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 meaotscopy, 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 professional—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 the days of indiscriminate application of podophyllin to all AGW should be over, but judicious use may still have its place for small numbers of soft poorly keratinised warts—for example, subpreputially.

There are still no studies comparing different modalities depending on morphology, although differing responses are much quoted. With the wider use of home based therapies, podophyllin and imiquimod, it may well be time to consign podophyllin and 5-FU to the archives. Neither guideline attempts to tackle the problem of interpreting combination therapies. One omission from the national guidelines is that monopolar electro surgery should not be used in pregnancy because of the risk of transmission of current to the uterine contents.

Guidance as to the frequency of cervical cytology specimens for women with AGW is not given in the European guidelines, which may be because there are different national guidelines across Europe. 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 certain to 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 unprotected 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 node, 1–3 cm in size, firm, mobile, non-tender, and without 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 tuberculosis 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, syphilitic adenitis, tuberculous adenitis, and lymphoma.

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 Iliac lymphadenopathy often develops in LGV as was observed in our patient.1 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 2 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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Canary to sparrow; what is in a name?

Editor,—The Contagious Diseases Act of 1864 allowed for the compulsory arrest, examination, and treatment of women considered (by an all male board) to be of loose morals. Women were detained in the so-called “Canary wards” and their identity made clear by the bright yellow garments they were made to wear.

In the year 2000, there is still perceived stigma and blame associated with the diagnosis of sexually transmitted infections (STIs) and this must be minimised if a screening programme for chlamydia is to be successful. It will help reduce stigma if people know and accept that it is not a disease of a few readily identifiable people but that it is common and easy to acquire. It has been estimated that one in 14 young people will acquire it at some time.

In the NHS chlamydia pilot screening programme in Wirral and Portsmouth we are confirming that this infection is indeed endemic. Information material for the pilot study clearly states that it is a very common infection. To reduce the element of blame, we have included the text “may be missed unless the index of suspicion is high.” 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 patriarchal opinions and legal implications—for example, for the partner of a C trachomatis positive youngster?

In two surveys performed in general practice in Amsterdam, Netherlands, a 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% in the opportunistic survey up to 22.4% in the opportunistic survey.”3 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%.4

Thus, the question is not only how acceptable home 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 come 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%).5 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 health-seeking behaviours is not an easy task. Moreover, a community based C trachomatis prevention programme will require not only opportunistic 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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Canary to sparrow; what is in a name?

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. Letters, Book review, Notices, Correction, Current publications. We assessed if there is any additional benefit from a verbal explanation, following written information, when an abnormal smear result is given, in understanding and future attendance for colposcopy and cytology follow up group.

Between April and December 1998 we recruited 89 women with abnormal cytology. All women attending for results are given the NHSCSP leaflet "What your abnormal result means" if their smear shows borderline changes, mild, moderate, or severe dyskaryosis. The study women completed a questionnaire after reading the leaflet. A nurse (BH) then gave a verbal explanation about the smear result. They then completed the questionnaire again. Attendance for colposcopy and cytology follow up was recorded, default being defined as non-attendance without cancellation. Default rates were compared with other women with abnormal cytology during the same period. They were not included in the study as they attended when the specified nurse was not available. They had all received the leaflet but not a structured explanation.

The explanation for each woman took approximately 15 minutes. The results of the questionnaire before and after explanation are shown in table 1. There was a significant improvement in understanding and reduction in anxiety. The control group comprised 104 women. In the study group 65 required colposcopy; three (4.6%) defaulted, compared with seven of 38 (18.4%) women not receiving a verbal explanation; p=0.03 Fisher's exact test; OR 0.21 (95% CI 0.03–1.03). Of the study group, 81 had should have attended for follow up colposcopy 6 months after colposcopy or smear showing borderline changes; 12 (15%) defaulted compared with 37 of 95 (38.9%) women not receiving a verbal explanation; p<0.001 χ² test; OR 0.18 (95% CI 0.08–0.41). Eventually only one (1.5%) in the study group and two (5.3%) of the controls did not attend for colposcopy, and 11 (13.8%) and 24 (25.3%) defaulted follow up cytology.

Despite the leaflet the women in our study still had misunderstandings and anxieties. The verbal explanation helped clarify these. Verbal information can be tailored to the individual, some requested detailed descriptions, others preferred a simpler explanation (as reported previously). This is not possible with written information. Marteau 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 cytology who defaulted colposcopy appointments were more worried about cancer with impairment of marital and sleeping. Following the explanation our default rate for colposcopy was within the 15% recommended target, and follow up cytology was similar to the rates reported in primary care.

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-attenders.

Table 1 The questionnaire results before and after the verbal explanation

<table>
<thead>
<tr>
<th>Question</th>
<th>Response (n=89)</th>
<th>Before</th>
<th>After</th>
<th>χ² 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>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>A little</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>
<td></td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>42</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td></td>
<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>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>40</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>13</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Are you worried that further investigations will be painful?</td>
<td>Yes</td>
<td>55</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don't know</td>
<td>11</td>
<td>14</td>
<td>0.0002</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>47</td>
<td></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>
<td></td>
</tr>
<tr>
<td></td>
<td>Don't know</td>
<td>25</td>
<td>4</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<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>
<td></td>
</tr>
<tr>
<td></td>
<td>Don't know</td>
<td>34</td>
<td>9</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>79</td>
<td></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>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>Don't know</td>
<td>34</td>
<td>10</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>40</td>
<td>77</td>
<td></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>
<td>0.004</td>
</tr>
<tr>
<td></td>
<td>Don't know</td>
<td>30</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<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>
<td></td>
</tr>
<tr>
<td></td>
<td>Don't know</td>
<td>13</td>
<td>10</td>
<td>0.36</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>68</td>
<td>75</td>
<td></td>
</tr>
</tbody>
</table>


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

EDITOR,—The recent article on the acceptability of home testing for chlamydia 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 makes extensive use of technology, in particular mobile phones. The presence of sex on the internet has been widely publicised. We propose that testing for sexually transmitted infection (STI) via mobile internet is the next logical step.

