LETTERS TO THE EDITOR

Lymphatic filariasis—lest we forget

EDITOR,—Lymphatic filariasis is characterised by a wide range of clinical manifestations. In a non-endemic area the diagnosis may be missed unless the index of suspicion is high. An 18 year old sexually active male presented with a progressively increasing painless nodular swelling in the right inguinal region of 4 months’ duration. The patient had an unprotected vaginal contact with a commercial sex worker 6 months earlier. There was no history of genital ulcer or urethral discharge. The general health of the patient was preserved. Examination revealed an enlarged right inguinal and external iliac lymph nodes, 1–3 cm in size, firm, mobile, non-tender, and with normal overlying skin. Examination of genital, anal, and buccal mucosae was normal. There was no other lymphadenopathy. A differential diagnosis of lymphogranuloma venereum (LGV) and tubercular lymphadenitis was considered. Complete blood count revealed mild leucocytosis and eosinophilia. Renal and hepatic functions, urinalysis, and chest x-ray were normal. A complement fixation test for chlamydia group specific antibody was negative. Fine needle aspiration cytology from the nodes revealed reactive hyperplasia with occasional giant cells and microfilariae of Wuchereria bancrofti. Nocturnal blood samples for microfilariae were negative.

The patient was given diethylcarbamazine 100 mg thrice daily for 2 weeks. The lymph nodes regressed and no relapse was observed in 6 months of follow up.

The differential diagnosis of inguinal lymphadenopathy in a sexually active male includes syphilis, genital herpes, chancroid, LGV, pyogenic adenitis, tuberculous adenitis, and lymphoma.1 In the present case a diagnosis of LGV was considered in view of a history of sexual contact, painless and non-suppurative lymphadenopathy not apparently preceded by a genital ulcer.

Demonstration of microfilariae was decisive in clinching the diagnosis of filariasis which was not considered in the differential diagnosis. Presentation with inguinal lymphadenopathy is a feature common to both LGV and filariasis. The most frequent manifestation of secondary stage of LGV in men is unilateral inguinal lymphadenopathy which does not suppurate in two thirds of cases.1 Lymphadenopathy often develops in LGV as was observed in our patient.2 Painful enlargement of inguinal lymph nodes with fever is the usual presentation in lymphatic filariasis. Lymphangitis can accompany recurrent attacks. Other complications include orchitis, funiculitis, and epididymitis.3,4 These were, however, absent in our patient. It is suggested that lymphatic filariasis should be considered in differential diagnosis of inguinal lymphadenopathy even in areas which are not known to be endemic for it. It is otherwise likely to be missed.

GURVINDER P THAMI SUKHJOT KAUR AMRINDER J KANWAR Department of Gynaecology and Obstetrics, Government Medical College and Hospital, Chandigarh 160 047, India

Correspondence to: Dr Kanwar gmchchd@chd.dot.net.in


Accepted for publication 15 May 2000

Canary to sparrow; what is in a name?

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

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

In the NHS chlamydia pilot screening programme in Wirral and Portsmouth we are confirming that this infection is indeed endemic. Information material for the pilot study clearly states that it is a very common infection. To reduce the element of blame, we have included teaching in some settings and have introduced instead of sexually transmitted, the term “sexually shared infection.” We hope that by measures such as these, young people will avoid stigmatisation as “canaries.”

We do not, however, suggest that you change the name of your journal again!

JENNIFER HOPWOOD HARRY MALLINSON SALLY WELSTEEDE Chlamydia Pilot Office, Evidence Based Practice Centre, St Catherine’s Hospital, Church Road, Birkenhead CH42 0LQ

