LETTERS TO THE EDITOR

A study on the possible association of dysfunctional uterine bleeding with bacterial vaginosis, mycoplasma, ureaplasma, and Gardnerella vaginalis

EDITOR,—A number of studies in the recent years have shown that bacterial vaginosis or its associated micro-organisms mycoplasma/ureaplasma may be associated with various obstetric and gynaecological complications such as pelvic inflammatory disease and infertility,1 premature rupture of membranes and preterm labour,2 plasma cell endometritis,3 non-specific urethritis in male partners,4 and in our previous study5 we showed colonisation of the endometrium by mycoplasma and ureaplasma in patients with bacterial vaginosis.

The purpose of this study was to see if there is any association between dysfunctional uterine bleeding (DUB) and mycoplasma, ureaplasma, and/or bacterial vaginosis.

Ten patients, all with dysfunctional uterine bleeding admitted for abdominal hysterectomy, were recruited for the study. Patients were between 38 and 48 years (mean age 44) and all except one were parous. Appropriate ethics committee approval and informed consents were taken.

A detailed history was taken, particularly obstetrics and gynaecological, and any history of bacterial vaginosis or troublesome vaginal discharge. A preoperative high vaginal swab for microscopic diagnosis of bacterial vaginosis was taken. At operation, the endometrial cavity was opened by splitting the anterior wall of the uterus and an endometrial biopsy was taken for microbial culture and scanning electron microscopy for mycoplasma, ureaplasma, and Gardnerella vaginalis.

None of the patient had any history of bacterial vaginosis, troublesome vaginal discharge, or any obstetric or gynaecological complications. Microscopic examination of the high vaginal swabs were all normal except one with possible bacterial vaginosis. Microbial culture and scanning electron microscopy showed no mycoplasma, ureaplasma, or Gardnerella vaginalis.

Although there is definite association of colonisation of the endometrium by mycoplasma and ureaplasma in patients with bacterial vaginosis, as we showed in our previous study, this study did not show any association of DUB with bacterial vaginosis, Gardnerella vaginalis, mycoplasma, or ureaplasma. Any significant association of DUB and bacterial vaginosis appears unlikely, as the age group of the majority of patients with DUB, as in this study, is also different from the age group for bacterial vaginosis.

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Accepted for publication 7 June 2000

Ethnicity and country of acquisition of HIV in the current Leicester genitourinary medicine clinic cohort

EDITOR,—We have surveyed the regular HIV infected attenders in the Leicester genitourinary medicine (GUM) HIV cohort; there are currently 60 men and 16 women. Twenty per cent are black African and 13% are of Indian/Pakistani/Bangladeshi stock, while 62% are white. This amounts to 19 of 8258 black Africans in the Leicestershire population, 10 of 77 537 Asians in the Leicestershire retail park, and all except one were parous. Appropriate ethics committee approval and informed consents were taken.

A detailed history was taken, particularly obstetrics and gynaecological, and any history of bacterial vaginosis or troublesome vaginal discharge. A preoperative high vaginal swab for microscopic diagnosis of bacterial vaginosis was taken. At operation, the endometrial cavity was opened by splitting the anterior wall of the uterus and an endometrial biopsy was taken for microbial culture and scanning electron microscopy for mycoplasma, ureaplasma, and Gardnerella vaginalis.

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A MURRAY
Department of Obstetrics and Gynaecology


Accepted for publication 14 June 2000

Table 1 Table of ethnicity in relation to country of acquisition of HIV, as found in the Leicester genitourinary medicine clinic HIV cohort, and assessed in April 2000

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Country of acquisition</th>
<th>Asian</th>
<th>African</th>
<th>White</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asia</td>
<td>2 (3%)</td>
<td>2 (3%)</td>
<td>0</td>
<td>4</td>
<td>60%</td>
</tr>
<tr>
<td>Africa</td>
<td>2 (3%)</td>
<td>2 (3%)</td>
<td>15 (25%)</td>
<td>19 (3%)</td>
<td>31%</td>
</tr>
<tr>
<td>UK</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
<td>43 (54%)</td>
<td>46 (58%)</td>
<td>60%</td>
</tr>
</tbody>
</table>

