</tr>
<tr>
<td>No cured (%)</td>
<td>29 (38)</td>
<td>27 (52)</td>
</tr>
<tr>
<td>No treatment failures (%)</td>
<td>6 (8)</td>
<td>0</td>
</tr>
<tr>
<td>Outcome uncertain*</td>
<td>41 (54)</td>
<td>25 (48)</td>
</tr>
<tr>
<td>Symptomatic cure (%)</td>
<td>8/35 (23)</td>
<td>4/25 (16)</td>
</tr>
<tr>
<td>Asymptomatic cure</td>
<td>13/41 (32)</td>
<td>7/27 (26)</td>
</tr>
</tbody>
</table>

*Originally asymptomatic with clear two glass urine, did not reattend (dna), possibly reinfected.

The results of the two glass urine test did not differ significantly between the two groups but overall was positive in 70% of symptomatic patients compared with only 47% asymptomatic (p<0.01). Its low sensitivity and specificity are likely to be even lower in asymptomatic patients. Default from follow up occurred more frequently in the asymptomatic patients, but was less evident in the azithromycin treated group, who had a lower default rate overall, as previously reported.

In conclusion, although the numbers are small, it would appear that azithromycin is an effective treatment for NSU, and can be given at the time of initial diagnosis, pending the chlamydial result. Financial considerations preclude the use of azithromycin as first line treatment for NSU in many centres, but better compliance resulting in fewer treatment failures, and fewer wasted appointments from defaults may counter the economic argument.

C THOMPSON
Fife Acute Hospitals NHS Trust, Victoria Hospital, Kirkcaldy, Fife, KY2 5AH


Accepted for publication 19 April 2000

Sexually transmitted infections in elderly people

EDITOR,—Jaleel et al recently presented the incidence of sexually transmitted infections and other conditions among elderly people attending a genitourinary medicine clinic.1 We, in our genitourinary medicine department at Royal Berkshire Hospital, Reading, studied the reasons for attendance of elderly people with suspected STIs is age specific, with longer delay behaviour among individuals with suspected STIs is age specific, with longer delay behaviour among individuals with suspected STIs is age specific, with longer delay behaviour among individuals with suspected STIs is age specific, with longer delay behaviour among individuals with suspected STIs is age specific, with longer delay behaviour among individuals with suspected STIs.3

However, the number of older patients who attended for non-STI management are comparable. The delay between symptom recognition and healthcare presentation is a feature of STI related illness behaviour. The delay behaviour among individuals with suspected STIs is age specific, with longer latency periods experienced by people over the age of 50.4 This finding was seen in our study as well.

NELSON DAVID
SASIKALA RAJAMANOHAR
ALAN TANG
Department of GU Medicine, Royal Berkshire Hospital, Reading RG1 5AH

Correspondence to: Dr Nelson David


Accepted for publication 30 April 2000

Tertiary syphilis

EDITOR,—I read Dr Reed’s letter on tertiary syphilis with interest.

The regimen he describes for the treatment of early syphilis—arsenic, bismuth, and roux in the clock aqueous penicillin, was used in our hospital from 1946–8 although daily penicillin in beeswax was also used. It was unclear how much inactive penicillin K was in the commercial product used. The penicillin G used here was higher than in Lincoln (40 000–75 000 units 3–4 hourly). There were 10 treatment failures (reinfections) out of 275 patients described.3 Trepomema pallidum remains viable in the CSF even after adequate clinical treatment.4

Many elderly people maintain heterosexual and homosexual activity. Therefore this age group is at a risk of all sexually transmitted infections.5 In our study, a smaller percentage of older attendees had STIs compared with previous studies.3,4 However, the number of older patients who attended for non-STI management are comparable. The delay between symptom recognition and healthcare presentation is a feature of STI related illness behaviour. The delay between symptom recognition and healthcare presentation is a feature of STI related illness behaviour. The delay behaviour among individuals with suspected STIs is age specific, with longer latency periods experienced by people over the age of 50. This finding was seen in our study as well.