Correspondence to: Dr Hopwood

Acceptance for publication 7 June 2000

Acceptability of home screening for chlamydial infection: some remaining issues

EDITOR,—In the recent article by Stephenson et al1 the authors describe participation rates of 39% for women and 46% for men for home screening and comment that this might form a useful component of a community based chlamydial screening programme in which non-responders could be offered opportunistic screening at the general practice.2 However, certain crucial issues remain unanswered. This acceptability survey was done among women aged 18–25 years and men 18–30 years. What happens with people below the age of 18? We know that Chlamydia trachomatis prevalence is associated with young age, but can we also send home screening kits to 15 year olds? What about the parastatal opinions and legal implications—for example, for the partner of a C trachomatis positive youngster? In two surveys performed in general practice in Amsterdam, Non systematized and opportunistic screening, prevalence was strongly associated with young age but also with ethnicity. Among young Surinam-Antillan women aged <25 years, prevalence ranged from 5% in the opportunistic survey up to 22.4% in the opportunistic survey.3 In the systematic survey an unexpectedly high C trachomatis prevalence of 10% was found among young Surinam-Antillan men. Among the 15–19 year olds visiting our health centre in Amsterdam which is located in a multiethnic neighbourhood, half of the population having a Surinam-Antillan background, C trachomatis prevalence was 25%.4 The question is not if opportunistic home screening is feasible for the youngest age group, who might be most at risk, but also how acceptable home testing is for people with different ethnic backgrounds and people living in low socioeconomic status and high risk environments.

We piloted a pharmacy assisted approach offering urine home testing to all sexually active women aged 15–30 years, which came to our pharmacy to collect their contraceptives. Since the start 4 months ago 189 people received an information leaflet and home test package together with their contraceptives. Fifty nine participated and sent their urine; four were positive (6.7%).5 The participation rate was 31%, lower than the reported rate for women in the article of Stephenson et al.6 The assumption by the authors that people who do not participate for home screening will turn up for opportunistic screening at the general practice, is, however, merely a hypothesis, and not a strong one, especially not for boys and men.

Tackling issues like risk perception and risk environment and changing healthcare seeking behaviours is not an easy task. Moreover, a community based C trachomatis prevention programme will require not only secondary prevention by active case finding but also primary prevention. What is needed is an integrated set of strategies, which are mutually reinforcing and that are age, sex, culture, and context specific. Quite a challenge!

J A M VAN BERGEN Netherlands’ Foundation for STD control, PO Box 8198 5803 RD, Utrecht, Netherlands j.vanbergen@sea.nl


www.sextransinf.com
Nurse counselling for women with abnormal cervical cytology improves colposcopy and cytology follow up attendance rates

EDITOR.—A well organised cervical screening programme has considerable benefits; however, one negative aspect is anxiety associated with abnormal results. The NHSCSP guidelines state that an explanatory leaflet should be given to women with abnormal cytology and those being referred for colposcopy, with a verbal explanation wherever possible. We assessed if there is any additional benefit from a verbal explanation, following written information, when an abnormal smear result is given, in understanding and future attendance for colposcopy and cytology follow up.

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

The explanation for each woman took approximately 15 minutes. The results of the questionnaire before and after explanation are shown in table 1. There was a significant improvement in understanding and reduction in anxiety. The control group comprised 104 women. In the study group 65 required colposcopy; three (4.6%) defaulted, compared with seven of 38 (18.4%) women not receiving a verbal explanation; p<0.03 Fisher’s exact test; OR 0.21 (95% CI 0.03–1.03). Of the study group, 81 should have attended for follow up colposcopy 6 months after colposcopy or smear showing borderline changes; 12 (15%) defaulted compared with 37 of 95 (38.5%) women not receiving a verbal explanation; p<0.001 χ² test; OR 0.18 (95% CI 0.08–0.41). Eventually only one (1.5%) in the study group and two (5.3%) of the controls did not attend for colposcopy, and 11 (13.8%) and 24 (25.3%) defaulted follow up cytology. Despite the leaflet the women in our study still had misunderstandings and anxieties. The verbal explanation helped clarify these. Verbal information can be tailored to the individual, some requested detailed descriptions, others preferred a simpler explanation (as reported previously). This is not possible with written information.

The default rates were lower in those receiving the verbal explanation. Lerman et al found that women with abnormal cytology who defaulted colposcopy appointments were more worried about cancer with impairment of mood and sleeping. Following the explanation our default rate for colposcopy was within the 15% recommended target, and follow up cytology was similar to the rates reported in primary care.

