LETTERS TO THE EDITOR

Carbamazepine in Reiter's syndrome

EDITOR,—A psoriatic spectrum with Reiter's syndrome as the most severe manifestation occurs with greater frequency in HIV infected individuals. Immunosuppressive therapies for RS are associated with a poor response and increased morbidity. We describe a case where carbamazepine showed an excellent response in an HIV infected patient with Reiter's syndrome.

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). Patellar and plantar keratoderma, andsoles involvement with a poor response were noted. 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 ×10³/l. Fetal bovine serum antibody 1/127 and rheumatoid factor were negative. The patient was 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 noradrenaline (norepinephrine) 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 subsequent resolution of lesions on withdrawal and reinstitution of carbamazepine respectively proves its efficacy in our patient. Also, the clinical remission maintained for 1 year after stopping carbamazepine was developed 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. 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 subsequent resolution of lesions on withdrawal and reinstitution of carbamazepine respectively proves its efficacy in our patient. Also, the clinical remission maintained for 1 year after stopping carbamazepine was developed 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.

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Accepted for publication 20 March 2000

Condoms and warts

EDITOR,—Weiner et al 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. 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 warts” cases would have been homosexually active men with anal warts. This is an important risk factors for penile and anal warts may differ, potentially confusing the results of the present study.

Condoms were developed as an HIV risk measure. The condom use variable at SSHC only refers to the previous 3 months or since the last registration/disease episode. Weg et al’s article failed to mention that this variable was time limited. As 3 months is the median duration before the appearance of exophytic warts, up to half of the relevant sexual behaviour may have been overlooked.

Finally, the reference grid 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 practiced 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 service 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.

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Accepted for publication 20 March 2000

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
Photosensitivity reaction to efavirenz

EDITOR,—The non-nucleoside reverse transcriptase inhibitor (NNRTI) efavirenz is a recent addition to the armamentarium available to physicians in the treatment of 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 (didanosine/ lamivudine) and ritonavir 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 presented 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 with his medication. One week later the rash had subsided. Then having spent a day outside in the sun he had a florid recurrence of the rash affecting the exposed areas (arms, back of neck, face, and ears). The rash was signifi- cantly worse over his elbows where there was obvious blistering and oedema. His medication was stopped and 3 weeks later the rash had completely resolved. Hepatitis C antibody and porphyria screening were negative. This man had been diagnosed as HIV positive in June 1997. In March 1998 his viral load was 356 790 copies/ml (Roche PCR) and his CD 4 count was 512 × 10^3 cells/l. He was commenced on dual therapy (HAART) in March 1999. As of June 1999, his CD 4 count was 512, his viral load 400 copies/ml, and his CD 4 count was 512 × 10^3 cells/l. For the first time the viral load became undetectable (<400 copies/ml). However, after 9 months on this combination his viral load began to rebound (3192 copies/ml) and a change in antiretroviral therapy was initiated to include nevirapine and efavirenz which he initiated in the normal way (dose escalation at 2 weeks of nevirapine). He was started on this combination as he wished to take a protease sparing regimen. However, 1 week later he developed a rash affecting his entire body, especially his trunk and arms, associated with enlarged lymph nodes and constitutional symptoms, fever, and lethargy. In view of the constitutional symptoms it was decided to stop this present combination. One month later, the rash had settled, he then commenced combi- vir 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 nega- tive. Switching from nevirapine to efavirenz in this context may have 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 therapy. Photosensitivity in the context of HIV infection may not only be a presenting condition but also secondary to concomitant treatment.

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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 hos- pital had the same protocol for the treatment of CMV retinitis and employed 3 monthly ophthalmological screening of all HIV in- fected patients with CD4 counts of less than 50 × 10^3 cells/l.

The study outcomes were visual loss and death. Moderate visual loss was defined as 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 0–192) 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 associ- ated 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 oppor- tunistic infections. Prolonged survival times with CMV retinitis have been demonstrated in patients who achieve immunological recov- ery 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 pro- spective evaluation is needed to confirm this finding.

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Azithromycin or 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 microscopy evidence of urethritis before the chlamydial result is available. Relatively few studies report the efficacy of azithromycin in the treatment of nongonococcal non-chlamydial urethritis (NGU), 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.

All of 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 leukocytes (PMNL) in five or more fields on microscopy of a urethral smear, negative culture of Neisseria gonorrhoea after direct plating onto modified New York culture medium and negative chlamydial screen on ELISA testing (Syva) of a urethral swab.

In cure was defined as either resolution of symptoms or clearing of previously positive two glass urine. A repeat urethral smear was not examined routinely.