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Accepted for publication 30 April 2000

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C THOMPSON
Fife Acute Hospitals NHS Trust, Victoria Hospital, Kirkcaldy, Fife, KY2 5AH

<table>
<thead>
<tr>
<th></th>
<th>Older clinic</th>
<th>Younger clinic</th>
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<tbody>
<tr>
<td>STIs</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>NSU</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital warts</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Treponema pallidum</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other conditions</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Condyloma acuminatum</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital eczema</td>
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<td>Genital skin tag</td>
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</tr>
<tr>
<td>Genital seborrheic glands</td>
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</tr>
<tr>
<td>Genital pruritus</td>
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<td>1</td>
</tr>
<tr>
<td>Genital sebaceous cyst</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>1</td>
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</tr>
</tbody>
</table>

(No of patients)
Book Reviews


The most striking first impression of these two volumes is the lavish production with marvellous illustrations, photographs, and tables. It has many excellent features. The text is well set out and easy on the eye. The experience of the authors in approaching various diseases and clinical syndromes comes through strongly. The sections comprehensively cover infectious disease from basic science to clinical management. The clinical microbiology section is an important anchor and could be a short textbook in itself.

I very much enjoyed the numerous practice points, which are oriented towards clinicians faced with funding solutions to problems. These consist of short essays with tables or illustrations and tackle particular clinical problems such as “the diagnosis of HIV in newborns,” “what is the treatment of a positive toxoplasma titre in pregnancy?” or are in a debating style—for example, “how long should osteomyelitis be treated?”

Each section is colour coded and although the American numbering system takes a few minutes to get used to one can easily navigate around the book. The contributors are all internationally famous in their fields and, with so many of them, I am quite impressed by how up to date the book is. They must have been chased hard to get their contributions in on time. One of the few criticisms would be that there could have been more on hepatitis C and its interaction with HIV.

However, if you can’t find what you want in this book, there is a comprehensive list of websites, which are of interest to infectious disease and other physicians. There is a free CD ROM which creates a direct internet link to these sites. The other important resource is a slide library, which comes on the same CD ROM. In all, 1500 tables and clinical and other photographs are stored and can be made up into personalised presentations; these can then be used as a teaching resource via computer generated images. The high quality of these images will impress anyone involved in producing material for teaching. However, it is a shame some of the useful tables have not made it from the text to the CD ROM.

Although this book is expensive, I would recommend it to anyone interested in infectious diseases especially those who have to teach at any level, undergraduate or postgraduate.

With the rise of the internet the big textbook might no longer be needed for extirpation. Thankfully this book delays the time when I will be downloading information from the super highway rather than turning over the pages of a well produced book. If I need to use my computer there is always that free CD ROM....

ANTON POZNIAK
St Stephen’s Centre, Chelsea and Westminster Health Care Trust, Chelsea and Westminster Hospital, London SW10 9TH


I was delighted when the editor sent me this book and asked me to review it. I had looked forward with anticipation to the original series that were published in the BMJ. I had thought then that each article was just superb and now they are all neatly packed together in this ABC, I am of the opinion that this is an excellent book which achieves its aim completely. On the cover, it says “it is an ideal reference for doctors, nurses and patients and all those not involved in the area of sexual health,” and Professor Adler adds in the foreword that this book will put the profession in touch with the real world, real people, with real problems, and fill a large gap in our knowledge.

John Tomlinson, the editor, has pulled together an excellent group of experts who have practical experience in the field and have managed to condense that experience into a series of short articles, all of which make informative, yet entertaining reading. In my opinion, no specific background is required to gain information from these articles and I have recommended specific sections of this book for individual patients who need to read about their problem.

Those of us who work in sexual medicine were amused that the BMJ had to carry a warning about the sexually explicit material inside and, indeed, John Tomlinson refers to this in the preface and admits that a very small number of readers were offended. However, given the general reticence in society about sexual matters, this is not surprising.

Sexual health is an essential part of having a happy and fulfilling life, and everyone who works in a caring profession should be comfortable when the conversation drifts into areas of sexuality. Patients, who often broach the topic with trepidation, need to be assured of a sensitive hearing. In my opinion, this excellent book will give anyone in the caring profession a good grounding in sexual matters, so that they can explore these areas with patients when appropriate, without embarrassment and have some idea of likely strategies of management.

DAVID GOLDMEIER

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DAVID GOLDMEIER

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMFM.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, Regional Office of the World Health Organization

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@osp.sheridan.com).

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 OXG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ac.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: dartcon@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 OXG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ac.ac.uk).

