LETTERS TO THE EDITOR

Carbamazepine in Reiter’s syndrome

Editor,—A psoriatic spectrum with Reiter’s syndrome as the most severe manifestation was described in a case where carbamazepine showed an excellent response in an HIV infected patient with Reiter’s syndrome.

A 30 year old 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). Papules and plaques 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 x103/μl. Fibrinogen level 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 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.

The exacerbation and subsequent resolution of lesions on withdrawal and reinstitution of carbamazepine confirms its efficacy in our patient. Also, the clinical remission maintained for 1 year after stopping carbamazepine confirms its 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.1 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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References

Condoms and warts

Editor,—Wen et al2 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 enrolled.

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 important as risk factors for penile and anal warts may differ, potentially confusing the results of the present study.

Originally 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’s3 article failed to mention that this variable was time limited. As 3 months is the median duration before the appearance of exophytic warts,4 up to half of the relevant sexual behaviour may have been overlooked.

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

Large relational quality assured clinical databases can be powerful tools for health 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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Reference

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 (zidovudine/lamivudine) and nevirapine in March of 1998. 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 as he wished to take a protease sparing regimen. However, 1 week later he developed a generalized itchy rash a few weeks later he presented with a general photodermatitis affecting his entire body, especially his neck, face, and ears. The rash was significantly worse over his elbows where there was a lack of sun exposure (arms, back of neck, face, and ears). The rash was subsiding. Then having spent a day outdoors in the sun he had a florid recurrence of the rash over the exposed areas (arms, back of neck, face, and ears). The rash was significant enough to affect his quality of life. His medication was stopped and 3 weeks later the rash had completely resolved. Hepatitis C antibody positive in June 1997. In March 1998 his viral load was 350 790 copies/ml (Roche PCR) and his CD4 count was 512 × 10^3 cells/l, he was commenced on dual antiviral therapy with lamivudine and nevirapine which he initiated in the normal way (dose escalation at 2 weeks). He was started on efavirenz which 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 combivir and efavirenz.

Photosensitivity in the context of HIV has been reported as a presenting sign of underlying HIV infection in a number of cases. In addition to this photosensitivity has been reported in the context of HIV infection and has been associated with concomitant hepatitis C infection; however, screening for both these conditions was negative. Switching from nevirapine to efavirenz in this context 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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5 Dupont Pharmaceuticals Company Research Laboratories. Wilmington, DE. In-house data 1990s.

Accepted for publication 20 March 2000

HIV associated cytomegalovirus retinitis in Melbourne, Australia

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

We conducted a retrospective review of all HIV infected patients diagnosed with CMV retinitis at Fairfield Hospital and the Alfred Hospital between 1984 and 1996, aiming to identify factors at diagnosis of CMV retinitis which were predictive of outcome. Both hospitals had the same protocol for the treatment of CMV retinitis and employed 3 monthly ophthalmological screening of all HIV infected patients with CD4 counts of less than 50 x 10^3. The study outcome was 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 advancing 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 prospective evaluation is needed to confirm this finding.

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Accepted for publication 20 April 2000


Sex Transm Infect: first published as 10.1136/sti.76.3.222 on 1 June 2000. Downloaded from http://sti.bmj.com/ on February 18, 2022 by guest. Protected by copyright.
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 chlamydia. The outcome is becoming more widespread as patient acceptability and improved compliance outweigh cost considerations. However, in men, treatment is often initiated on the basis of presumptive evidence of urethritis before the chlamydial result is available. Relatively few studies report the efficacy of azithromycin in the treatment of non-gonococcal non-chlamydial urethritis (NSU), but recently published evidence-based guidelines for the management of NSU recommend only 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 microscopically visible urethritis in which no Gram negative diplococci were evident. 

NSU was defined as the presence of at least five polymorphonuclear leucocytes (PMNL) in five or more fields on microscopy of a urethral swab. A repeat urethral smear was taken because of ongoing symptoms or if the microscopic evidence of urethritis remained. The diagnosis of a urethral smear was not examined routinely.

"Treatment failure" was defined as persistent symptoms or clearing of previously positive two glass urine. A repeat urethral smear was not examined routinely.

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.

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

<table>
<thead>
<tr>
<th>Age group</th>
<th>1997</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxytetracycline</td>
<td>Azithromycin</td>
<td></td>
</tr>
<tr>
<td>Number treated</td>
<td>76</td>
<td>52</td>
</tr>
<tr>
<td>Median age (range)</td>
<td>28 (16–36)</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>39 (50)</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 diagnosis</td>
<td>8 (35)</td>
<td>25 (48)</td>
</tr>
<tr>
<td>Asymptomatic diagnosis</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 reinfe

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.1

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

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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.2 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 50.3 This finding was seen in our study as well.

