Comparing guidelines for the management of anogenital warts

What is the purpose of guidelines for management of clinical conditions? Implicit in the term guidelines is that they should provide a guide to diagnosis, treatment, and related management issues of a specific condition without being unduly prescriptive as that may alienate their use by those who do not always want to follow the “mantra.” Successful guidelines based on sound evidence should be seen to improve outcomes for patients and be adapted across the spectrum of services to which the particular condition presents. Two recently published evidence based guidelines—the national guidelines for the management of anogenital warts1 (AGW) and the European course on the HPV associated pathology: guidelines for the diagnosis and management of AGW,2 are efforts to accomplish these aims. Comparing these two, the most striking differences are ones of style and scope. The national guidelines is the work of a single author written to a brief which imposed a “house” style and concision to conform with the 22 other national guidelines on sexually transmitted infections jointly commissioned by the UK professional bodies, the Medical Society for the Study of Venereal Diseases, and the Association of Genitourinary Medicine. The European guidelines is the product of a multinational group of clinicians, pathologists, and virologists dedicated to teaching important principles for practice and management of HPV disease to physicians, gynaecologists, and other disciplines. As such, the European guidelines adopt a more didactic style with an expanded text which allows, among other things, for direction on how to perform procedures such as meatoscopy, the acetic acid test, differential diagnosis, and details of mechanism of action and outcomes of therapies. Both use the same guidelines to grading of evidence supporting treatment recommendations developed by the agency of Health Care Policy and Research.3 Of the treatments covered in both texts it is reassuring that identical conclusions as to the level of evidence available was reached. What is, of course, evident is that much yet remains to be done to provide a sound evidence base for all available treatments. The most striking difference on treatment is the exclusion for consideration by the European guidelines of the use of podophyllin and 5-fluorouracil, both being dismissed as no longer recommendable—a view which others would hold.4 In the United Kingdom podophyllin is still a widely used clinic based treatment and as such it would not have been possible to omit from the national guidelines. Certainly as far as the United Kingdom is concerned, many women have cytology taken at too young an age, and too frequently if they have AGW. This is a hangover from the evolution of our understanding of the natural history of human papillomavirus infection of the cervix which needs correcting.

Included in the national guidelines are reference to the use of the guidelines against which to audit practice. This is of particular importance with respect to clinical governance which is certainly the forefront in United Kingdom medicine today. Also, treatments are costed in the national guidelines although, with different pricing structures, it would not have been possible to give figures for the European guidelines. Overall, the encouraging feature of these two guidelines is their concordance in almost all aspects of practice, with the greater detail making the European guidelines perhaps more of a teaching aid. Both help to highlight areas of deficiency in our practice and as such should be useful in pointing the way for areas of research. The greatest challenge as far as these and other guidelines are concerned is how they are going to be disseminated outside a relatively small group of specialists to many other practitioners who encounter these conditions in daily practice.

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LETTERS TO THE EDITOR

Lymphatic filariasis—lest we forget

EDITOR,—Lymphatic filariasis is characterised by a wide range of clinical manifestations. In a non-endemic area the diagnosis may be missed unless the index of suspicion is high.

An 18 year old sexually active male presented with a progressively increasing painless nodular swelling in the right inguinal region of 4 months’ duration. The patient had an unprovoked vaginal contact with a commercial sex worker 6 months earlier. There was no history of genital ulcer or urethral discharge. The general health of the patient was preserved. Examination revealed an enlarged right inguinal and external iliac lymph nodes, 1–3 cm in size, firm, mobile, non-tender, and matted with normal overlying skin. Examination of genital, anal, and buccal mucosa was normal. There was no other lymphadenopathy. A differential diagnosis of lymphogranuloma venereum (LGV) and tuberculous lymphadenitis was considered. Complete blood count revealed mild leucocytosis and eosinophilia. Renal and hepatic functions, urinalysis, and chest X-ray were normal. A complement fixation test for chlamydia group specific antibody was negative. Fine needle aspiration cytology from the nodes revealed reactive hyperplasia with occasional giant cells and microfilariae of Wuchereria bancrofti. Nocturnal blood samples for microfilariae were negative.