NOTICES
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, Eissenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.uunet.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: sympreg@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: sympreg@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: sympreg@ic.ac.uk).

XIII International AIDS Conference, 9–14 July 2000, Durban, South Africa
Further details: Congress Sweden AB, PO Box 5619, Linnegatan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 601 91 25; email: aids2000@congrex.se).


Ethical Issues in International Health Research, Durban, South Africa, 16–21 July 2000 (immediately following XIII International AIDS Conference)
Further details: Marie-Christine Ryckaert, Program director, Ethical Issues in International Health Research, Harvard University, John F Kennedy School of Government, Cambridge, MA 02138, USA (tel: (617) 496-0484 ex 7474; fax: (617) 495-3090; email: Marie-Christine_Ryckaert@harvard.edu).

Further details: PACIFICOO, SA, E Granados, 44, 08008 Barcelona, Spain (tel: +34.93.454.54.00; fax: +34.93.451.74.38; email: gp@pacific-meetings.com).

MSSVD Clinical Developments Fund
The MSSVD Clinical Developments Fund is asking for applications for funding to support projects that advance the understanding and practice of genitourinary medicine. An amount of £10 000 is available to one or more successful applicant(s). Closing date for application is 25 August 2000. Further details: Dr Keith Radcliffe, Honorary Assistant Secretary MSSVD, Whitall Street Clinic, Whitall Street, Birmingham B4 6DH (tel: 0121 237 5719; fax: 0121 237 5729; email: keith.radcliffe@bscht.wmids.nhs.uk).

3rd Congress of the Baltic Association of Dermatovenerology, 7–9 September 2000, Riga, Latvia
Further details: Professor Andris Y Rubins, Department of Dermatovenerology, Medical Academy of Latvia, K Valdemara Street, 76–75, Riga, LV-1051, Latvia (tel: +(371) 7303995; fax: +(371) 7361615; email: arubins@apollo.lv).

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

11th Regional Meeting of International Union against Sexually Transmitted Infections, South East Asian and Western Pacific Branch and 24th National Conference of Indian Association for the Study of Sexually Transmitted Diseases and AIDS, 13–15 October 2000, Chandigarh, India
Further details: Dr Bhushan Kumar, Organising Secretary, 11th Regional Meeting of IUSTTI–Asia Pacific (SE Asia and W Pacific Branch), Department of Dermatology, Venereology and Leprosy, PGIMER, Chandigarh - 160 012, India (tel: +91 (0172) 745330; fax: +91 (0172) 744401/745078; email: kumarbhushan@hotmail.com).

Consortium of Thai Training Institutes for STDs and AIDS—10th STDs/AIDS diploma course, Bangkok Hospital, Bangkok (30 Oct–12 Nov) and Prince of Songkla University, Hat Yai, Thailand (13–23 Nov) 30 October–23 November 2000
Further details: Hat Yai Secretariat, Dr Ve- rapol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cvverapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bang- kok 10120, Thailand (fax: (66-2) 286 3013; email: phanit@email.ksc.net).

Consortium of Thai Training Institutes for STDs and AIDS—International Re- union and Refresher Course on Sexual Health, Lee Garden Plaza Hotel, Hat Yai, Thailand 24–26 November 2000
Further details: Hat Yai Secretariat, Dr Ve- rapol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cvverapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bang- kok 10120, Thailand (fax: (66-2) 286 3013; email: phanit@email.ksc.net).

CURRENT PUBLICATIONS

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

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

Gonorrhoea

Susceptibility to gonococcal infection during the menstrual cycle.

‘Broken windows’ and the risk of gonorrhoea.


Rise in gonorrhoea in London, UK.

Urine screening for gonococcal and chlamydial infections at community-based organizations in a high-morbidity area.

Evaluation of four commercial transport media for the survival of Neisseria gonorrhoeae.


Prevalence and tetM subtype of tetracycline-resistant Neisseria gonorrhoeae in Ohio, 1994.


Effects of the immunoglobulin A1 proteinase on Neisseria gonorrhoeae trafficking across polarized T84 epithelial monolayers.

Charged tmRNA but not tmRNA-mediated proteolysis is essential for Neisseria gonorrhoeae viability.

Chlamydia

Acute primary Chlamydia trachomatis infection in male adolescents after their first sexual contact.