There are deficits in this study. The lack of randomisation means the improvement in default rates could be the result of baseline differences rather than the verbal explanation. However, it has shown benefit to the women by improving understanding. The department has also benefited; although extra nursing workload has also benefited; although extra nursing time nor-}

Table 1 The questionnaire results before and after the verbal explanation

<table>
<thead>
<tr>
<th>Question</th>
<th>Response (n=89)</th>
<th>Before</th>
<th>After</th>
<th>χ² test p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well do you understand the result you have been given?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>26</td>
<td>1</td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>A little</td>
<td>36</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>27</td>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you worried about the result of your smear test?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A little</td>
<td>45</td>
<td>13</td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>A lot</td>
<td>42</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will it worry you if we need to do further investigations?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A little</td>
<td>36</td>
<td>11</td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>A lot</td>
<td>40</td>
<td>46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you worried that further investigations will be painful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td>55</td>
<td>28</td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>23</td>
<td>47</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think that any abnormality found can be treated?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>61</td>
<td>85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>25</td>
<td>4</td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Do you think you have cancer?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>9</td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Do you think this smear result will affect your ability to have children?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>2</td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think this result will change your attitude to sex with your partner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
<td>13</td>
<td></td>
<td>0.004</td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think this result will affect the way your partner thinks of you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>4</td>
<td></td>
<td>0.36</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Accepted for publication 19 June 2000

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

EDITOR.—The recent article on the acceptability of home testing for chlamydia was noted.1 We would like to extrapolate this concept. Young people could be accessed via an internet clinic. Our experience during the chlamydia pilot study is that this population are highly receptive of use of technology, in particular mobile phones. The presence of sex on the internet has been widely publicised. We propose that testing for sexually transmitted infection (STI) via the internet is the next logical step.

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

After screening for chlamydia, a means of contacting clients to give results was arranged—for example, letter or phone call. On the Wirral, 2651 patients were screened in the first 4 months—2323 women and 285 men (34, sex not recorded). Sixty eight (2.6%) gave a mobile phone number, half (35) using this as their only means of contact. Sixty five were female and two male (one patient not recorded). Thus, women (2.8%) were more likely to use mobile phones than men (0.7%) (p<0.03). The gonitourinary medicine (GUM) clinic screened 358 patients. Only 68 (19%) gave an address. The results of a further 469 (17.7%) of the screened population went back to the screening site. These clients could be interested in contact via mobile phone if it was openly offered (data collected from the Public Health Laboratory Service (PHLS) database and analysed on SPSS version 6). According to a survey by NOP Social and Political, confidentiality is important to people in the target age group (unpublished data). Patients consider their mobile phones to be a secure method of communication between themselves and us. The advent of DNA amplification in the detection of STIs has opened up new possibilities.3,5 There are 30 000 websites pertaining to chlamydia. An internet clinic would be aimed at mildly symptomatic or asymptomatic patients. The client would access the website and request swabs or urine pots through the post then return them the same way.

If the patients were positive, they would need to attend a GUM clinic or equivalent.
Other infections should not be overlooked. Partner notification is necessary. Contact slips could be supplied but the health adviser’s role should not be underestimated.

Security on the internet would have to be addressed. However, the anonymity and convenience of participating from home may increase testing for STIs. This may appeal to younger patients particularly, in view of their experience with IT.

In summary, STI is rising in the younger population. Their utilisation of technology is demonstrated by mobile phone use in the population. Their comfort in use of media with which the target group is comfortable. We might just access a whole generation. The future’s bright . . .

Conflicts of interest: None.

Funding of chlamydia pilot study: Department of Health.

MARY HERNON
JENNIFER HOPWOOD
HARRY MALLINSON
Liverpool Laboratory, P Hicks North West
Correspondence to: Dr M Hernon, Department of Genitourinary Medicine, Arrowe Park Hospital, Upton, Wirral, Merseyside L49 5PE
mary.hernon@ccmail.wirralh-tr.nwest.nhs.uk


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

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

An incidence graph of Mersey Region figures (fig 1) for the 1990s and a discussion on the possible factors associated with the changing pattern is presented here. The incidence from the Mersey Region shows a steady decline until the mid 1990s followed by a recent increase and represents the trend in most areas. In spite of the advances in the diagnostic and therapeutic field, organised health advisory system, easy access walk-in clinics, complete confidentiality, and free treatments; the incidence of gonorrhoea is rising. From the broader analysis of the situation, it is possible to say that most of the factors behind this changing pattern are socioeconomic. The factors may include advances in contraceptive, sexual liberalisation, increase in the mobility of population, and the changing economic environment. The cumulative result of all these factors is an increase in casual relationships. Casual sex is made riskier when it is performed unprotected and without much knowledge about the partner and is possibly the main reason behind the poor contact tracing of only 0.5 out of an average of 1.5 per patient.

