LETTERS TO THE EDITOR

Carbamazepine in Reiter’s syndrome

EDITOR,—A psoriatic spectrum with Reiter’s syndrome as the most severe manifestation was described by us when discussing the treatment of a patient infected with human leucocyte antigen B27 and rheumatoid factor. The patient had joint pain and swelling. Three times daily without any concomitant analgesics were stopped. Carbamazepine was continued in the same dose for 6 months. On follow up at 3–4 days. Carbamazepine was then stopped appearing. Prednisolone was then stopped. 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). Papules and plaques showed keratoderma blennorrhagica and subungual hyperkeratosis with distal onycholyysis. 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/μL. Human leucocyte 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 analgesics 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 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 GABA 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 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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Condoms and warts

EDITOR,—Wen 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 previous 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 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 confounding the results of the present study.

Finally, the reference table in the paper describes condom use deemed as “Not used” and “Used” for research purposes, and this may have been overlooked. These variables would have had more validity if patients had been asked about 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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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 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 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 over the exposed areas (arms, back of neck, face, and ears). The rash was signifi- cantly worse over his elbows where there was obvious blistersing and oedema. His medi- cation was stopped and 3 weeks later the rash had completely resolved. Hepatitis C anti- body and porphyria screening were negative. This man had been diagnosed as HIV antibody positive in June 1997. In March 1998 his viral load was 356 790 copies/ml (Roche PCR) and his CD 4 count was 512 × 10^6 cells/l, he was commenced on dual antiretroviral therapy with stavudine and didanosine (patient choice). Initially he did very well with a viral load becoming undetect- able (<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 stavudine and nevirapine which he initiated in the normal way (dose escalation at 2 weeks of nevirapine). He was started on this combi- nation 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 constitu- tional 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 in the context of underlying HIV infection in a number of cases.1 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.1 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 1980s.

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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 in- fected patients with CD4 counts of less than 50 × 10^6.

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 1999, 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 1.1–4.2). 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 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 opportu- nistic infections. Prolonged survival times with CMV retinitis have been demonstrated in patients who achieve immunological recov- ery with HAART.1 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 HAART.

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 infection, is becoming more widespread as patient acceptance 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 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 a 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.2

NSU was defined as the presence of at least five polymorphonuclear leukocytes (PMNL) in five or more fields on microscopy of a urethral smear or positive culture of Neisseria gonorrhoea after direct plating onto modified New York culture medium and negative chlamydial screen on ELISA testing (Svya) of a urethral swab.3

Failure was defined as either resolution of symptoms or clearing of previously positive two glass urine. A repeat urethral smear was not examined routinely.4

“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

Environ.—Jaleel et al recently presented the incidence of sexually transmitted infections and other conditions among elderly people attending a genitourinary medicine clinic.5 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 10–35 years are likely to be even lower

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.6

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.7

Table 1

<table>
<thead>
<tr>
<th>Diagnoses of older and younger clinic attendees</th>
<th>Older clinic</th>
<th>Younger clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>(No of patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIs</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Genital warts</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Zoon's balanitis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>1</td>
<td></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></td>
</tr>
<tr>
<td>Lichen sclerosus</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Zinke's balanitis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Genital psoriasis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Genital eczema sebaceous glands</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>

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-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 50.8 This finding was seen in our study as well.

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Tertiary syphilis

EDITOR—I read Dr Reed’s letter on tertiary syphilis9 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 was 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.10 Trepomema pallidum remains viable in the CSF even after adequate clinical treatment.11

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<th>Letters, Book reviews, Notices, Correction, Current publications</th>
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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 treponemical 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.

To answer 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 contributions 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 is a shame some 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 not be needed for extinction. 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 there is always that free CD ROM.

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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, 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, without embarrassment and have some idea of likely strategies of management.

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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 of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ac.ca.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 9396/97; 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 of Medicine, Queen Charlotte’s and Chelsea Hospital, Goldhawk Road, London W6 0XG (tel: 020 8383 3904; fax: 020 8383 8555; email: sympreg@ac.ca.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 Erard, Eisenestraat 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: 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, Linneagatan 89A, 114 86 Stockholm, Sweden (tel: +46 8 459 6600; fax: +46 8 601 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 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).

Further details: PACTIFICO, SA, E Granados, 44, 08008 Barcelona, Spain (tel: +34.93.454.54.00; fax: +34.93.451.74.38; email: gp@pacific-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 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) 744014/745078; 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 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: cvverapol@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: cvverapol@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).

Letters, Book reviews, Notices, Correction, Current publications

CORRECTION

CURRENT PUBLICATIONS

Selected titles from 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

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 RICHATSON, J PAWONEN. 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.
F 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.


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


Pelvic inflammatory disease


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.

RM WHITE. Arch Intern Med 2000;160:585–601

Nodular tertiary syphilis mimicking granuloma annulare.


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

R ROTHENBERG, L KINBROUCH, R LEWISHARDY et al. Sex Transm Dis 2000;27:12–8

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EH KOUAMNS, M STERNBERG, M OWNN et al. AIDS 2000;14:279–88

HIV prevalence in patients with syphilis, United States.

MR BLOCKER, WC LEVINE, ME STILLOUS. Sex Transm Dis 2000;27:53–9

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


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

D SATCHER. Sex Transm Dis 2000;27:68–73

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

JS HUANG, WB ROGERS, BBC BAILEY. Sex Transm Dis 2000;27:168–74

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

TI BELLATI, DA WILKINSON, JS SHEFFIELD et al. Infect Dis 2000;181:283–92

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CY CHEN, BC BALLARD, CM BUCKSAUGE et al. Sex Transm Dis 2000;27:21–9

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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.


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DNA immunization utilizing a herpes simplex virus type 2 myogenic DNA vaccine protects mice from mortality and prevents genital herpes.

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Papillomavirus detection: demographic and behavioral characteristics influencing the identification of cervical disease.

Evaluation of a human papillomavirus assay in cervical screening in Zimbabwe.

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S Song, A Liem, JA Miller, PF Lambert. Virology 2000; 267:141–50

The effects of interferon on the expression of human papillomavirus oncoproteins.

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N FORD, S KOETSAWANG. Bull WHO 1999;77:888–94

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MS COHEN, G ONG, K FOX, GE HENDERSON. Sex Transm Dis 2000;27:143–5

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