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Accepted for publication 30 April 2000

Sexually transmitted infections in elderly people

EDITOR,—Jaleel et al recently presented the incidence of sexually transmitted infections and other conditions among elderly people attending a genitourinary medicine clinic.1 We, in our genitourinary medicine department at Royal Berkshire Hospital, Reading, studied the reasons for attendance of elderly people 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 clinic attendance. Of 31 symptomatic attendees in the younger age group 10 (32%) waited over 2 weeks for symptom recognition and clinic attendance (p<0.001).

Table 1 Diagnoses of older and younger clinic attendees

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Older</th>
<th>Younger</th>
</tr>
</thead>
<tbody>
<tr>
<td>STIs</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Latent syphilis</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Genital herpes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Genital warts</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Other conditions</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Erectile dysfunction</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Balanitis</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Lichen sclerosis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Zoon’s balanitis</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Genital psoriasis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Genital eczema</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Genital skin tag</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Genital sebaceous cyst</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous (hepatitis B vaccination)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Accepted for publication 30 April 2000

Tertiary syphils

EDITOR,—I read Dr Reed’s letter on tertiary syphilis1 with interest.

The regimen he describes for the treatment of early syphilis—arsenic, bismuth, and rontalthe 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 we 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.1

Treponema pallidum remains viable in the CSF even after adequate clinical treatment1

Correspondence to: Dr David Nelson


Accepted for publication 30 April 2000

Tertiary syphilis
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 treponemal and non-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.

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

DAVID GOLDMEIER

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?”

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, patients and all those not involved in the area of sexual health,” and Professor Adler adds in the foreword that this book will put the profession in touch with the real world, real people, with real problems, and fill a large gap in our knowledge.

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

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

Sexual health is an essential part of having a happy and fulfilling life, and everyone who works in a caring profession should be comfortable when the conversation drifts into areas of sexuality. Patients, who often broach the topic with trepidation, need to be assured of a sensitive hearing. In my opinion, this excellent book will give anyone in the caring profession a good grounding in sexual matters, so that they can explore these areas with patients when appropriate and have a little idea of likely strategies of management.

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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.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.ec.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: dartcon@mpx.com.au).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics, and Gynaecology, Caring for Sexuality in Health and Illness (for healthcare professionals and nurses), jointly with Association of Psychosexual Nursing 27 June 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ac.ec.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 Euraz, Eisenestr 77, B-1740 Temat, 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: sympreg@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: 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 8 601 91 25; email: aids2000@congresx.se).

Further details: Rebecca Mitchell (tel: 023 9286 6796; fax: 023 9286 6769).

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).

12th Annual Meeting of the Spanish Association of Cervical Pathology and Colposcopy (AEPPCC) and HPV Clinical Workshop, 21–23 July 2000 and 18th International Papillomavirus Conference, 23–28 July 2000, Palau de Congressos, Barcelona, Spain
Further details: PACIFICO, 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: 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) 745330; fax: +91 (0172) 744001/745078; email: kumarbhushan@hotmail.com).

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 Veparol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: vervapol@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).

Consortium of Thai Training Institutes for STDs and AIDS—International Reunion and Refresher Course on Sexual Health, Lee Garden Plaza Hotel, Hat Yai, Thailand 24–26 November 2000
Further details: Hat Yai Secretariat, Dr Veparol Chandeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: vervapol@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).

**CORRECTION**

An error occurred in the February issue of Sex Transm Infect: first published as 10.1136/sti.76.3.222 on 1 June 2000. Downloaded from http://sti.bmj.com on February 18, 2022 by guest. Protected by copyright.
CURRENT PUBLICATIONS

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

Gonorrhoea
Chlamydia
Candidiasis
Pelvic inflammatory disease
Sepsis and other opportunistic infections
Hepatitis
Herpes
Human papillomavirus infection
Cervical cytology and colposcopy
Human papillomavirus infection
Herpes
Syphilis and other treponematoses
Candidiasis
Gonorrhoea
Following sections:

GM LI, Q CHEN, SC WANG. Sex Transm 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

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

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

Candidiasis

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

Effects of reproductive hormones on experimental vaginal candidiasis.

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

Clonal and spontaneous origins of fluconazole resistance in Candida albicans.

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

Bacterial vaginosis

Bacterial vaginosis.
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 CALDERA, B NIEVES, A QUINTANA. Anaerobe 1999;5:403–4

Sex Transm Infect: first published as 10.1136/sti.76.3.222 on 1 June 2000. Downloaded from http://sti.bmj.com/ on February 18, 2022 by guest. Protected by copyright.
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.

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 Kibrough, 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 Koumans, M Sternberg, M Owen 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, WB Rogers, S Bailey. Sex Transm Dis 2000;27:168–74

Virulent Treponema pallidum lipoprotein and synthetic lipopeptides induce CCR5 on human monocytes and enhance its 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 life into a global problem.