Some of these factors are part of the wider evolutionary process and are difficult issues to deal with, but preventive measures may be taken against the others. In spite of the recent advances and better understanding of the disease in the recent years, there is still a lack of awareness, in the general population, of the possible mental and physical effects of such infection. The significant fall in the incidence of gonorrhoea seen in the late 1980s, secondary to extensive media coverage of HIV infection, shows how effective such campaigns can be. The present rise in the incidence of gonorrhoea in the past few years shows clearly that our prevention campaigns are not effective.

The young teenagers who make up the pool of supply and the young females who make up the pool of asymptomatic reservoirs of the infection, are the two core groups our campaigns should be targeting.

At present there is no programme in the school curriculum about sexual health and no regular screening programme for sexually active young females.

A programme of long term measures, such as education on sexual health and sexually transmitted infections in schools, and a programme of regular screening for gonorrhoea (and chlamydia) for all sexually active young females, may be useful and this can be, to start with, combined with the cervical smear screening programme at very little additional cost. Short term programmes, like vigorous media campaigns nationally and poster and leaflet campaigns locally in high risk recreational areas like pubs and clubs, may have an educational value and help reduce the incidence.

B BHATTACHARJEE
A K GHOSH
Department of GU Medicine, Royal Liverpool University Hospital, Prescot Street, Liverpool L7 8XP
Correspondence to: Dr Bhattacharjee, Department of Genitourinary Medicine, Arrowe Park Hospital, Upton, Wirral, Merseyside L49 5PE


Accepted for publication 19 June 2000

Russian STI


We hope for further collaboration. We shall inform you about our future plans.

M A GOMBERG
A Acting editor
L G DOUGACHIEVA
Assistant editor
SANAM, Russian Association for the Prevention of Sexually Transmitted Infections, WHO Collaborating Centre, Drozor Strauss, 13, 119084 Moscow, Russia
2354.g23@g23.relcom.ru

Accepted for publication 19 June 2000

Cheilitis in association with indinavir

EDITOR.—There is increasing speculation that indinavir may cause side effects which have been previously associated with high concentrations of retinoids. In the presence of all-trans-retinoic acid (ATRA), indinavir, but not other protease inhibitors (PIs), alters stem cell differentiation in vitro, not seen in the presence of ATRA alone. Alopecia and cheilitis are side effects associated with both retinoids and the protease inhibitor indinavir (but not with any of the other protease inhibitors). These side effects can be

![Figure 1 Total incidence of gonorrhoea in the Mersey Region in 1990–9 (in absolute numbers).](http://www.sextransinf.com)
reversed on changing from indinavir to an alternative PI. We report a case of cheilitis associated with indinavir which resolved rapidly on changing treatment.

A 35 year old African man developed cheilitis (fig 1A) 5 months after commencing HAART with stavudine, lamivudine, and indinavir. His CD4 lymphocyte count at that time was 238 cells $\times 10^3/l$, with an HIV viral load of 78 copies per ml (Chiron bDNA assay version 3) He had a medical history of granulomatous uveitis of undetermined cause, which developed before HAART. It responded to prolonged treatment with oral prednisolone 40 mg daily and has since remained quiescent. The oral corticosteroids were tailed off and finally discontinued a month before the cheilitis developed. Following the development of cheilitis, further investigations showed: positive IgG antinuclear antibodies with a homogeneous pattern and a titre of 1 in 320; rheumatoid factor positive 1 in 40; anti-RO and anti-SCL-70 both negative; serum angiotensin converting enzyme 75 U/l (normal range 20–95); chest x-ray normal; C reactive protein 1 mg/l; erythrocyte sedimentation rate 4 mm in the first hour. Biopsy of the lip showed acanthosis and parakeratosis without associated inflammation. It was initially considered that the cheilitis might be an autoimmune phenomenon, but topical treatment with Eumovate (clobetasone butyrate, GlaxoWellcome) failed to improve the condition, which persisted for 10 months until the indinavir was changed to efavirenz. At the time of changing therapy his CD4 count was 418 cells $\times 10^3/l$, with an HIV viral load below 20 copies per ml, and his CD4 cell count improved to 585 cells $\times 10^3/l$. His HBeAg and HBeAb were negative.

