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 mottled with normal overlying skin. Examination of genital, anal, and buccal mucosae was normal. There was no other lymphadenopathy. A differential diagnosis of lymphogranuloma venereum, Chlamydia trachomatis, syphilis, genital herpes, and tuberculosis 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 microscopic features 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, tuberculosis, 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 Iliac 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.1,3 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.

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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 groups but something 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 text saying that it can happen 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!

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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 method 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 parental opinions and legal issues—for example, for the partner of a C trachomatis positive youngster?

In two surveys performed in general practice in Amsterdam, Netherlands, the systematic and opportunistic screening, prevalence was strongly associated with young age but also with ethnicity. Among young Surinam-Antillian women aged <25 years, prevalences ranged from 5.4% in the general practice survey up to 22.4% in the opportunistic survey.3,4 In the systematic survey an unexpectedly high C trachomatis prevalence of 10% was found among young Surinam-Antillian men. Among the 15–19 year olds seeing our health centre in Amsterdam which is located in a multiethnic neighbourhood, half of the population having a Surinam-Antillian background, C trachomatis prevalence was 25%.

Thus, the question is not that the non-acceptable home screening is 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 age 15–30 years. It 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 second chance 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!


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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.1 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 not attending for colposcopy, and 11 (13.8%) and 24 (29.5%) defaulted for 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. Marteau et al found that a brief, simple booklet increased knowledge and reduced anxiety whereas a more complex booklet increased knowledge but did not reduce anxiety.

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 mental and sleeping function. Following the explanation our default rate for colposcopy was within the 15% recommended target,1 and follow up cytology was similar to the rates reported in primary care.2

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 time and follow up was recorded, default being defined as not attending for colposcopy, and 11 (13.8%) and 24 (29.5%) defaulted for follow up cytology.

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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 chlamydia pilot study. Health providers should respond using media with which the target population 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.

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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 diseases, is necessary. Some of these factors are part of the wider societal issues, which can only be addressed by education on sexual health and sexually transmitted diseases and perhaps by changing the economic environment.

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.

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

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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 two 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).

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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) 8 months after commencing HAART with stavudine, lamivudine, and indinavir. His CD4 lymphocyte count at that time was 238 cells x 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 antibody 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 the change in antiretroviral treatment his CD4 count was 418 cells x 10^3/l, with an HIV viral load below detection. Within a week of changing therapy the cheilitis resolved completely (fig 1B).

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BOOK REVIEW


This book is a must for anyone interested in how this fascinating organism causes disease. The first part reviews the knowledge on the molecular phylogeny, genomic autobiography, developmental biology, and metabolism of chlamydiae. It shows how far our knowledge of the organism has broadened in the past few years, particularly as gene sequencing has changed our view of chlamydiae. Until this was made available, metabolic studies on chlamydiae were hampered by its intracellular obligate nature, lack of knowledge of the enzyme pathways, and the relatively small genome which suggested very limited metabolic activity. It now becomes apparent that the organism, which we believed to be biologically crippled, has quite sophisticated biosynthetic capabilities. This opens the way to creating a non-cell dependent culture system in the future.

A chapter by Ted Hackstadt on the cell biology shows a whole spectrum of novel interactions with the host cell that contribute to the success of the genus as pathogens. This is followed by an excellent chapter by Julius Schachter on infection and disease epidemiology. He makes the interesting point that given that some individuals lose antibody over time it is possible that almost all humans have met the organism at sometime in their lives. This may be quite important in understanding some of the longer term consequences of chlamydial infections, where the organism may not be isolated and antibody tests may be negative. These sequelae are covered in subsequent chapters by Michael Ward, Robert Brumam, and Roger Rank. Since all three chapters discuss immunological response to chlamydia there is bound to be some overlap, but also some differences and interesting emphasis. For example Ward plays down the current obsession with cross reactions between chlamydia and human heat shock proteins.

A lot of our information, particularly on the immunology, comes from animal studies and their relevance to human pathology remains to be established. In an excellent final chapter Penelope Hitchcock points to the future directions of research. In particular, she laments that little research has been done in men with chlamydia. Certainly the book is rather short on discussion of the male. There is also a need to find a male model for pathogenesis. Non-gonococcal urethritis maybe a suitable, and easily accessible, marker of chlamydial infection in men and deserves more in-depth study. Much more research also needs to be done, particularly, on clinically inapparent infections in the future. In particular, we should also divert some resources into the “how” of sexual transmission we should not lose site of the “why” and the “how” of sexual transmission we should not lose site of the “why” and

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).

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@bsch.tmwids.nhs.uk).

3rd Congress of the Baltic Association of Dermatovenerology, 7–9 September 2000, Riga, Latvia

Further details: Professor Andris Y Rubins, Department of Dermatology, 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 IUSS-T 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) 7440174078; email: kumarbhushan@hotmail.com).
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 (Maori) “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).

Memorial Symposium—Celebrating a Century of Venereal Disease Research

Corrigenda

Letters, Book reviews, Notices, Current publications

Current publications

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

Gonorrhoea

Chlamydia

CORRECTION

An error occurred in the editorial by R D Maw which was published in the June issue (STI 2000;76:155). In the second column, lines 3–6, 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.
RJ PALER, 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 candidiasis. Pathogenesis, prevention, therapy.
E SEGAL. Mycoses 2000;42:55–60

Estrogen effects on Candida albicans: a potential virulence-regulating mechanism.
XQ ZHANG, M ESSMANN, ET BURT, B LARSEN. J Infect Dis 2000;181:1441–6

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

Cytokine modulation of specific and nonspecific immunity to Candida albicans.
I 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).
JN KRUEGER. Sex Transm Dis 2000;27:241–7

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 cysteine proteinase (CP65) of Trichomonas vaginalis involved in cytotoxicity.

Pelvic inflammatory disease

Risk factors for pelvic inflammatory disease in inner-city adolescents.
AL SUNS, P HOMEL, M HAMBERSCHLAG, K KROMBERG. Sex Transm Dis 2000;27:289–91

Syphilis and other treponematosis

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 DEBACKE. 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.

Herpes

Herpes simplex virus type 1 as a cause of genital herpes: impact on surveillance and prevention.
WE LAPPERTY, L DOWNEY, C CUM, A WARD. Infect Dis 2000;181:1454–7

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

HSV-2 specific serology should be offered routinely to antenatal patients. ZA BROWN. Rev Med Virol 2000;10:141–4


Herpes simplex virus-type 2 seropositivity in a Danish adult population denying previous episodes of genital herpes.
CS PETERSEN, FG LARSEN, C ZACHARIAE, M HEIDENHEIM. Acta Dermato-Venereol 2000;80:158
Seroprevalence of herpes simplex virus type 1 and type 2 in selected German populations—relevance for the incidence of genital herpes.

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

Characterization of an acylovir-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.
SL 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 premarket evaluation of the POCkit HSV-2 type-specific serologic test in

Hydrogels containing monocaprin 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 Akarapupachat, CT Lowden, 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.

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.

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?


**Other sexually transmitted infections**

*Mycoplasma genitalium* in males with nongonococcal urethritis—prevalence and clinical efficacy of eradication.

Development of a serological test for *Haemophilus ducreyi* for serore prevalence studies.

An isogenic hemoglobin receptor-deficient mutant of *Haemophilus ducreyi* is attenuated in the human model of experimental infection.

**Public health and social aspects**

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

Condom acceptance is higher among travelers in Uganda.
M MARES, MJ WAWER, F MAKUMBI et al. *AIDS* 2000;14:733–42

**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, AAP HOLGADO, ME NADERMACI. *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

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