Carbamazepine in Reiter's syndrome

EDITOR,—A psoriatic spectrum with Reiter's syndrome (fig 1). Pains and soles showed keratoderma blennorrhagica and subungual hyperkeratosis with distal onycholysis. Both knees and wrists had painful swelling with restriction of movements. With this clinical presentation Reiter's syndrome was inferred. All routine investigations were normal except a raised erythrocyte sedimentation rate of 100 mm in the first hour. x Rays of the affected joints were normal. ELISA for HIV-1 and HIV-2 was positive with two kits (Immunocomb, Tri-dot) and confirmed with western blotting technique (Speciality Ranbaxy Limited). The absolute helper T lymphocyte count was 435 cells £10/l. Human immunodeficiency virus antigen B27 and rheumatoid factor were negative. The patient was commenced on prednisolone by mouth 60 mg daily and indomethacin by mouth 25 mg three times daily without any concomitant antiretroviral therapy. New erythematous papules and plaques appeared with no relief in joint pain and swelling. In seeking an effective treatment, we serendipitously came across the efficacy of carbamazepine in an HIV infected patient with psoriatic erythroderma. We started carbamazepine 200 mg daily in two divided doses in addition to above. The erythema cleared rapidly within 7 days. To confirm the effect of carbamazepine, it was stopped. New lesions similar to the old ones appeared within 3–4 days. Carbamazepine was then reintroduced in the same dose. Erythema cleared again within 7 days followed by scaling and joint swelling and pain. New lesions stopped appearing. Prednisolone was then tapered off rapidly and allergies were stopped. Carbamazepine was continued in the same dose for 6 months. On follow up at 1 year, the patient showed no recurrence of skin lesions and synovitis, no change in liver and renal function tests, with no further deterioration in his overall health and no opportunistic infections. It has been proposed that in genetically predisposed people, the release of neuuropeptides 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.1 Carbamazepine significantly inhibits the uptake of substance P, calcitonin gene related peptide and blocks a cyclic AMP mediated calcium influx that is associated with neutrophil release and control of a slow potassium current.2

The rapid clearing of erythema, secondary to raised levels of neuropsyptides, with carbamazepine may have been mediated through inhibition of these neuropsyptides and by inhibition of uptake of noradrenaline. The exacerbation and subsequent resolution of lesions on withdrawal and reinstatement of carbamazepine respectively proves its efficacy in our patient. Also, the clinical remission maintained for 1 year after stopping carbamazepine and by inhibition of these neuropeptides and by inhibition of uptake of noradrenaline. The readers of the journal need to know that many of these male “genital wart” cases would have been homosexually active men with anal warts. This is important as risk factors for penile and anal warts may differ, potentially confusing the results of the present study.

Currently 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. Wen 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,3 up to half of the relevant sexual behaviour may have been overlooked. Poorly, the reference group in the table describing condom use deemed as “Not applicable, no sex” should have been more accurately described as “No vaginal or anal sex in the previous 3 months.” Many of these people would have practised oral sex or other sexual acts during those 3 months. Others may have ceased practising vaginal or anal intercourse up to 3 months earlier because of their persistent or recent 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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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 (Zidovudine/lamivudine) and efavirenz 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 diagnosis 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 in the previously 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 medi-
cation was stopped and 3 weeks later the rash had completely resolved. Hepatitis C anti-
gen was stopped and 3 weeks 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 mimetic 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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4 O’Connor WJ, Murphy GM, Darby C, et al. Porphyrin abnormalities in acquired immunodefi-
sity syndrome Arch Dermatol 1996;132:
1443-7.
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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-
pitals had the same protocol for the treatment of CMV retinitis and employed 3 monthly ophthalmological screening of all HIV infec-
ted patients with CD4 counts of less than 50 x10^9/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 1.4-2.2). Fifty eight of 138 patients (42%) with visual symptoms at diagnosis developed moderate visual loss, compared with 16 of 64 patients (25%) who were asymptomatic at diagnosis (p=0.02). The presence of visual symptoms at diagnosis was not predictive of the development of severe visual loss, or early death (p=0.2). Other factors measured at diagnosis of CMV retinitis included the patients’ age, CD4 count, weight, visual acuity, and the presence of any previous AIDS defining condition. None of these was associated with the development of visual loss or early death (p>0.1).

The advent of highly active antiretroviral therapy (HAART) has resulted in a reduction in the incidence of new diagnoses of opportunistic infections. Prolonged survival times with CMV retinitis have been demonstrated in patients who achieve immunological recovery with HAART. The ability to predict those patients who are at highest risk of visual loss may assist in advising those who also 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.
Azithromycin v 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 direct evidence of urethritis before the chlamydia result is available. Relatively few studies report the efficacy of azithromycin in the treatment of nongonococcal non-chlamydial urethritis (NSU), but recently published evidence based guidelines for the management of NSU recommend either doxycycline 100 mg twice daily for 7 days or azithromycin 1 g immediately.1

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

NSU was defined as the presence of at least five polymorphonuclear leukocytes (PMNL) in five or more fields on microscopy of a urethral smear, positive 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.

"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 possibility of reinfection denied.

The results (see table 1) demonstrate that azithromycin is as effective as oxytetracycline in curing NSU, and produces fewer treatment failures, possibly owing to better 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.

**Sexually transmitted infections in elderly people**

Evans, Jaleel et al recently presented the incidence of sexually transmitted infections and other conditions among elderly people attending a genitourinary medicine clinic.1 We, in our genitourinary medicine department at Royal Berkshire Hospital, Reading, studied the reasons for attendance of elderly people 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 60 and above who attended the clinic for non-STD attendance were also compared.