*Thailand.
Detection of 14-3-3 brain protein in cerebrospinal fluid of HIV infected patients

Editor,—The 14-3-3 proteins are a group of highly conserved proteins involved in intracellular signalling. The detection of 14-3-3 brain protein has been described in cerebrospinal fluid (CSF) of patients with transmissible spongiform encephalopathies including both sporadic and variant Creutzfeldt-Jakob disease.1,2 False positive results have been reported in conditions producing (sub)acute neuronal destruction, including herpes simplex encephalitis, ischaemic stroke, multi-infarct dementia, and paraneoplastic syndromes.1,3 We postulated that 14-3-3 brain protein may be detected in CSF from patients with HIV associated dementia complex (HADC) as this condition is characterised neuropathologically by a giant cell encephalitis, leukoencephalopathy, astroglisis and neuronal loss.

We prospectively studied 17 HIV antibody positive patients (14 men) aged 27–60 (median 37) years, with CD4 counts of 0–220 (median 20) cells μl⁻¹ who underwent lumbar puncture for investigation of HADC (six patients), staging of lymphoma (five patients), or investigation of other neurological conditions (two), cervical radiculopathy (one), chronic demyelinating polyradiculopathy (one), CMV encephalitis (one), self limiting headache (one). Of those with HADC, the severity of dementia assessed using Memoiral Sloan-Kettering criteria, was mild in two and moderate in four. The degree of atrophy on cranial magnetic resonance imaging, used as a marker of neuronal loss, was mild in four and moderate in two. Clinical details of those with lymphoma are given in table 1. At each lumbar puncture an aliquot of CSF (250 μl) was frozen immediately in table 1. At each lumbar puncture an aliquot of CSF (250 μl) was frozen immediately.

CSF was routinely processed as described previously.1 Detection of 14-3-3 protein was done without knowledge of the patient’s diagnosis, using a technique described by Hsich et al,4 modified to use anti-14-3-3γ polyclonal rabbit antibody.

In 14 of 17 patients CSF was negative for 14-3-3 protein. Of the three with detectable 14-3-3 protein in CSF, all had lymphoma but only one had CNS disease, the other two had only extraneural disease (table 1). These data, although from a small study population, suggest that detection of 14-3-3 protein in CSF is not useful for diagnosis of HADC. Detectable 14-3-3 protein has previously been reported in a non-HIV infected patient with CNS lymphoma,1 so this observation in our patient is not unique, although brain necrosis from coexisting cerebral toxoplasmosis provided an alternative explanation. Of the two patients with extraneural lymphoma and detectable 14-3-3 protein in CSF, one had EBV DNA in CSF and so was at high risk of developing cerebral lymphoma. This possibility could not be confirmed as necropsy was not performed. In neither of the latter two patients was there a CSF pleocytosis, so contamination by peripheral blood leucocytes is unlikely. In the final case the absence of limbic encephalitis or cerebral degeneration makes it difficult to ascribe the finding to a paraneoplastic process.

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Accepted for publication 14 July 2000

Table 1 Clinical features, results of CSF brain protein detection, and outcome in patients with lymphoma

<table>
<thead>
<tr>
<th>Patient</th>
<th>Type of lymphoma</th>
<th>No of lumbar puncture</th>
<th>Interval between lumbar puncture (weeks)</th>
<th>14-3-3 detection</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Primary CNS</td>
<td>1</td>
<td>11</td>
<td>No</td>
<td>Died 2 weeks after second lumbar puncture. Necropsy showed also cerebral toxoplasmosis</td>
</tr>
<tr>
<td>2</td>
<td>Primary CNS</td>
<td>2</td>
<td>3</td>
<td>Yes</td>
<td>Died 2 weeks after second lumbar puncture. Necropsy confirmed diagnosis</td>
</tr>
<tr>
<td>3</td>
<td>Primary CNS</td>
<td>2</td>
<td>NA</td>
<td>No</td>
<td>Died 3 weeks later. No necropsy</td>
</tr>
<tr>
<td>4</td>
<td>Systemic, disseminated extraneural</td>
<td>2</td>
<td>NA</td>
<td>Yes</td>
<td>Died 6 weeks later. Cranial MR scan normal but EBV DNA detected in cell free CSF. No necropsy</td>
</tr>
<tr>
<td>5</td>
<td>Systemic, extra neural</td>
<td>1</td>
<td>NA</td>
<td>Yes</td>
<td>Alive. Cranial MR scan normal. Treated with local RT and HAART. No lymphoma recurrence after 39 months follow up</td>
</tr>
</tbody>
</table>