The patient was given diethylcarbamazine 100 mg thrice daily for 2 weeks. The lymph nodes regressed and no relapse was observed in 6 months of follow up.

The differential diagnosis of inguinal lymphadenopathy in a sexually active male includes syphilis, genital herpes, chancroid, LGV, pyogenic adenitis, tuberculosis, and lymphoma.1 In the present case a diagnosis of LGV was considered in view of a history of sexual contact, painless and non-suppurative lymphadenopathy not apparently preceded by a genital ulcer.

Demonstration of microfilariae was decisive in clinching the diagnosis of filariasis which was not considered in the differential diagnosis. Presentation with inguinal lymphadenopathy is a feature common to both LGV and filariasis. The most frequent manifestation of secondary stage of LGV in men is unilateral inguinal lymphadenopathy which does not suppurate in two thirds of cases.1 In inguinal lymphadenopathy often develops in LGV as was observed in our patient.2 Painful enlargement of inguinal lymph nodes with fever is the usual presentation in lymphatic filariasis. Lymphangitis can accompany recurrent attacks. Other complications include orchitis, funiculitis, and epididymitis.1,3 These were, however, absent in our patient. It is suggested that lymphatic filariasis should be considered in differential diagnosis of inguinal lymphadenopathy even in areas which are not known to be endemic for it. It is otherwise likely to be missed.

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Accepted for publication 7 June 2000

Acceptability of home screening for chlamydial infection: some remaining issues

EDITOR,—In the recent article by Stephenson et al4 the authors describe participation rates of 39% for women and 46% for men for home screening and comment that this might form a useful addition to a community-based chlamydial screening programme in which non-responders could be offered opportunistic screening at the general practice.5 However, certain crucial issues remain unanswered. This acceptability survey was done among women aged 18–25 years and men 18–30 years. What happens with people below the age of 18? We know that Chlamydia trachomatis prevalence is associated with young age, but can we also send home screening kits to 15 year olds? What about the paraphilias and legal implications—for example, for the partner of a C trachomatis positive youngster? In two surveys performed in general practice in Amsterdam, Netherlands, the systematic and opportunistic screening, prevalence was strongly associated with young age but also with ethnicity. Among young Surinam-Antillan women aged <25 years, prevalence ranged from 5–10% in the general survey up to 22.4% in the opportunistic survey.1,2 In the systematic survey an unexpectedly high C trachomatis prevalence of 10% was found among young Surinam-Antillan men. Among the 15–19 year olds visiting our health centre in Amsterdam which is located in a multiethnic neighbourhood, half of the population having a Surinam-Antillan background, C trachomatis prevalence was 25%.3,4,5 The question is not whether home acceptable screening is for the youngest age group, who might be most at risk, but also how acceptable home testing is for people with different ethnic backgrounds and people living in low socioeconomic status and high risk environments.

We piloted a pharmacy assisted approach offering urine home testing to all sexually active women age 15–30 years who came to our pharmacy to collect their contraceptives. Since the start 4 months ago 189 people received an information leaflet and home test package together with their contraceptives. Fifty nine participated and sent their urine; four were positive (6.7%).6 The participation rate was 31%, lower than the reported rate for women in the article of Stephenson et al.

The assumption by the authors that people who do not participate for home screening will turn up for opportunistic screening at the general practice is, however, merely a hypothesis, and not a strong one, especially not for boys and men.

Tackling issues like risk perception and risk environment and changing healthcare seeking behaviours is not an easy task. Moreover, a community based C trachomatis prevention programme will require not only secondary prevention by active case finding but also primary prevention. What is needed is an integrated set of strategies, which are mutually reinforcing and that are age, sex, culture, and context specific. Quite a challenge!