**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><strong>No of patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIs</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>NSU</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital warts</td>
<td>11</td>
<td>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></td>
<td></td>
</tr>
<tr>
<td>Erectile dysfunction</td>
<td>15</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>Zeis’ balanitis</td>
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<td>1</td>
</tr>
<tr>
<td>Genital psoriasis</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Genital ecopic sebaceous 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>

Many elderly people maintain heterosexual and homosexual activity. Therefore this age group is at a risk of all sexually transmitted infections.1 In our study, a smaller percentage of older attendees had STIs compared with previous studies.1 However, the number of older patients who attended for non-STD management was 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 50.1 This finding was seen in our study as well.

**Tertiary syphilis**

**EDITOR—**I read Dr Reed’s letter on tertiary syphilis2 with interest.

The regimen he describes for the treatment of early syphilis—arsenic, bismuth, and rubeola in the clock aqueous penicillin, was used in our hospital from 1946–8 although daily penicillin in beeswax was also used. It was unclear how much inactive penicillin K was in the commercial product used. The penicillin used here was higher than in Lincoln (40 000–75 000 units 3–4 hourly). There were 10 treatment failures (reinfections) out of 275 patients described.3 Treponema pallidum remains viable in the CSF even after adequate clinical treatment3.
The old adage that we achieve clinical but not microbiological cure of syphilis with antibiotics is probably true.

It is likely that most people in developed countries nowadays who have untreated syphilis have received treponeminal antibiotics 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 question: ‘we haven’t seen anyone treated since the second world war who has developed neurosyphilis in subsequent years.

DAVID GOLDMEIER

1 Reed TAG. Tertiary syphilis. Sex Transm Inf 1999;75:75.

BOOK REVIEWS


The most striking first impression of these two volumes is the lavish production with marvellous illustrations, photographs, and tables. It has many excellent features. The text is well set out and easy on the eye. The experience of the authors in approaching various diseases and clinical syndromes comes through strongly. The sections comprehensively cover infectious disease from basic science to clinical management. The clinical microbiology section is an important anchor and could be a short textbook in itself. I very much enjoyed the numerous practice points, which are oriented towards clinicians faced with funding solutions to problems. These consist of short essays with tables or illustrations and tackle particular clinical problems such as “the diagnosis of HIV in newborns,” “what is the treatment of a positive toxoplasma titre in pregnancy?” or are in a debating style—for example, “how long should osteomyelitis be treated?”

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

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

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

With the rise of the internet the big textbook might well be found falling for extinction. Thankfully this book delays the time for many years. My computer there is always that free super highway rather than turning over the pages of a well produced book. If I need to use my computer there is always that free CD ROM.

ANTON POZNIAK

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I was delighted when the editor sent me this book and asked me to review it. I had looked forward with anticipation to the original series that were published in the BMJ. I had thought then that each article was just superb and now they are all neatly packed together in this ABC. I am of the opinion that this is an excellent book which achieves its aim completely. On the cover, it says “it is an ideal reference for doctors, nurses and students.”

In my opinion, no specific background is required to read this book as the authors are experts in their respective fields. In the Preface, it says, “we plan to write an ABC of Sexual Health for everyone who is involved in all aspects of sexual health.”

In summary, this book is fully justified in the title of ABC of Sexual Health. The book is an excellent reference book for doctors, nurses, students and all others involved in the area of sexual health.

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

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

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

COML O’MAHONY

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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.IHMF.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).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Advanced Course for Obstetricians and Gynaecologists, 19–23 June 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: 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 9369/97; 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 Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (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 Ezard, Esseneastrat 77, B-1740 Ter- nat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.uunet.be).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, New Horizons in Recurr- 


dant Pregnancy Loss, 29 June–1 July 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotta’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Bereavement, 5 July 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotta’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Advances in Obstetric Medicine: International Meeting of Obstetric Medicine Societies (satellite to ISSHP; Paris, 6–7 July 2000
Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotta’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ic.ac.uk).

XIII International AIDS Conference, 9–14 July 2000, Durban, South Africa
Further details: 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@congress.se).

Ethical Issues in International Health Research, Durban, South Africa, 16–21 July 2000 (immediately following XIII International AIDS Conference)
Further details: Marie-Christine Rycckaert, 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_Rycckaert@harvard.edu).

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

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

3rd Congress of the Baltic Association of Dermatovenerology, 7–9 September 2000, Riga, Latvia
Further details: Professor Andris Y Rubins, Department of Dermatovenerology, Medical Academy of Latvia, K Valdemara Street, 76–75, Riga, LV-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 IUSSI–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) 744401/745078; email: kumarbhushan@hotmail.com).

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

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

CORRECTION
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.

Antigenicity 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.

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Unraveling the Tuskegee Study for untreated syphilis.
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Nodular tertiary syphilis mimicking granuloma annulare.

Social network method for endemic foci of syphilis: a pilot project.
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Geographic variation of HIV infection in childbearing women with syphilis in the United States.
EH KOUAMAS, M STERNBERG, M OWEN et al. AIDS 2000;14:279–88

HIV prevalence in patients with syphilis, United States.
MR BLOCKER, WC LEVINE, ME STLOUIS. Sex Transm Dis 2000;27:53–9

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

Genital herpes and public health: addressing a global problem.
L COREY, HH HANDSFIELD. JAMA 2000;283:791–4

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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.

Hepatitis

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‘Silent killer’ or benign disease? The dilemma of hepatitis C virus outcomes.
KR HIRSCH, TL WRIGHT. Hepatology 2000;31:536–7

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