CNS = central nervous system. NA = not applicable. EBV = Epstein-Barr virus. CSF = cerebrospinal fluid. MR = magnetic resonance. RT = radiotherapy. HAART = highly active antiretroviral therapy.

Hepatitis B vaccination in a high risk MSM population: the need for vaccine education

Editor,—Estimates of the prevalence of hepatitis B virus (HBV) markers among men who have sex with men (MSM) range from 5% to 81%, and the prevalence of HBV surface antigen varies from 1% to 11%.1,2 Despite a safe and effective vaccine against HBV, sexually active MSM are not vaccinated adequately.1,4 Few empirical data describe the factors associated with HBV vaccination among MSM. We conducted a study to identify correlates of HBV vaccination among MSM that could inform future interventions designed to enhance HBV vaccination.

Data were collected at two male “gay” bars in Birmingham, Alabama, USA, using a brief, self administered questionnaire. Of 130 bar patrons, our sample consisted of 111 respondents who identified themselves as MSM and knew their vaccination status. Their average age was 31 years with a range of 18–48 years. The sample was disproportionately white (91.9%); 42% reported being vaccinated for HBV.

Based on bivariate analysis nine characteristic significances were associated with HBV vaccination—age; HIV knowledge; hepatitis B knowledge; HCV knowledge; HBV vaccination knowledge; number of sources for information about hepatitis; information from a physician; and information from professional training. Two factors retained significance when adjusting for all other factors in a multivariate logistic regression model: respondents’ HBV vaccination knowledge (OR=10.18; 90% CI = 4.0–25.37, p = 0.0001) and their frequency of condom use (OR=6.1; 90% CI = 2.54–14.67, p = 0.0007). The predictive power of the model (χ² = 82.33; p = 0.0001) was high, correctly classifying 76.4% of the respondents into their actual vaccination status categories (p = 0.0001). These findings suggest that respondents with high HBV vaccination knowledge and condom use are significantly more likely to have been vaccinated against HBV.

There is need to enhance awareness and facilitate vaccination among this high risk population for HBV infection; 32% reported having no information about hepatitis. Many respondents reported engaging in behaviours that put them and their sexual partners at risk for HBV infection; 95.5% and 30.6% reported using a condom less than 50% of the...
time during oral and anal intercourse, respectively. Given that HBV transmission usually results from mucous membrane exposure to infectious body fluids, including semen, the failure to vaccinate this high risk population is a missed opportunity to prevent disease.

Our findings suggest that MSM lack information about HBV risk and vaccination, and are engaging in behaviours that put them at risk for HBV infection. It is critical to develop innovative interventions that encourage condom use and increase knowledge of HBV vaccination among MSM.

This study was supported financially by the researchers themselves. We wish to thank the participants, the bar owners, managers, and staff.

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A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics and Gynaecology, symposium on Maternal Mental Health and the Child, 12 October 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlottetown’s and Chelsea Hospital, Goldhawk Road, London W6 0XG, UK (tel: +44 (0) 20 8383 3904; fax: +44 (0) 20 8383 8555; email: sympreg@ic.ac.uk).

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 IU SSTI–Asia Pacific (SE Asia and WP Pacific Branch), Department of Dermatology, Venereology and Leprosy, PGIMER, Chandigarh – 160 012, India (tel: +91 (0172) 745330; fax: +91 (0172) 744401/745078; email: kumarbhushan@hotmail.com).