A 35 year old African man developed cheilitis (fig 1A) 5 months after commencing HAART with stavudine, lamivudine, and indinavir. His CD4 lymphocyte count at that time was 238 cells $\times 10^3/l$, with an HIV viral load of 78 copies per ml (Chiron bDNA assay version 3) He had a medical history of granulomatous uveitis of undetermined cause, which developed before HAART. It responded to prolonged treatment with oral prednisolone 40 mg daily and has since remained quiescent. The oral corticosteroids were tailed off and finally discontinued a month before the cheilitis developed. Following the development of cheilitis, further investigations showed: positive IgG antinuclear antibodies with a homogeneous pattern and a titre of 1 in 320; rheumatoid factor positive 1 in 40; anti-RO and anti-SCL-70 both negative; serum angiotensin converting enzyme 75 U/l (normal range 20–95); chest x-ray normal; C reactive protein 1 mg/l; erythrocyte sedimentation rate 4 mm in the first hour. Biopsy of the lip showed acanthosis and parakeratosis without associated inflammation. It was initially considered that the cheilitis might be an autoimmune phenomenon, but topical treatment with Eumovate (clobetasone butyrate, GlaxoWellcome) failed to improve the condition, which persisted for 10 months until the indinavir was changed to efavirenz. At the time of changing therapy his CD4 count was 418 cells $\times 10^3/l$, with an HIV viral load below 20 copies per ml, and his CD4 cell count improved to 585 cells $\times 10^3/l$. His HBeAg and HBeAb were negative.
New Zealand Venereological Society Conference, Centennial Convention Centre, Palmerston North, New Zealand, 18–20 October 2000

Ka Hikotia Ka Korerotia Mo Te Tau Rua Mano (Maoei) “Walk the Talk 2000.” Further details: Sue Peck, Conference Organiser, SP Conference Management, PO Box 4400, Palmerston North, New Zealand (tel: 64 6 357 1466; fax 64 6 357 1426; email suepeck@xtra.co.nz).

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 Verapol Chandyung, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cverapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanh Panalunye, 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 Verapol Chandyung, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cverapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanh Panalunye, Bangkok Hospital, 189 Sathorn Road, Bangkok 10120, Thailand (fax: (66-2) 286 3013; email: pthanit@email.ksc.net).

Royal Society of Medicine and National Institutes of Health of International Conference, RSM London, 7–5 December 2000

The RSM in London, UK, and the NIH in Bethesda, Maryland, US, are organising an international conference to be held at the RSM on “New trends in HIV management and research.” Further details: Victoria Boswell, Academic Conference Assistant, Royal Society of Medicine (tel: +44 (0)20 7290 2965; fax:+44 (0)20 7290 2977; email: victoria.boswell@roysocmed.ac.uk).

Call for papers—6th European Forum on Quality Improvement in Health Care, 29–31 March 2001, Bologna, Italy

Further details: BMA/BMJ Conference Unit, BMA House, Tavistock Square, London WC1H 9JS, UK (tel: +44 (0) 20 7383 6400; fax: +44 (0) 20 7383 6869; email: quality@bma.org.uk; website: www.quality.bmj.org).

CURRENT PUBLICATIONS

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

Gonorrhoea

Gonorrhoea, chlamydia and the sexual network—pushing the envelope (Editorial).

JM ZEINELMAN. Sex Transm Dis 2000;27:224–5

Gonorrhoea in male adolescents and young adults in Newark, New Jersey—implications of risk factors and patient preferences for prevention strategies.


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


Chlamydia

Unique gonococcal phenotype associated with asymptomatic infection in men and with erroneous diagnosis of nongonococcal urethritis.

WH WHITTINGTON, KK HOLMES. J Infect Dis 2000;1044–8

Asymptomatic infections have been associated with strains of Neisseria gonorrhoeae belonging to certain phenotypes; arginine, hypoxanthine, and uracil requiring (AHU) and proline, citrulline, and uracil requiring (PCU). This study describes an outbreak caused by a new phenotype, citrulline and uracil requiring, which has unique clinical presentation. The authors report an increase in the prevalence of gonococci belonging to the CU auxotype from 1.6% in 1987 to 16.5% in 1997 in King County, Washington, USA. The characteristics of these strains were that they belonged to one of two closely related serovars, IB-1 and IB-3 that differ only by reactivity with a single antibody, they were all susceptible to penicillin, tetracycline, and erythromycin and were highly susceptible to broad spectrum cephalosporins and fluoroquinolones. The number of cases rose from 57 to 75 per year in the 1980s to 125 and 115 in 1996 and 1997 respectively despite a fall in the total number of cases of gonorrhoea seen. The CU auxotype was also isolated more frequently than other types from healthcare facilities other than GU clinics.