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.
B Song, JI Liang, KC Yeh, DM Knipe. Virology 2000;267:326–34

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

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


Effect of route of vaccination with vaccinia virus expressing HSV-2 glycoprotein D on protection from genital HSV-2 infection. DJ BERNSTEIN. Vaccine 2000;18:1351–8

DNA immunization utilizing a herpes simplex virus type 2 myogenic DNA vaccine protects mice from mortality and prevents genital herpes. JR GERHARD, R ZHU, X CAO et al. Vaccine 2000;18:1837–46


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


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


Telomerase, p53 and human papilloma-virus infection in the uterine cervix. PN NAM, PG JAYAPRakash, MK NAIR, MR PILLAI. Acta Oncol 2000;39:65–70


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

Human papillomavirus infection

Nuclear matrix attachment regions of human papillomavirus type 16 repress or activate the E6 promoter, depending on the physical state of the viral DNA.


Repression of the integrated papillomavirus E6/E7 promoter is required for growth suppression of cervical cancer cells.


Recombinant adeno-associated virus expressing human papillomavirus type 16 E7 peptide DNA fused with heat shock protein DNA as a potential vaccine for cervical cancer.


Adeno-associated virus major Rep78 protein disrupts binding of TATA-binding protein to the P97 promoter of human papillomavirus type 16.


Correlation of TGβ1 overexpression with down-regulation of proliferation-inducing molecules in HPV-11-transformed human tissue xenografts.


Human papillomavirus E7 proteins stimulate proliferation independently of their ability to associate with retinoblastoma protein.


The hinge of the human papillomavirus type 11 E2 protein contains major determinants for nuclear localization and nuclear matrix association.


The E7 oncogene of human papillomavirus type 16 interacts with F-actin in vitro and in vivo.


The human papillomavirus type 11 E1/E4 protein is phosphorylated in genital epithelium.

JT Bryan, A Han, KH Hfe, DB Brown. Virology 2000;268:430–9

Cervical cytology and colposcopy

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


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


Revisiting age effect of the Pap test on cervical cancer.


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


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


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

TV Ellerbrock, MA Chaisson, TJ Bush et al. JAMA 2000;283:1031–7

Vaginal intraepithelial neoplasia and the Pap smear.


Effects of tamoxifen on cervicovaginal smears from patients with breast cancer.


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


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


Expression of MNCA9 protein in Pan-pannicolau smears containing atypical glandular cells of undetermined significance is a diagnostic biomarker of cervical dysplasia and neoplasia.


Other sexually transmitted infections

Scabies and pediculosis.


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


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


Dukers et al respond to “Sexual practices associated with HH8V infection”.


Antibodies to human herpes virus type 8 (HHV8) in general population and in individuals at risk for sexually transmitted diseases in Western Sicily.


Prevalence and risk factors for human herpes virus 8 infection in northern Cameroon.

O Reza, O Tchangona, M Andreoni et al. Sex Transm Dis 2000;27:168–74

Localization of Haemophilus ducreyi at the pustular stage of disease in the human model of infection.


Public health and social aspects

Evidence of declining STD prevalence in a South African mining community following a core-group intervention.

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.

Factors associated with condom use for oral sex among female brothel-based sex workers in Singapore.
ML Wong, PWC Chan, D Koh, S WEE. Sex Transm Dis 2000;27:38–45

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.

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

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.
LR Rare, SL Hillier. Sex Transm Dis 2000;27:74–8

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

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.

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

Mucopidermoid carcinoma arising in the glans penis.

Penile Kaposi’s sarcoma preceded by chronic penile lymphoedema.

Pathergy reaction in Behçet’s disease: lack of correlation with mucocutaneous manifestations and systemic disease expression.

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

An unusual case of a metastatic lesion to the penis.

Is there a case for school-based screening for sexually transmitted diseases?
DH Hicks. Lancet 2000;355:864


Epidemiologic trends of sexually transmitted diseases in China.

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

Preventative intervention to reduce sexually transmitted infections: a field trial in the Royal Thai Army.

Etiology of sexually transmitted infections among street-based female sex workers in Dhaka, Bangladesh.

Prevalence of serum antibodies against bloodborne and sexually transmitted agents in selected groups in Somalia. 
YA NUR, J Groen, AM ELMI et al. Epidemiol Infect 2000;124:137–42

Recurrent urinary tract infections in postmenopausal women.

Women’s sexual health after childbirth.

New policy on circumcision—cause for concern.

Acceptability of formulations and application methods for vaginal microbicides among drug-involved women—results of product trials in three cities.

Implications of asymptomatic endocervical leukocytosis in infertility.
Interleukin 1 receptor antagonist gene polymorphism in women with vulvar vestibulitis.

Sexual behaviour, STDs and risks for prostate cancer.

Incidence of erectile dysfunction in men 40 to 69 years old: longitudinal results from the Massachusetts male aging study.

Recurrent epididymo-orchitis in patients with Behçet’s disease.

Hypertrophy of labia minora: experience with 163 reductions.

Would women trust their partners to use a male pill?