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Nurse counselling for women with abnormal cervical cytology improves colposcopy and cytology follow up attendance rates

Editor,—A well organised cervical screening programme has considerable benefits; however, one negative aspect is anxiety associated with abnormal results. The NHSCSP guidelines state that an explanatory leaflet should be given to women with abnormal cytology and that an explanatory leaflet should be written in the language in which the woman is comfortable. In the Wirral, 2651 patients were screened in the clinic. Our experience during the chlamydia pilot study is that this population prefer oral, written, or written and verbal explanations. Lerman et al found that a brief, simple booklet increased knowledge and reduced anxiety whereas a more complex booklet increased knowledge but did not reduce anxiety. The default rates were lower in those receiving the verbal explanation. Lerman et al found that women with abnormal cervical cytology who defaulted colposcopy appointments were more worried about cancer with impairment of mood and sleeping. If following the explanation our default rate for colposcopy was within the 15% recommended target,1 and follow up cytology was similar to the rates reported in primary care.2

There are deficits in this study. The lack of randomisation means the improvement in default rates could be the result of baseline differences rather than the verbal explanation. However, it has shown benefit to the women by improving understanding. The department has also benefited; although extra nursing time has been required, the lower default rates for colposcopy and cytology has reduced the clerical, medical, and secretarial time normally required recalling non-attendees.

Table 1 The questionnaire results before and after the verbal explanation

<table>
<thead>
<tr>
<th>Question</th>
<th>Response (n=89) Before</th>
<th>After</th>
<th>χ² test p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well do you understand the result you have been given?</td>
<td>Not at all</td>
<td>26</td>
<td>1</td>
</tr>
<tr>
<td>A little</td>
<td>3</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>27</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Are you worried about the result of your smear test?</td>
<td>Yes</td>
<td>45</td>
<td>13</td>
</tr>
<tr>
<td>A little</td>
<td>42</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Will it worry you if we need to do further investigations?</td>
<td>Yes</td>
<td>36</td>
<td>11</td>
</tr>
<tr>
<td>A little</td>
<td>40</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Are you worried that further investigations will be painful?</td>
<td>Yes</td>
<td>55</td>
<td>28</td>
</tr>
<tr>
<td>Don’t know</td>
<td>11</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>23</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Do you think that any abnormality found can be treated?</td>
<td>Yes</td>
<td>61</td>
<td>85</td>
</tr>
<tr>
<td>Don’t know</td>
<td>25</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Do you think you have cancer?</td>
<td>Yes</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>34</td>
<td>9</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>No</td>
<td>50</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Do you think this smear result will affect your ability to have children?</td>
<td>Yes</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>34</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>40</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Do you think this result will change your attitude to sex with your partner?</td>
<td>Yes</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Don’t know</td>
<td>30</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>41</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Do you think this result will affect the way your partner thinks of you?</td>
<td>Yes</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Don’t know</td>
<td>13</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>68</td>
<td>75</td>
<td></td>
</tr>
</tbody>
</table>


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Phone sex: information technology (IT) and sexually transmitted infection in young people

Editor,—The recent article on the acceptability of home testing for chlamydial was noted.1 We would like to extrapolate this concept. Young people could be accessed via an internet clinic. Our experience during the chlamydia pilot study is that this population prefer oral, written, and verbal explanations. Bryant et al found that a brief, simple booklet increased knowledge and reduced anxiety whereas a more complex booklet increased knowledge but did not reduce anxiety. The default rates were lower in those receiving the verbal explanation. Bryant et al found that women with abnormal cervical cytology who defaulted colposcopy appointments were more worried about cancer with impairment of mood and sleeping. If following the explanation our default rate for colposcopy was within the 15% recommended target,1 and follow up cytology was similar to the rates reported in primary care.2

There are deficits in this study. The lack of randomisation means the improvement in default rates could be the result of baseline differences rather than the verbal explanation. However, it has shown benefit to the women by improving understanding. The department has also benefited; although extra nursing time has been required, the lower default rates for colposcopy and cytology has reduced the clerical, medical, and secretarial time normally required recalling non-attendees.

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Letters, Book reviews, Notices, Correction, Current publications

www.sextransinf.com
Other infections should not be overlooked. Partner notification is necessary. Contact slips could be supplied but the health adviser’s role should not be underestimated.