“Treatment failure” was defined as persistent PMNL on microscopy of a urethral smear taken because of ongoing symptoms or persistent positive two glass urine test, with compliance with single dose therapy. Compliance with multidose regimens might be expected to be less good in asymptomatic patients, but with no satisfactory “test of cure” this was difficult to ascertain. Overall, there was a 25% non-attendance rate for follow up, biased towards the asymptomatic patients and those treated with oxytetracycline.

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 clinical 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.

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Accepted for publication 19 April 2000

Many elderly people maintain heterosexual and homosexual activity. Therefore this age group is at a risk of all sexually transmitted infections. In our study, a smaller percentage of older attendees had STIs compared with previous studies. 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. This finding was seen in our study as well.

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ALAN TANG
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Correspondence to: Dr Nelson David

Table 1  Diagnoses of older and younger clinic attendees

<table>
<thead>
<tr>
<th></th>
<th>Older clinic</th>
<th>Younger clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>STIs</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Latent syphilis</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital warts</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HIV</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other conditions</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Erectile dysfunction</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Balanitis</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Lichen sclerosus</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Zoon's balanitis</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital psoriasis</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital eczematous glands</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital skin tag</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital sebaceous cyst</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Miscellaneous (hepatitis B vaccination)</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Sexually transmitted infections in elderly people

Evron—Jaleel et al recently presented the incidence of sexually transmitted infections and other conditions among elderly people attending a genitourinary medicine clinic. In our genitourinary medicine department at Royal Berkshire Hospital, Reading, we studied the reasons for attendance of elderly people and compared them with the younger age group. Data were collected from patients aged 60 and above who attended the clinic between January 1998 and December 1998. Randomly selected sex matched people aged 20–35 years are taken for comparison. A total of 68 elderly people attended the clinic. The mean age was 66.5 years (range 60–83); 61 (90%) were male and seven (10%) were female. Forty one (60%) attended for STI screening and 27 (40%) attended for non-STI management. In the younger age group 60 (98%) attended for STI screening and eight (12%) attended for non-STI management (p<0.001). Sixteen (24%) older attendees had an STI compared with 35 (51%) in the younger age group (see table 1). Of the 16 older attendees with suspected STIs 11 (68%) waited over 2 weeks between symptom recognition and clinical attendance. Of 31 symptomatic attendees in the younger age group 10 (32%) waited over 2 weeks for symptom recognition and clinical attendance (p<0.001).

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

<table>
<thead>
<tr>
<th></th>
<th>1997</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number treated</td>
<td>76</td>
<td>52</td>
</tr>
<tr>
<td>Median age (range)</td>
<td>28 (18–63)</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 dm</td>
<td>8/35 (23)</td>
<td>4/25 (16)</td>
</tr>
<tr>
<td>Asymptomatic dm</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.

Many elderly people maintain heterosexual and homosexual activity. Therefore this age group is at a risk of all sexually transmitted infections. In our study, a smaller percentage of older attendees had STIs compared with previous studies. 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. This finding was seen in our study as well.

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 round 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 K 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.

Treponema pallidum remains viable in the CSF even after adequate clinical treatment.

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The old adage that we achieve clinical but not microbiological cure of syphilis with antibiot-
ics is probably true.

It is likely that most people in developed
countries nowadays who have untreated
syphilis have received treponemal antibi-
ocics for other intercurrent infections, so that
any neurosyphilis that developed would either be modified’ with few physical signs or
would be completely treated and clinically
cured. However, others disagree with this.

Dr Reed’s questioner, we haven’t seen anyone treated since the second
world war who has developed neurosyphilis in subsequent years.

DAVID GOLDMEIER

BOOK REVIEWS

Infectious Diseases. By Donald Armstrong
and Jonathan Cohen. Pp 2000; £250 (two
0723 423288.

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 com-
prehensively 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 clinical
problems. These consist of short essays with
tables or illustrations and tackle particular clinical
problems such as “the diagnosis of HIV in
pregnancy,” “what is the treatment of a posi-
tive 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 contribu-
tion in on time. One of the few criticism
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 fair to say that a large part 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 infec-
tious diseases especially those who have to
teach at each level, undergraduate or post-
graduate.

With the rise of the internet the big
textbook might perhaps be falling for extinc-
tion. 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 then there is always free
CD ROM....

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Care Trust, Chelsea and Westminster Hospital,
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1373-5.

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 com-
pletely. On the cover, it says “it is an ideal ref-
dition. 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 then there is always free
CD ROM....

