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 unproctected 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 node group, 1–3 cm in size, firm, mobile, non-tender, and matted 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 tubercular lymphadenitis was considered. Bright yellow garments they were made to wear. Fine needle aspiration cytology of the lymph node revealed acid fast positive cells. Women were detained in the so called “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. The assumption by the authors that people 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 Chlamydia 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!

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, defaulting being defined as non-attendance without cancellation. 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 sleep. 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 time has been required, the lower default rates for colposcopy and cytology has reduced the clerical, medical, and secretarial time normally required recalling non-attenders.

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>$\chi^2$ test p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well do you understand the result you have been given?</td>
<td>Not at all</td>
<td>26</td>
<td>1</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>36</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lot</td>
<td>27</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Are you worried about the result of your smear test?</td>
<td>Yes</td>
<td>45</td>
<td>13</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>42</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Will it worry you if we need to do further investigations?</td>
<td>Yes</td>
<td>36</td>
<td>11</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>40</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Are you worried that further investigations will be painful?</td>
<td>Yes</td>
<td>55</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>5</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>11</td>
<td>14</td>
<td>0.0002</td>
</tr>
<tr>
<td>Do you think that any abnormality found can be treated?</td>
<td>Yes</td>
<td>61</td>
<td>3</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>25</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Do you think you have cancer?</td>
<td>Yes</td>
<td>3</td>
<td>0</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Do you think this smear result will affect your ability to have children?</td>
<td>Yes</td>
<td>15</td>
<td>2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>10</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Do you think this result will change your attitude to sex with your partner?</td>
<td>Yes</td>
<td>18</td>
<td>13</td>
<td>0.0004</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>30</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Do you think this result will affect the way your partner thinks of you?</td>
<td>Yes</td>
<td>8</td>
<td>4</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>13</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Default</td>
<td>68</td>
<td>75</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 was that this population makes extensive 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 chlamydia are cheap and effective. The cost of complications to the individual is enormous, as is the cost to the NHS—£200 million per year.2 The presence of sex on the internet is the next logical step, in 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—2332 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. Fifty 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 genitourinary 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–INFO 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 4 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, IT 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.1,2 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 contraceptives, 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.

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Russian STI


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

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L G DOUGACHIEVA
Assistant editor

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Accepted for publication 19 June 2000
Correspondence to: Dr Fox

alternative PI.

reversed on changing from indinavir to an

this fascinating organism causes damage.

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Figure 1 (A) Shows the indinavir related

considered that the

phenomenon, but topical treatment with Eumovate

clear antibodies with a homogeneous pattern

expected to create a non-cell dependent

to the success of the genus as pathogens. This

showed a wide spectrum of novel interactions with the host cell that contribute to

roseacea. Biopsy of the lip showed acneform and parakeratosis without associated inflamma-

the development of cheilitis, further investiga-

A 35 year old African man developed

80 mg daily and has since remained quiescent. The oral corticosteroids

tailored off and finally discontinued a month before the cheilitis developed. Follow-

the cheilitis resolved completely (fig 1B).

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 ×10⁹/L, with an HIV viral load of 78 copies per ml (Chiron bDNA assay version 3). He had a medical history of granulo-

As with indinavir which resolved rapidly on changing treatment.

AHART with stavudine, lamivudine, and idoxuridine on changing therapy.

which 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 ×10⁹/L, with an HIV viral load below detection. Within a week of changing therapy the cheilitis resolved completely (fig 1B).

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 sometimes 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 Brunum, and Roger Rank. Since all three concentrate on 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.

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BOOK REVIEW


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M SHAHMANESH

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.IHMFM.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@bscht.wmids.nhs.uk).

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

Further details: Professor Andris Y Rubins, Department of Dermatovenerology, Medical Academy of Latvia, K Valdemara Street, 76–75, Riga, LV-1013, Latvia (tel: +371 7370395; fax: +371 7361615; email: arubins@apollo.lv).

National NCCG Update Meeting, Bromsgrove Stakis Hotel, 23–24 September 2000

Further details: Kathy Taylor (tel: 01384 235207; email: palmtraining@tesco.net).

11th Regional Meeting of International Union against Sexually Transmitted Infections, South East Asian and Western Pacific Branch and 24th National Conference of Indian Association for the Study of Sexually Transmitted Diseases and AIDS, 13–15 October 2000, Chandigarh, India

Further details: Dr Bhushan Kumar, Organising Secretary, 11th Regional Meeting of IUSSI-Asia Pacific (SE Asia and W Pacific Branch), Department of Dermatology, Venereology and Leprosy, PGIMER, Chandigarh - 160 012, India (tel: +91 (0172) 749330; fax: +91 (0172) 744001/745078; email: kumarbhushan@hotmail.com).
New Zealand Venereological Society Conference, Centennial Convention Centre, Palmerston North, New Zealand, 18–20 October 2000
Ka Hikotia Ka Korereotia 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).

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 Chandyong, 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 Thanh Panalune, Bangkok Hospitai, 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 Chandyong, 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 Thanh Panalune, Bangkok Hospita211, 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 International Conference, RSM London, 7–9 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) (020) 7290 2965; fax: (44) (020) 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 9JP (tel: +44 (0) 20 7383 6409; fax: +44 (0) 20 7383 6886; email: quality@bma.org.uk; website: www.quality.bmj.org).

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, line 3, podophyllin should be replaced by podophyllotoxin in each case.

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 ZENILMAN. Sex Transm Dis 2000;27:224–5

Gonorrhoea in male adolescents and young adults in Newark, New Jersey—implications for prevention strategies.
KI MERTZ, I FINELLI, WC LIVNIE et al. Sex Transm Dis 2000;27:201–7

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;184:4–8

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 heterosexual 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 concern when 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;59:801–14

Neisseria gonorrhoeae MS11 mKCP opacity protein expression in vitro and during human volunteer infectivity studies.
KA SCHMIDT, CD DEAL, M IWAN et al. Sex Transm Dis 2000;27:278–83

Gonococcal lipo-oigosaccharide is a ligand for the asialoglycoprotein receptor on human sperm.
HA HARVEY, NC PORT, CA CAMPBELL et al. Mol Microbiol 2000;36:1059–70

Reexamining the prevalence of Chlamydia trachomatis infection among gay men with urethritis—implications for STD policy and HIV prevention activities.
EL CEMENS, J FLOOD, CK KENT et al. Sex Transm Dis 2000;27:249–51

Pooling of urine specimens for detection of asymptomatic Chlamydia trachomatis infections by PCR in a low-prevalence population: cost-saving strategy for epidemiological studies and screening programs.

Multiple drug-resistant Chlamydia trachomatis associated with clinical treatment failure.
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 methods 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, D R 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 infection.

Candidiasis

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.

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