Security on the internet would have to be addressed. However, the anonymity and convenience of participating from home may increase testing for STIs. This may appeal to younger patients particularly, in view of their experience with IT.

In summary, IT is rising in the younger population. Their utilisation of technology is demonstrated by mobile phone use in the chlamydia pilot study. Health providers should respond using media with which the target population is comfortable. We might just access patients more effectively through the use of the Internet, particularly for younger patients particularly, in view of their experience with IT.

EDITOR,—Gonorrhoea is one of the oldest and most widespread sexually transmitted infections. The incidence of this infection has changed from a trend of steady decline to a recent increase in many parts of the world.1–3 The pattern of incidence is closely related to socioeconomic conditions.1–4

An incidence graph of Mersey Region figures (fig 1) for the 1990s and a discussion on the possible factors associated with the changing pattern is presented here. The incidence from the Mersey Region shows a steady decline until the mid 1990s followed by a recent increase and represents the trend in most areas. In spite of the advances in the diagnostic and therapeutic field, organised health advisory system, easy access walk-in clinics, complete confidentiality, and free treatments; the incidence of gonorrhoea is rising. From the broader analysis of the situation, it is possible to say that most of the factors behind this changing pattern are socioeconomic. The factors may include advances in contraceptives, sexual liberalisation, increase in the mobility of population, and the changing economic environment. The cumulative result of all these factors is an increase in casual relationships. Casual sex is made riskier when it is performed unprotected and without much knowledge about the partner and is possibly the main reason behind the poor contact tracing of only 0.5 out of an average of 1.5 per patient.4

Some of these factors are part of the wider evolutionary process and are difficult issues to deal with, but preventive measures may be taken against them. In spite of the recent advances and better understanding of the disease in the recent years, there is still a lack of awareness, in the general population, of the possible mental and physical effects of such infection. The significant fall in the incidence of gonorrhoea seen in the late 1980s, secondary to extensive media coverage of HIV infection, shows how effective such campaigns can be. The present rise in the incidence of gonorrhoea in the past few years shows clearly that our prevention campaigns are not effective.

The young teenagers who make up the pool of supply and the young females who make up the pool of asymptomatic reservoirs of the infection, are the two core groups our campaigns should be targeting. At present there is no programme in the school curriculum about sexual health and no regular screening programme for sexually active young females.

A programme of short term measures, such as education on sexual health and sexually transmitted diseases to sexual transmitted diseases in sexually abused children and adolescents, combined with the cervical smear screening programme at very little additional cost. Short term programmes, like vigorous media campaigns nationally and poster and leaflet campaigns locally in high risk recreational areas like pubs and clubs, may have an educational value and help reduce the incidence.

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Russian STI


We hope for further collaboration. We shall inform you about our future plans.

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Acting editor

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Chelitis in association with indinavir

EDITOR,—There is increasing speculation that indinavir may cause side effects which have been previously associated with high concentrations of retinoids. In the presence of all-trans-retinoic acid (ATRA), indinavir, but not other protease inhibitors (PIs), alters stem cell differentiation in vitro, not seen in the presence of ATRA alone.5 Alopecia and chelitis are two side effects associated with both retinoids and the protease inhibitor indinavir (but not with any of the other protease inhibitors). These side effects can be
reversed on changing from indinavir to an alternative PI. We report a case of cheilitis associated with indinavir which resolved rapidly on changing treatment.