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London SW10 9TH

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
unnecessary embarrassment and have some idea of likely
strategies of management.

COLM O’MAHONY
Countess of Chester Hospital NHS Trust,
Chester CH1 2UL

NOTICES

International Herpes Alliance and Inter-
national Herpes Management Forum
The International Herpes Alliance has intro-
duced a website (www.herpessalliance.org)
from which can be downloaded patient infor-
modation leaflets. Its sister organisation the
International Herpes Management Forum
(website: www.IHMF.org) has launched new
guidelines on the management of herpesvirus
infections in pregnancy at the 9th Inter-
national Congress on Infectious Disease
(ICID) in Buenos Aires.

Pan-American Health Organization, re-
gional office of the World Health Organiza-
tion
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).

Imperial College School of Medicine,
Division of Paediatrics, Obstetrics, and
Gynaecology, Advanced Course for Ob-
stetricians and Gynaecologists, 19–23
June 2000
Further details: Symposium Office, Imperial
College School of Medicine, Queen Char-
lotte’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
9398; fax: 02 9418 9398; email:
dartconv@mpx.com.au).

Imperial College School of Medicine,
Division of Paediatrics, Obstetrics, and
Gynaecology, Caring for Sexuality in
Health and Illness (for healthcare
professionals and nurses), jointly with
Association of Psychosexual Nursing
27 June 2000
Further details: Symposium Office, Imperial
College School of Medicine, Queen Char-
lotte’s and Chelsea Hospital, Goldhawk Road,
London W6 OXG (tel: 020 8383 3904; fax:
020 8383 8555; email: sympreg@ac.ac.uk).
Sexual Health and HIV Conference: Facing the Millennium, Portsmouth Marriott Hotel, Portsmouth, 28 June 2000
Further details: Rebecca Mitchell (tel: 023 9286 6796; fax: 023 9286 6769).

6th ESC Congress on Contraception in the Third Millennium: a (R)Evolution in Reproductive and Sexual Health, Ljubljana, Slovenia, 28 June–1 July 2000
Further details: Orga-Med Congress Office, Mr Peter Erazd, Essenestraat 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, Bereavement, 5 July 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: symprog@ic.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, New Horizons in Recurrent Pregnancy Loss, 29 June–1 July 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: symprog@ic.ac.uk).

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

Consortium of Thai Training Institutes for STDs and AIDS—10th STD/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 Verapol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cverapol@iatree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bangkok 10120, Thailand (fax: (66-2) 286 3013; email: pthanit@email.ksc.net).

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: palmttraining@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) 745530; fax: +91 (0172) 744001/745078; email: kumarbhushan@hotmail.com).

CURRENT PUBLICATIONS

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

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

**Gonorrhoea**

Susceptibility to gonococcal infection during the menstrual cycle.
S NOWICKI, A HARTVANTASSEL, B NOWICKI. JAMA 2000;283:1291

‘Broken windows’ and the risk of gonorrhoea.

LV TORIAN, HA MAKKI, IB MENZIES et al. AIDS 2000;14:189–96

Rise in gonorrhoea in London, UK.
IMC MARTIN, CA ISON. Lancet 2000;355:623

Urine screening for gonococcal and chlamydial infections at community-based organizations in a high-morbidity area.
CA JONES, RC KNAUP, M HAYES, BP STONER. Sex Trans Dis 2000;27:146–51

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


Prevalence and tetM subtype of tetracycline-resistant Neisseria gonorrhoeae in Ohio, 1994.
DL TREES, V FAELE, SW NEAL, JS KNAUP. Sex Trans Dis 2000;27:46–8

GM LI, Q CHEN, SC WANG. Sex Trans Dis 2000;27:115–8

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

Charged tmRNA but not tmRNA-mediated proteolysis is essential for Neisseria gonorrhoeae viability.
CH HUANG, WC WOLFGANG, J WITHEY et al. EMBO J 2000;19:1098–1107

**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.
SN TABRIZI, CK FAIRLEY, SJ CHEN et al. Sex Trans Dis 2000;27:133–7

EL CEMINS, CK KENT, J FLOOD, JD KLAUSNER. Sex Trans Dis 2000;27:165–7

Impact of switching laboratory tests on reported trends in Chlamydia trachomatis infections.
LW DICKER, DJ MOSURE, WC LEVINE, CM BLACK, JS WEBB, JF OGRIZO, X ZHOU, SG FILLER. J Infect Dis 2000;182:413–6

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

**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.
OL FIDEL, J CUTRIGH, C STEELE. Infect Immun 2000;68:413–9

Evaluation of the Oricut-N dipslide for laboratory diagnosis of vaginal candidiasis.
P CARLSON, M RICHATTSON, J PAVONEN. J Clin Microbiol 2000;38:1063–76