The chlamydia pilot study was funded by the Department of Health, to investigate the feasibility of screening 16–25 year old women (and some men), for chlamydia, using a urine specimen. Antibiotics for chlamydia are cheap and effective. The cost of complications to the individual is enormous, as is the cost to the NHS—£200 million per year.2 Screening reduced the prevalence of infection in Sweden and the United States.3 Computer modelling suggests that screening in this country would be cost effective.4

After screening for chlamydia, a means of contacting clients to give results was arranged—for example, letter or phone call. On the Wirral, 2651 patients were screened in the first 4 months—2323 women and 285 men (34, sex not recorded). Sixty eight (2.6%) gave a mobile phone number, half (35) using this as their only means of contact. Sixty five were female and two male (one patient not recorded). Thus, women (2.8%) were more likely to use mobile phones than men (0.7%) (p > 0.05). The genitourinary medicine (GUM) clinic screened 358 patients. Only 68 (19%) gave an address. The results of a further 469 (17.7%) of the screened population went back to the screening site. These clients could be interested in contact via mobile phone if it was openly offered (data collected from the Public Health Laboratory Service (PHLS) database and analysed on iPH-INFO 6).

According to a survey by NOP Social and Political, confidentiality is important to people in the target age group (unpublished data). Patients consider their mobile phones to be a secure method of communication between themselves and us. The advent of DNA amplification in the detection of STIs has opened up new possibilities.5 6 There are 30 000 websites pertaining to chlamydia. An internet clinic would be aimed at mildly symptomatic or asymptomatic patients. The client would access the website and request swabs or urine pots through the post then return them the same way.

If the patients were positive, they would need to attend a GUM clinic or equivalent.
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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 a whole generation. The future’s bright . . .

Conflicts of interest: None.

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Figure 1 Total incidence of gonorrhoea in the Mersey Region in 1990–9 (in absolute numbers).


Gonorrhoea: an incidence graph of Mersey region data for the 1990s and discussion on the factors behind the changing pattern of incidence

Editor.—Gonorrhoea is one of the oldest and a highly infectious sexually transmitted infection. Its prevalence is dynamic and fluctuates over time and is influenced by a number of factors. The incidence of this infection has changed from a trend of steady decline to a recent increase in many parts of the world.\(^1\)\(^2\) The pattern of incidence is closely related to socioeconomic conditions.\(^3\)\(^4\)

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.\(^5\)

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 the others. 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 long term measures, such as education on sexual health and sexually transmitted infections in schools, and a programme of regular screening for gonorrhoea (and chlamydia) for all sexually active young females, may be useful and this can be, to start with, 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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Cheilitis 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.\(^1\) Alopecia and cheilitis 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 $\times 10^3$/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 Sc1-70 both negative; serum angiotensin 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 $\times 10^3$/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 autobiography, 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 novel 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 site of the “why” and the “how” of sexual transmission we should also divert some resources into the “how” of its damage.

M SHAHMANESH

NOTICES

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.IHMFOrg) 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@tpsp.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 of 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) 744041/745078; email: kumarbhushan@hotmail.com).
CURRENT PUBLICATIONS

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

**Gonorrhoea**

- *Gonorrhoea, chlamydia and the sexual network—pushing the envelope (Editorial).* JM ZEILMAN, Sex Transm Dis 2000; 27:224–5

Comparative epidemiology of heterosexual gonococcal and chlamydial networks—implications for transmission patterns.


- *AC SENA, WC MILLER, IF HOFFMAN ET AL. Clin Infect Dis 2000; 30:742–9*  
  Unique gonococcal phenotype associated with asymptomatic infection in men and with erroneous diagnosis of nongonococcal urethritis.

- *WH WHITTINGTON, KK HOLMES. J Infect Dis 2000; 181:1044–8*  
  Asymptomatic infections have been associated with strains of *Neisseria gonorrhoeae* belonging to certain phenotypes; arginine, hypoxanthine, and uracil requiring (AHU) and proline, citrulline, and uracil requiring (PCU).

  Reexamination of the prevalence of *Chlamydia trachomatis* infection among gay men with urethritis—implications for STD policy and HIV prevention activities.

- *EL CEMENS, J FLOOD, CK KENT ET AL. Sex Transm Dis 2000; 27:249–51*  
  Pooling of urine specimens for detection of asymptomatic *Chlamydia trachomatis* infections by PCR in a low-prevalence population: cost-saving strategy for epidemiological studies and screening programs.

- *KA MOORE, CLM MEIJER, C MUNK ET AL. J Clin Microbiol 2000; 38:1679–83*  
  Multiple drug-resistant *Chlamydia trachomatis* associated with clinical treatment failure.

**Chlamydia**

- *J SOMAN, VR BHULLAR, KA WORKOFFSE ET AL. J Infect Dis 2000; 181:1421–7*  
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  Multiple drug-resistant *Chlamydia trachomatis* associated with clinical treatment failure.
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.

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Bacterial vaginosis

Bacterial vaginosis.

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A simplified and reliable HPV testing of archival Papanicolaou-stained cervical smears: application to cervical smears from cancer patients starting with cyto logical normal smears.

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