A 35 year old African man developed cheilitis (fig 1A) 5 months after commencing HAART with stavudine, lamivudine, and indinavir. His CD4 lymphocyte count at that time was 238 cells ×10⁹/l, with an HIV viral load of 78 copies per ml (Chiron bDNA assay version 3) He had a medical history of granulomatous uveitis of undetermined cause, which developed before HAART. It responded to prolonged treatment with oral prednisolone 40 mg daily and has since remained quiescent. The oral corticosteroids were tailed off and finally discontinued a month before the cheilitis developed. Following the development of cheilitis, further investigations showed: positive IgG antinuclear antibodies with a homogeneous pattern and a titre of 1 in 320; rheumatoid factor positive 1 in 40; anti-Ro and anti-Scl-70 both negative; serum antigens converting enzyme 75 U/l (normal range 20–95); chest x-ray normal; C reactive protein 1 mg/l; erythrocyte sedimentation rate 4 mm in the first hour. Biopsy of the lip showed acanthosis and parakeratosis without associated inflammation. It was initially considered that the cheilitis might be an autoimmune phenomenon, but topical treatment with Eumovate (clobetasone butyrate, GlaxoWellcome) failed to improve the condition, which persisted for 10 months until the indinavir was changed to efavirenz. At the time of changing therapy his CD4 count was 418 cells ×10⁹/l, with an HIV viral load below detection. Within a week of changing therapy the cheilitis resolved completely (fig 1B).

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M SHAHMANESH

BOOK REVIEW


This book is a must for anyone interested in how this fascinating organism causes disease. The first part reviews the knowledge on the molecular phylogeny, genomic autotigraphy, developmental biology, and metabolism of chlamydiae. It shows how far our knowledge of the organism has broadened in the past few years, particularly as gene sequencing has changed our view of chlamydiae. Until this was made available, metabolic studies on chlamydiae were hampered by its intracellular obligate nature, lack of knowledge of the enzyme pathways, and the relatively small genome which suggested very limited metabolic activity. It now becomes apparent that the organism, which we believed to be biologically crippled, has quite sophisticated biosynthetic capabilities. This opens the way to creating a non-cell dependent culture system in the future.

A chapter by Ted Hackstadt on the cell biology shows a whole spectrum of novel interactions with the host cell that contribute to the success of the genus as pathogens. This is followed by an excellent chapter by Julius Schachter on infection and disease epidemiology. He makes the interesting point that given that some individuals lose antibody over time it is possible that almost all humans have met the organism at sometimes in their lives. This may be quite important in understanding some of the longer term consequences of chlamydial infections, where the organism may not be isolated and antibody tests may be negative. These sequelae are covered in subsequent chapters by Michael Ward, Robert Brunam, and Roger Rank. Since all three concentrate on immunological response to chlamydia there is bound to be some overlap, but also some differences and interesting emphasis. For example Ward plays down the current obsession with cross reactions between chlamydia and human heat shock proteins.

A lot of our information, particularly on the immunology, comes from animal studies and their relevance to human pathology remains to be established. In an excellent final chapter Penelope Hitchcock points to the future directions of research. In particular, she laments that little research has been done in men with chlamydia. Certainly the book is rather short on discussion of the male. There is also a need to find a male model for pathogenesis. Non-gonococcal urethritis maybe a suitable, and easily accessible, marker of chlamydial infection in men and deserves more in-depth study. Much more research also needs to be done, particularly, on clinically inapparent infections in the human. This book is a must for all those interested in this fascinating organism. Perhaps while not losing sight of the “why” and the “how” of sexual transmission we should also divert some resources into the “how” of its damage.

NOTES

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@tsp.sheridan.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-1013, Latvia (tel: +(371) 7370395; fax: +(371) 7361615; email: arubins@apollo.lv).

National NCCG Update Meeting, Bromsgrove Stakis 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, Organising Secretary, IUSTI–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) 744001/745078; email: kumarbhushan@hotmail.com).
An error occurred in the editorial by R D Maw which was published in the June issue (JST 2000;76:153). In the second column, lines 2–5, pheophytin should be replaced by podophyllotoxin in each case.
Prevalence of *Chlamydia trachomatis* in urine of male patients with ankylosing spondylitis is not increased.


The value of *Chlamydia trachomatis* antibody testing as part of routine infertility investigations.

K THOMAS, L BOUGHELIN, PT MANNING, NG HADDAD. *Hum Reprod* 2000;15:1079–82

Low correlation of serology with detection of *Chlamydia trachomatis* by ligase chain reaction and antigen ELISA.


The relationship of inflammation in the Papanicolaou smear to *Chlamydia trachomatis* infection in a high-risk population.