Clonal and spontaneous origins of fluconazole resistance in Candida albicans.
JX XU, AR RAMOS, R VILGALYS, TG MITCHELL. J Clin Microbiol 2000;38:1214–20

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

**Bacterial vaginosis**

Bacterial vaginosis.
B NIEVES. Anaerobe 1999;5:343–6

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

Pre-term labor associated with bacterial vaginosis.
H CALDERAS, B NIEVES, A QUINTANA. Anaerobe 1999;5:403–4
Trichomoniasis

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


Antigencity of Trichomonas vaginalis heat-shock proteins in human infections.


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.


Syphilis and other treponematoses

Unraveling the Tuskegee Study for untreated syphilis.


Nodular tertiary syphilis mimicking granuloma annulare.


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

R Rothenberg, L Knebrough, R Lewishardy et al. Sex Transm Dis 2000;27:12–8

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

EH Koulman, M Sternberg, M OWNN et al. AIDS 2000;14:279–88

HIV prevalence in patients with syphilis, United States.


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


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


Primary and secondary syphilis in the metropolitan area of Nashville and Davidson County, Tennessee—1996 to 1998 epidemic described.

JS Huang, WR Rogers, BBC Bailey. Sex Transm Dis 2000;27:168–74

Virulent Treponema pallidum lipoprotein and synthetic lipopeptides induce CCR5 on human monocytes and enhance their susceptibility to infection by human immunodeficiency virus type 1.


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.


‘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.


Hepatitis

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

L Corey. Sex Transm Dis 2000;27:30–1

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.


Pelvic inflammatory disease

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


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


Medical care expenditures for genital herpes in the United States.


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.


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

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.

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MA ARADI, RR BARAKAT, PR SAGO. Acta Cytol 2000;44:141–6

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

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

Other sexually transmitted infections

Scabies and pediculosis.
O CHRISSON. 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.

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**STD prevention: effectively reaching the core and a bridge population with a four-component intervention.**

CJ VANDAM, KK HOLMES. Sex Transm Dis 2000;27:9–11

**A pragmatic intervention to promote condom use by female sex workers in Thailand.**

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**Factors associated with condom use for oral sex among female brothel-based sex workers in Singapore.**

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**Effectiveness of an intervention promoting the female condom to patients at sexually transmitted disease clinics.**


**Comparisons of sexual behaviors, unprotected sex and substance use between two independent cohorts of gay and bisexual men.**

KJP CRAIB, AC WEBER, PGA CORNELISSE et al. AIDS 2000;14:303–12

**High prevalence of asymptomatic STDs in incarcerated minority male youth—a case for screening.**

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**Microbiology and immunology**

**Effects of contraceptive method on the vaginal microbial flora: a prospective evaluation.**


**Intravaginal practices, vaginal flora disturbances and acquisition of sexually transmitted diseases in Zimbabwean women.**


**Effect of chlorhexidine on genital microflora, Neisseria gonorrhoeae and Trichomonas vaginalis in vitro.**

LK RAE, SL HILLIER. Sex Transm Dis 2000;27:74–8

**Molecular epidemiologic approaches to urinary tract infection gene discovery in uropathogenic Escherichia coli.**


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**Dermatology**

**Circumcision and genital dermatoses.**


**Vulvar intraepithelial neoplasia of the simplex (differentiated) type: a clinicopathologic study including analysis of HPV and p53 expression.**


**Vulvovaginal soft tissue tumours: update and review.**

MR NUCCI, CDM FLETCHER. Histopathol 2000;36:97–108

**Protocol for the examination of specimens from patients with carcinomas and malignant melanomas of the vulva: a basis for checklists.**

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**Mucoepidermoid carcinoma arising in the glans penis.**


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**Case report: Artificial nodules of the penis—case report of an Indonesian man.**


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**Vaccines against sexually transmitted infections: promise and problems of the magic bullets for prevention and control.**

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**Ambulatory STD management in an inner-city emergency department—descriptive epidemiology, care utilization patterns and patient perceptions of local public STD clinics.**

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**Epidemiologic trends of sexually transmitted diseases in China.**

XX CHEN, XD GONG, GJ XIANG, GC ZHANG. Sex Transm Dis 2000;27:138–42

**Editorial—sexually transmitted diseases in the People’s Republic of China in 2K.**

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Interleukin 1 receptor antagonist gene polymorphism in women with vulvar vestibulitis.

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Would women trust their partners to use a male pill?