New Zealand Venereology Society Conference, Centennial Convention Centre, Palmerston North, New Zealand, 18–20 October 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).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics and Gynaecology, symposium on Women and Children with HIV and AIDS, 20 October 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charles’s and Chelsea Hospital, Goldhawk Road, London W6 0XG, UK (tel: +44 (0) 20 8383 3904; fax: +44 (0) 20 8383 8555; email: sympreg@ic.ac.uk).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics and Gynaecology, symposium on key issues in the Care of Women and Gynaecological Cancers for Nurses, 30 October 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charles’s and Chelsea Hospital, Goldhawk Road, London W6 0XG, UK (tel: +44 (0) 20 8383 3904; fax: +44 (0) 20 8383 8555; email: sympreg@ic.ac.uk).

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(0)20 446 361; email: cvetrap@ratree.psuzu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bangkok 10120, Thailand (fax: +66(0)286 3013; email: phthanit@ 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: Symposium Office, Imperial College School of Medicine, Queen Charles’s and Chelsea Hospital, Goldhawk Road, London W6 0XG, UK (tel: +44 (0) 20 8383 3904; fax: +44 (0) 20 8383 8555; email: sympreg@ic.ac.uk).

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

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Pan-American Health Organization, regional office of the World Health Organization

www.sextransinf.com
CORRECTION

The paper by Hughes et al. "Comparison of risk factors for four sexually transmitted infections: results from a study of attenders at three genitourinary medicine clinics in England" published in the August issue of STI (2000;76:262–7) contained errors in tables 1 and 2. The correct versions of these tables are published here. The multivariable statistical analyses presented in tables 3 and 4, on which the paper focuses and on which the discussion and conclusions are based, are unaffected by the errors and remain unchanged.

Table 1  Characteristics of patients attending three GUM clinics in England, April 1994 to September 1997

<table>
<thead>
<tr>
<th>Royal Hallamshire,</th>
<th>St Thomas’s, London</th>
<th>Mortimer Market Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheffield (%)</td>
<td>(%)</td>
<td>(%)</td>
</tr>
<tr>
<td>Total attenders</td>
<td>20 334</td>
<td>15 155</td>
</tr>
<tr>
<td>Sex:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>9 992 (49)</td>
<td>7 969 (53)</td>
</tr>
<tr>
<td>Females</td>
<td>10 314 (51)</td>
<td>7 186 (47)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>28 (&lt;1)</td>
<td>–</td>
</tr>
<tr>
<td>Age group:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13–15</td>
<td>189 (1)</td>
<td>64 (&lt;1)</td>
</tr>
<tr>
<td>16–19</td>
<td>2 319 (11)</td>
<td>977 (6)</td>
</tr>
<tr>
<td>20–24</td>
<td>5 672 (28)</td>
<td>3 199 (21)</td>
</tr>
<tr>
<td>25–34</td>
<td>7 809 (38)</td>
<td>7 425 (49)</td>
</tr>
<tr>
<td>35+</td>
<td>4 254 (21)</td>
<td>3 485 (23)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>91 (&lt;1)</td>
<td>5 (&lt;1)</td>
</tr>
<tr>
<td>Male sexual orientation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>9 181 (92)</td>
<td>6 744 (85)</td>
</tr>
<tr>
<td>Hom/bisexual</td>
<td>800 (8)</td>
<td>1 174 (15)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>11 (&lt;1)</td>
<td>51 (1)</td>
</tr>
<tr>
<td>Ethnic group:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>18 014 (89)</td>
<td>8 383 (55)</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1 038 (5)</td>
<td>4 308 (28)</td>
</tr>
<tr>
<td>Black African</td>
<td>140 (1)</td>
<td>1 611 (11)</td>
</tr>
<tr>
<td>Asian</td>
<td>483 (2)</td>
<td>496 (3)</td>
</tr>
<tr>
<td>Other/mixed†</td>
<td>297 (1)</td>
<td>357 (2)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>362 (2)</td>
<td>5 381 (34)</td>
</tr>
<tr>
<td>Presenting diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital warts†</td>
<td>1 976 (10)</td>
<td>963 (6)</td>
</tr>
<tr>
<td>Genital HSV†</td>
<td>548 (3)</td>
<td>433 (3)</td>
</tr>
<tr>
<td>Gonorrhoea†</td>
<td>389 (2)</td>
<td>559 (4)</td>
</tr>
<tr>
<td>Chlamydia†</td>
<td>2 175 (11)</td>
<td>752 (5)</td>
</tr>
<tr>
<td>Number of recorded partners (heterosexuals):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–1</td>
<td>10 353 (53)</td>
<td>7 299 (53)</td>
</tr>
<tr>
<td>2</td>
<td>5 027 (26)</td>
<td>3 541 (26)</td>
</tr>
<tr>
<td>3+</td>
<td>3 042 (15)</td>
<td>2 802 (20)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>13 (&lt;1)</td>
<td>159 (1)</td>
</tr>
<tr>
<td>Previous STI:</td>
<td></td>
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</tr>
<tr>
<td>Yes</td>
<td>5 791 (28)</td>
<td>5 807 (38)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>3 (&lt;1)</td>
<td>7 533 (47)</td>
</tr>
<tr>
<td>Ever injected drugs:</td>
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<td></td>
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<tr>
<td>Yes</td>
<td>361 (2)</td>
<td>228 (2)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>2 (&lt;1)</td>
<td>7 486 (47)</td>
</tr>
<tr>
<td>Commercial sex work (ever):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>543 (3)</td>
<td>181 (1)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>–</td>
<td>15 155 (100)</td>
</tr>
</tbody>
</table>