Candida vaginitis—self-reported incidence and associated costs.


Experimental candidiasis. Pathogenesis, prevention, therapy.

E SEGAL. *Mycoses* 2000;45–8

Estrogen effects on *Candida albicans*: a potential virulence-regulating mechanism.

XQ ZHANG, M ESMANN, ET BURT, B LARSEN. *J Infect Dis* 2000;181:1441–6

Investigation of e-glucosidase as a potential virulence factor of *Candida albicans*.


Cytokine modulation of specific and nonspecific immunity to *Candida albicans*.

L ROMANI. *Mycoses* 2000;42:45–8

Histidine kinase, two-component signal transduction proteins of *Candida albicans* and the pathogenesis of candidiosis.

JA CALERA, R CALDERONE. *Mycoses* 2000;42:49–54

Differential activation of a *Candida albicans* virulence gene family during infection.


Bacterial vaginosis.

**Bacterial vaginosis.**


Candida vaginitis—self-reported incidence and associated costs.


Pelvic inflammatory disease.

**Pelvic inflammatory disease.**

Risk factors for pelvic inflammatory disease in inner-city adolescents.

AL SUNS, F HOMEL, H MAMMERBACHL, K BROMBERG. *Sex Transm Dis* 2000;27:289–91

Syphilis and other treponematoses.

**Syphilis and other treponematoses.**

Potential for community-based screening, treatment and antibiotic prophylaxis for syphilis prevention.

RH KAIN, KE MOSELEY, G JOHNSON, TA FARLEY. *Sex Transm Dis* 2000;27:188–92

Posterior uveitis in patients with positive serology for syphilis.


*Treponema pallidum* surface immunofluorescence assay for serologic diagnosis of syphilis.


A pilot study evaluating ceftriaxone and penicillin G as treatment agents for neurosyphilis in human immunodeficiency virus-infected individuals.


Opsonic potential, protective capacity and sequence conservation of the *Treponema pallidum* subspecies *pallidum* Tp92.


**Hepatitis**

Natural history of hepatitis C: its impact on clinical management.

AM DURCZELL. *Hepatology* 2000;31:1014–9

Seroprevalence and risk factors of hepatitis B, hepatitis C and human cytomegalovirus among HIV-infected and high-risk uninfected adolescents—findings of the REACH study.


**Herpes**

Herpes simplex virus type 1 as a cause of genital herpes: impact on surveillance and prevention.

WE LAFERTY, L DOWNBY, C CELLUM, A WALD. *J Infect Dis* 2000;181:1454–7

Testing for herpes simplex virus type 2—full steam ahead? (Editorial).

J MILLS. *Sex Transm Dis* 2000;27:270–1

HSV-2 specific serology should be offered routinely to antenatal patients.


HSV-2 specific serology should not be offered routinely to antenatal patients.


Seroprevalence of herpes simplex virus type 2 infection among attendees of a sexually transmitted disease clinic in Italy.


Herpes simplex virus-type 2 seropositivity in a Danish adult population denying previous episodes of genital herpes.

CS PETERSEN, FG LARSEN, C ZACHARIAE, M HEIDENHEIL. *Acta Dermato-Venereol* 2000;80:158
Seroprevalence of herpes simplex virus type 1 and type 2 in selected German populations—relevance for the incidence of genital herpes.

Valaciclovir—a review of its long term utility in the management of genital herpes simplex virus and cytomegalovirus infections.

Characterization of an acyclovir-resistant herpes simplex virus type 2 strain isolated from a premature neonate.

HSV.com: Maneuvering the internet-works of viral neuropathogenesis and evasion of the host defense.

Molecular epidemiology of herpes simplex virus type 1 genital infection in association with clinical manifestations.

Evaluation of an enzyme-linked viral inducible system for the rapid detection of herpes simplex virus.

Premarket evaluation of the POCkit HSV-2 type-specific serologic test in culture–documented cases of genital herpes simplex virus type 2.

Immunisation with phage displaying peptides representing single epitopes of the glycoprotein G can give rise to protective immunity to HSV-2.

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