The demographic and behavioural data showed that men infected with the CU auxotype were more often black, heterosexual, younger, less likely to seek care for symptoms and to be co-infected with Chlamydia trachomatis than were men infected with other auxotypes. Among homosexual men, infection with the CU auxotype produced symptoms of urethral discharge or dysuria or signs of moderate or profuse urethral discharge less often than in men infected with other auxotypes. Symptoms of dysuria and discharge were also of longer duration and urethral smears showing intracellular Gram negative diplococci were found in only 67% of patients with the CU auxotype compared with 95% of men with other types.

The characteristics of the CU auxotype may enable these strains to evade detection and hence confer a selective advantage for survival. This is of particular interest as the total numbers have fallen and the pressure for screening asymptomatic populations has decreased.

Concurrent gonococcal and chlamydial infection—how best to treat.

AJ ROBINSON, GL RIDGWAY. Drugs 2000;59:801–11

Neisseria gonorrhoeae MS11 mKOP opacity protein expression in vitro and during human volunteer infectivity studies.

KA SCHMITT, CD DEAL, M KIAN et al. Sex Transm Dis 2000;27:278–83

Gonococcal lipo-oligosaccharide is a ligand for the asialoglycoprotein receptor on human sperm.


Correction

An error occurred in the editorial by R D Maw which was published in the June issue (STI 2000;76:153). In the second column, line 4–5, podophyllin should be replaced by podophyllotoxin in each case.
Prevalence of Chlamydia trachomatis in urine of male patients with ankylosing spondylitis is not increased.

The value of Chlamydia trachomatis antibody testing as part of routine infertility investigations.

Low correlation of serology with detection of Chlamydia trachomatis by ligase chain reaction and antigen EIA.

The relationship of inflammation in the Papanicolaou smear to Chlamydia trachomatis infection in a high-risk population.
RI Palmer, DR Simpson, AM Kaye et al. Contraception 2000;61:231–4

In situ analysis of the evolution of the primary immune response in murine Chlamydia trachomatis genital tract infection.

Candidiasis

Practice guidelines for the treatment of candidiasis.

Candida vaginitis—self-reported incidence and associated costs.

Experimental candidosis. Pathogenesis, prevention, therapy.
E Segal. Mycoses 2000;42:55–60

Estrogen effects on Candida albicans: a potential virulence-regulating mechanism.

Investigation of e-glucosidase as a potential virulence factor of Candida albicans.

Cytokine modulation of specific and nonspecific immunity to Candida albicans.
L Romani. Mycoses 2000;42:45–8

Histidine kinase, two-component signal transduction proteins of Candida albicans and the pathogenesis of candidosis.
JA Calera, R Calderone. Mycoses 2000;42:49–54

Differential activation of a Candida albicans virulence gene family during infection.

Bacterial vaginosis

Bacterial vaginosis.

Urinary tract infections in women with bacterial vaginosis.

Characterisation and selection of a Lactobacillus species to re-colonise the vagina of women with recurrent bacterial vaginosis.

Induction of human immunodeficiency virus type 1 expression by anaerobes associated with bacterial vaginosis.

Trichomoniasis

Consider diagnosis and treatment of trichomoniasis in men (Editorial).

Comparative prevalence of infection with Trichomonas vaginalis among men attending a sexually transmitted diseases clinic.

A meta-analysis of the Papanicolaou smear and wet mount for the diagnosis of vaginal trichomoniasis.

A novel cystine proteinase (CP65) of Trichomonas vaginalis involved in cytotoxicity.

Pelvic inflammatory disease

Risk factors for pelvic inflammatory disease in inner-city adolescents.
AL Sun, P Homel, M Hamamershlag, K Brombberg. Sex Transm Dis 2000;27:289–91

Syphilis and other treponematoses

Potential for community-based screening, treatment and antibiotic prophylaxis for syphilis prevention.

Posterior uveitis in patients with positive serology for syphilis.

Treponema pallidum surface immunofluorescence assay for serologic diagnosis of syphilis.

A pilot study evaluating ceftriaxone and penicillin G as treatment agents for neurosyphilis in human immunodeficiency virus-infected individuals.