1 Data for 1 April 1994 to 30 September 1997.
2 Data for 1 April 1994 to 31 December 1996.
3 Data for 1996 only.
4 Includes “black other.”
5 First episode.
6 Uncomplicated infection.
7 Number of partners in past 12 months for Sheffield and St Thomas’s clinics and in past 3 months for MMC (see methods for details).

Table 2  Numbers of attenders diagnosed with first episode genital warts, first episode genital HSV, uncomplicated gonorrhoea and uncomplicated chlamydia, showing concurrent infections, in attenders at three GUM clinics in England, April 1994 to September 1997 (+ = present, − = absent)

<table>
<thead>
<tr>
<th>No of attenders (%)</th>
<th>Warts</th>
<th>HSV</th>
<th>Gonorrhoea</th>
<th>Chlamydia</th>
</tr>
</thead>
<tbody>
<tr>
<td>3320</td>
<td>(6.46)</td>
<td>+</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>3101</td>
<td>(6.04)</td>
<td>–</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>1184</td>
<td>(2.30)</td>
<td>+</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>957</td>
<td>(1.86)</td>
<td>–</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>233</td>
<td>(0.45)</td>
<td>–</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>187</td>
<td>(0.36)</td>
<td>+</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>28</td>
<td>(0.05)</td>
<td>−</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>21</td>
<td>(0.04)</td>
<td>+</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>21</td>
<td>(0.04)</td>
<td>+</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>11</td>
<td>(0.02)</td>
<td>+</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>9</td>
<td>(0.02)</td>
<td>+</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>2</td>
<td>(0.00)</td>
<td>−</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>42 297</td>
<td>(82.34)</td>
<td>–</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>Total 51 371 (100)</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

Gonorrhoea
Chlamydia
Candida
Bacterial vaginosis
Trichomoniasis
Syphilis and other treponematoses
Hepatitis
Herpes
Human papillomavirus infection
Cervical cytology and colposcopy
Other sexually transmitted infections
Public health and social aspects
Microbiology and immunology
Dermatology
Miscellaneous

Gonorrhoea

Sexually transmitted disease clinic clients at risk for subsequent gonorrhoea and chlamydia infections—possible ‘core’ transmitters.

RA GUNN, S FITZGERALD, SO ARAL


Gonorrhoea among men who have sex with men: outbreak caused by a single genotype of erythromycin-resistant Neisseria gonorrhoeae with single-base pair deletion in mtrR promoter region.

MS XIA, WIL WHITTINGTON, WM SHAPER, KK HOLMES

J Infect Dis 2000;181:2080–2

Amultiplex polymerase chain reaction to differentiate β-lactamase plasmids of Neisseria gonorrhoeae.

HM PALMER, JP LEENING, A TURNER

J Antimicrob Chemother 2000;45:777–82

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