Evaluation of patient-administered tampon specimens for Chlamydia trachomatis and Neisseria gonorrhoeae.


Impact of switching laboratory tests on reported trends in Chlamydia trachomatis infections.

Detection of Chlamydia trachomatis in pregnant women by the Papanicolaou technique, enzyme immunoassay and polymerase chain reaction.

Multicenter evaluation of the AMPICOR and automated COBAS AMPLICOR CT/NG tests for detection of Chlamydia trachomatis.

Chlamydial development is adversely affected by minor changes in amino acid supply, blood plasma amino acid levels and glucose deprivation.

Bacterial vaginosis

Differential regulation of CD4 lymphocyte recruitment between the upper and lower regions of the genital tract during Chlamydia trachomatis infection.

T-cell epitopes in variable segments of Chlamydia trachomatis major outer membrane protein elicit serovarspecific immune responses in infected humans.

Candidiasis

Vaginal colonization by Candida in asymptomatic women with and without a history of recurrent vulvovaginal candidiasis.

Effects of reproductive hormones on experimental vaginal candidiasis.

Evaluation of the Oricult-N dipslide for laboratory diagnosis of vaginal candidiasis.

Clonal and spontaneous origins of fluconazole resistance in Candida albicans.

Mechanisms of the proinflammatory response of endothelial cells to Candida albicans infection.

Bacterial vaginosis

Bacterial vaginosis.

Metronidazole to prevent preterm delivery in pregnant women with asymptomatic bacterial vaginosis.

Pre-term labor associated with bacterial vaginosis.
**Trichomoniasi**

**Resistence of *Trichomonas vaginalis* to metronidazole: report of the first three cases from Finland and optimization of in vitro susceptibility testing under various oxygen concentrations.**


**Antigenicity of *Trichomonas vaginalis* heat-shock proteins in human infections.**


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**Pelvic inflammatory disease**

**Pelvic inflammatory disease—an evidence-based approach to diagnosis.**


**Influence of human immunodeficiency virus infection on pelvic inflammatory disease.**


**Direct medical cost of pelvic inflammatory disease and its sequelae: decreasing but still substantial.**


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**Syphilis and other treponematoses**

**Unraveling the Tuskegee Study for untreated syphilis.**

RM WHITE. *Arch Intern Med* 2000;160:585–601

**Nodular tertiary syphilis mimicking granuloma annulare.**


**Social network method for endemic foci of syphilis: a pilot project.**

R ROTHEMBEUF, L KINBROUCH, R LEWISHARD et al. *Sex Transm Dis* 2000;27:12–8

**Geographic variation of HIV infection in childbearing women with syphilis in the United States.**


**HIV prevalence in patients with syphilis, United States.**

MR BLOCKER, WC LEVINE, ME STLOUIS. *Sex Transm Dis* 2000;27:53–9

**From the CDC—syphilis elimination: history in the making—opening remarks.**

J KOPLAN. *Sex Transm Dis* 2000;27:63–5

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**Genital herpes and public health: addressing a global problem.**

L COREY, HH HANDSFIELD. *JAMA* 2000;283:791–4

**Reactivation of genital herpes simplex virus type 2 infection in asymptomatic seropositive persons.**


**Herpes simplex virus type 2 shedding in human immunodeficiency virus-negative men who have sex with men: frequency, patterns and risk factors.**


**Editorial response: Asymptomatic herpes simplex virus shedding and Russian roulette.**

LA STANBERRY. *Clin Infect Dis* 2000;30:268–9

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**Hepatitis**

**International congress on viral hepatitis A and B: experience in education and prevention.**

Vaccine 2000;18:Suppl 1 (whole issue)

**The seroprevalence of hepatitis A and B in people testing positive for hepatitis C.**

LA KIEFER, A HONISH, G PREDY, JA TALBOT. *Can Med Assoc J* 2000;162:207–8

**‘Silent killer’ or benign disease? The dilemma of hepatitis C virus outcomes.**


**Hepatitis C epidemiology: injecting new tools in the field.**

DL THOMAS. *Hepatology* 2000;31:790–806

**45-Year follow-up of hepatitis C virus infection in healthy young adults.**


**Prevalence of hepatitis G virus in patients with hemophilia and their steady female sexual partners.**


**Are booster immunizations needed for lifelong hepatitis B immunity?**


**Cellular and humoral immune responses induced by intradermal or intramuscular vaccination with the major hepatitis B surface antigen.**