Opsonic potential, protective capacity and sequence conservation of the Treponema pallidum subspecies pallidum Tp92.

Hepatitis

Natural history of hepatitis C: its impact on clinical management.
AM Derschel. Hepatology 2000;31:1014–9

Seroprevalence and risk factors of hepatitis B, hepatitis C and human cytomegalovirus among HIV-infected and high-risk uninfected adolescents—findings of the REACH study.
CA Holland, W MA, AB Moscoso et al. Sex Transm Infect 2000;27:296–302

Herpes

Herpes simplex virus type 1 as a cause of genital herpes: impact on surveillance and prevention.

Testing for herpes simplex virus type 2—full steam ahead? (Editorial).
J Mills. Sex Transm Infect 2000;27:270–1

HSV-2 specific serology should be offered routinely to antenatal patients.

HSV-2 specific serology should not be offered routinely to antenatal patients.

Seroprevalence of herpes simplex virus type 2 infection among attendees of a sexually transmitted disease clinic in Italy.
M Cusini, M Cusano, C Parolin et al. Sex Transm Infect 2000;76:232–5

Herpes simplex virus type 2 seropositivity in a Danish adult population denying previous episodes of genital herpes.
Seroprevalence of herpes simplex virus type 1 and type 2 in selected German populations—relevance for the incidence of genital herpes.

Valaclocivir—a review of its long term utility in the management of genital herpes simplex virus and cytomegalovirus infections.

Characterization of an acyclovir-resistant herpes simplex virus type 2 strain isolated from a premature neonate.

HSV.com: Maneuvering the internet-works of viral neuropathogenesis and evasion of the host defense.
S. Tan, MG Katze. Proc Natl Acad Sci USA 2000;97:5684–6

Molecular epidemiology of herpes simplex virus type 1 genital infection in association with clinical manifestations.

Evaluation of an enzyme-linked viral inducible system for the rapid detection of herpes simplex virus.

Premarket evaluation of the POCkit HSV-2 type-specific serologic test in culture–documented cases of genital herpes simplex virus type 2.

Immunisation with phase displaying peptides representing single epitopes of the glycoprotein G can give rise to partial protective immunity to HSV-2.

Use of herpes simplex virus type 1 ISCOMs 703 vaccine for prophylactic and therapeutic treatment of primary and recurrent HSV-2 infection in guinea pigs.

Antibody responses, cytokine levels and protection of mice immunized with HSV-2 antigens formulated into NISV or ISCOM delivery systems.

Interferon-γ up-regulates intercellular adhesion molecule-1 and vascular cell adhesion molecule-1 and recruits lymphocytes into the vagina of immune mice challenged with herpes simplex virus-2.
MR Farr, EL Farr. Immunology 2000;99:540–5

Evaluation of the inactivation of infectious herpes simplex virus by host-defense peptides.

Hydrogels containing monoprecin prevent intravaginal and intracutaneous infections with HSV-2 in mice: impact on the search for vaginal microbicides.

1,3-dihydroxyacridone derivatives as inhibitors of herpes virus replication.
P Akantapachat, CT Lowdin, KF Bastow. Antiviral Res 2000;45:123–34

Human papillomavirus infection

Papillomaviruses causing cancer: evasion from host-cell control in early events in carcinogenesis.

Contemporary theories of cervical carcinogenesis: the virus, the host and the stem cell.


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

High prevalence of human papillomavirus type 16 infection among children.

Human papillomaviruses and vulvar vestibulitis.

Human papillomavirus DNA in penile carcinomas in Argentina: analysis of primary tumors and lymph nodes.

Comparison of human papillomavirus genotypes in archival cervical cancer specimens from Alaska natives, Greenland natives and Danish Caucasians.

Warty (condylomatous) squamous cell carcinoma of the penis—a report of 11 cases and proposed classification of ‘verruciform’ penile tumors.

Type of human papillomavirus and expression of p53 in elderly women with cervical cancer.

High prevalence of serum antibodies to Ras and type 16 E4 proteins of human papillomavirus in patients with precancerous lesions of the uterine cervix.

Boosting with recombinant vaccinia increases HPV-16 E7-specific T cell precursor frequencies of HPV-16 E7-expressing DNA vaccines.

Human tumor growth is inhibited by a vaccinia virus carrying the E2 gene of bovine papillomavirus.