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**Herpes**

**Herpes simplex type 2 infection in the developing world: is it time to address this disease?**

L COREY. *Sex Transm Dis* 2000;27:30–1

**Human immunodeficiency virus infection and genital ulcer disease in South Africa: the herpetic connection.**


**Medical care expenditures for genital herpes in the United States.**

CY TAO, WJ KASSLER, DB REIN. *Sex Transm Dis* 2000;27:32–8

**Herpes simplex virus DNA in amniotic fluid without neonatal infection.**


**Herpes simplex virus infection of the uterine cervix—relationship with a cervical factor?**


**The herpesvirus proteases as targets for antiviral chemotherapy.**


**Monoclonal antibodies suitable for type-specific identification of herpes simplex viruses by a rapid culture assay.**


**Establishment of latent herpes simplex virus type 1 infection in resistant, sensitive and immunodeficient mouse strains.**

AR ELLISON, L YANG, C VOYTEK, TP MARGOLIS. *Virology* 2000;268:17–28

**Herpes simplex virus infection blocks events in the G1 phase of the cell cycle.**

B SONG, J LIEG, KC YEH, DM KNIPPE. *Virology* 2000;267:326–34

Virus-induced neuronal apoptosis blocked by the herpes simplex virus latency-associated transcript. GC PERNG, C JONES, J CIACCIANELLA et al. Science 2000;287:1500–2

Herpes simplex virus type-1 and -2 pathogenesis is restricted by the epithelial basement membrane. BS WEEKS, RS RAMCHANDRAN, JJ HOPKINS, HS FRIEDMAN. Arch Virol 2000;145:385–96


Human papillomavirus-associated carcinomas in Hawaii and the mainland US. M FRANCHI, MT GOODMAN. Cancer 2000;88:1464–9


Human papillomavirus types 16 E6 and E7 contribute differently to carcinogenesis. S SONG, A LIEM, JA MILLER, PF LAMBERT. Virology 2000;267:141–50


The human papillomavirus type 16 E5 protein modulates ERK1/2 and p38 MAP kinase activation by an EGFR-independent process in stressed human keratinocytes. K CRESUES, J RODRIGUEZ, A ALONSO. Virus Genes 2000;20:65–70

Human papillomavirus infection

Cervical cytology and colposcopy

Is it feasible for women to perform their own Pap smears? A research question in progress.

Human papillomavirus testing for triage of women with cytologic evidence of low-grade squamous intraepithelial lesions: baseline data from a randomized trial.

Revisiting age effect of the Pap test on cervical cancer.

MR KOK, ME BOON, RH SCHREINER-KOK, LG KESS. Hum Pathol 2000;31:23–8

Comparison of immediate and deferred colposcopy in a cervical screening program.

Quality control of cervical cytology in high-risk women: PAPNET system compared with manual rescreening.

Incidence of cervical squamous intraepithelial lesions in HIV-infected women.

Vaginal intraepithelial neoplasia and the Pap smear.
RM DAVILA, MC MIRANDA. Acta Cytol 2000;44:137–40

Effects of tamoxifen on cervicovaginal smears from patients with breast cancer.
MA ARADA, RR BARAKAT, PR SAIGO. Acta Cytol 2000;44:141–6

A comparison of the side effects of prilocaine with felypressin and lignocaine with adrenaline in large loop excision of the transformation zone of the cervix: results of a randomized trial.

Completeness of excision and follow up cytology in patients treated with loop excision biopsy.

Expression of MNCA9 protein in Pananicolau smears containing atypical glandular cells of undetermined significance is a diagnostic biomarker of cervical dysplasia and neoplasia.
AY LIAO, EJ STANBRIDGE. Cancer 2000;88:1108–21

Other sexually transmitted infections

Scabies and pediculosis.
O CROSSENDON. Lancet 2000;355:819–26

Risk factors for human herpesvirus 8 seropositivity and seroconversion in a cohort of homosexual men.

Invited commentary: Determining specific sexual practices associated with human herpesvirus 8 transmission.

Dukers et al respond to “Sexual practices associated with HHV8 infection”.
NHTM DUCKERS, RA COUTENHO, J GOMSMAIT. Am J Epidemiol 2000;151:230

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