Human papillomavirus type 16 E7 oncoprotein represses transcription of human fibronectin.

Interleukin-10 increases Th1 cytokine production and cytotoxic potential in human papillomavirus-specific CD8(+) cytotoxic T lymphocytes.

Cytokine profile of draining lymph node lymphocytes in mice grafted with syngeneic keratinocytes expressing human papillomavirus type 16 E7 protein.

Cervical cytology and colposcopy

Advances in cervical screening technology.
MH Stoler. Mod Pathol 2000;13:275–84

Clinical significance of the qualification of atypical squamous cells of undetermined significance: an analysis on the basis of histologic diagnoses.

Qualitative analysis of value judgments in interpreting cervicovaginal smears using the Bethesda System.

Papanicolaou smear history and diagnosis of invasive cervical carcinoma among members of a large prepaid health plan.
HY Jung, KA Kearney, M Miller et al. Cancer 2000;88:2283–9

Cytologic and histologic diagnosis and significance of controversial squamous lesions of the uterine cervix.

Photodetection of cervical intraepithelial neoplasia using 5-aminolevulinic acid-induced porphyrin fluorescence.

www.sextransinf.com

The effects of loop excision of the transformation zone on cervical length: implications for pregnancy.

Treatment of vaginal dysplasia: just a simple loop electrosurgical excision procedure?


**Microbiology and immunology**

Pathogenesis of abnormal vaginal bacterial flora.

Wet mount microscopy reflects functional vaginal lactobacillary flora better than gram stain.

Induction of mucosal immune responses in the human genital tract.

Surface characteristics of lactobacilli isolated from human vagina.
VS OCANA, E BRU, AAD HOLGADO, ME NADERMA-CIAS. *J Gen Appl Microbiol Tokyo* 1999;45:203–12

Cytokine profile in genital tract secretions from female adolescents: impact of human immunodeficiency virus, human papillomavirus and other sexually transmitted pathogens.

Evidence that anoreceptive intercourse with ejaculate exposure is associated with rapid CD4 cell loss.
DJ WILEY, BR VISSCHER, S GROSSER et al. *AIDS* 2000;14:707–16

**Dermatology**

Recurrent squamous cell carcinoma of the vulva—clinopathologic determinants identifying low risk patients.
M PRETI, G RONCO, G GHERINGHELLO, L MICHELETTI. *Cancer* 2000;88:1869–76

Anaerobic bionanostothesis: two cases and review of the literature.

Proliferative epidermal lesions associated with anogenital Paget’s disease.

Caruncles at the external urethral meatus.

Cutaneous metastatic carcinoma of the penis: suspected metastasis implantation from a bladder tumor.
T MIYAMOTO, A REHARA, M ARAKI et al. *J Urol* 2000;163:1519

**Miscellaneous**

When is a sexually transmitted disease not an ‘STD’?

Notify or not to notify—STD patients’ perspectives of partner notification in Seattle.

Treatment of sexually transmitted bacterial diseases in pregnant women.
GOG DONDER. *Drug* 2000;59:377–86

Traditional intravaginal practices and the heterosexual transmission of diseases—a review.
JE BROWN, RB BROWN. *Sex Transm Dis* 2000;27:183–7

Extent of regretted sexual intercourse among young teenagers in Scotland: a cross sectional survey.
D WIGHT, M HENDERSON, G RAAB et al. *BMJ* 2000;320:1243–4

Sexually transmitted infections in European HIV-infected women: incidence in relation to time from infection.

Prevalence and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls.

Antibiotics for bacterial prostatitis.
JR NICKEL. *J Urol* 2000;163:1407

Saw palmetto for the treatment of men with lower urinary tract symptoms.
GS GERBER. *J Urol* 2000;163:1408–12

Cost utility analysis of sildenafil compared with papaverine-phenolomaline injections.

Non-Hodgkin’s lymphoma involving the vagina—a clinicopathologic analysis of 14 patients.

S HANKE FISCHER. *Cancer* 2000;88:2319–25

Finger-length ratios and sexual orientation.

A prospective study on condom slippage and breakage among female brothel-based sex workers in Singapore.
ML WONG, RKW CHAN, D KOH, S WEE. *Sex Transm Dis* 2000;27:208–14

Condorn acceptance is higher among travelers in Uganda.

www.sextransinf.com