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 microscopical diagnosis of bacterial vaginosis was taken. At operation, the endometrial cavity was opened by splitting the anterior wall of the uterus and an endometrial cavity was opened by splitting the posterior 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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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 five per cent are black African and 13% are of Indian/Pakistani/ethnic stock, while 62% are white. This amounts to 19 of 8258 black Africans in the Leicestershire total county population (which includes Leicester central district) being HIV positive. Forty seven of 75 537 Asians in the total county population were also HIV positive (Leicester City Council, from 1991 census figures, 2000, personal communication).

For acquisition of HIV related to ethnicity, the results are as displayed in table 1.

In 1997, of those with heterosexually transmitted HIV in the United Kingdom, 3.3% were black Caribbeans, 49% were black Africans, with 33% being white, and 2.3% were Asian.

In 1999, the Communicable Disease Report6 stated that, of female HIV infected people in England and Wales, 32% were white people and 49.5% were black Africans, and 2.7% were black Caribbeans, and 1.3% were south Asians.

Compared with the latter England and Wales figures, Leicester appears to have a moderate underrepresentation of black Africans with HIV, and a moderate overrepresentation of Asians in its cohort. This latter figure is to be expected because Leicester’s Asian population is 3.23% of the total population of the city (Leicester City Council, 1991 census figures, 2000, personal communication). However, the Asian figure

<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></td>
<td></td>
<td>2 (3%)</td>
<td>2 (3%)</td>
<td>2 (3%)</td>
<td>6 (9%)</td>
</tr>
<tr>
<td>Asia</td>
<td></td>
<td>1 (3%)</td>
<td>19 (25%)</td>
<td>19 (25%)</td>
<td>39 (56%)</td>
</tr>
<tr>
<td>Africa</td>
<td></td>
<td>2 (3%)</td>
<td>19 (25%)</td>
<td>2 (3%)</td>
<td>23 (33%)</td>
</tr>
<tr>
<td>UK</td>
<td></td>
<td>19 (25%)</td>
<td>19 (25%)</td>
<td>19 (25%)</td>
<td>57 (82%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>9%</td>
<td>31%</td>
<td>60%</td>
<td>100%</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. 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. 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. 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, leucencephalopathy, 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 × 10⁹/l, who underwent lumbar puncture for investigation of HADC (six patients), staging of lymphoma (five patients), or investigation of other neurological conditions (six patients). No patients were taking potent HAART. No lymphoma recurrence after 39 months follow up.

In 14 of 17 patients CSF was negative for 14–3–3 brain protein in cerebrospinal fluid as a marker for transmissible spongiform encephalopathies. 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 14–3–3 protein derived from peripheral blood leucocytes is unlikely. In the final case the absence of limbic encephalitis or cerebellar degeneration makes it difficult to ascribe the finding to a paraneoplastic process.

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Correspondence to: Dr Miller

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</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Necropsy showed also cerebral toplasmosis</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</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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>1</td>
<td>NA</td>
<td>Yes</td>
<td>Died 6 weeks later. Cranial MR scan normal but EBV DNA detected in cell free CSF</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.
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 research participants. We wish to thank the participants, the bar owners, managers, and staff.

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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 infection in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

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

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

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

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’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 Infections and AIDS, 13–15 October 2000, Chandigarh, India

Further details: Dr Bhushan Kumar, Organising Secretary, 11th Regional Meeting of IUSTI–Asia Pacific (SE Asia and 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 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).

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 Charlotte’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 Charlotte’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 Chandyeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: +66-74) 446 361; email: verapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, Bangkok Hospital, 189 Sathorn Road, Bangkok 10120, Thailand (fax: (66-2) 286 3013; email: pthanit@email.ksc.net).

Imperial College School of Medicine, Division of Paediatrics, Obstetrics and Gynaecology, revision course for DCH (at Wolfson Conference Centre), 13–17 November 2000

Further details: Symposium Office, Imperial College School of Medicine, Queen Charlotte’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 Chandyeying, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: +66-74) 446 361; email: verapol@ratree.psu.ac.th or Bangkok Secretariat, Dr Thanit Palanuvej, 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 International Conference, RSOM, London, 7–8 December 2000

The RSOM in London, UK, and the NIH in Bethesda, Maryland, US, are organising an international conference to be held at the RSOM on “New trends in HIV management and research.” Further details: Victoria Boswell, Academic Conference Assistant, Royal Society of Medicine (tel: +44 (0) 20 7292 2965; fax: +44 (0) 20 7290 2977; email: victoria.boswell@royalsocmed.ac.uk).

International Symposium on Disorders of the Prostate, 21–23 March 2001, Castres, France

Further details: Dr Mike Briley, Scientific Director, Pierre Fabre Medicament, Parc Industriel de la Chartreuse, F-81106 Castres Cedex, France (tel:+33 563 714 501; fax: +33 563 725; email: briley@pierre-fabre.imagenet.fr).

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, UK (tel: +44 (0) 20 7383 6409; fax: (04) 20 7383 6869; email: quality@bma.org.uk; website: www.quality.bmjg.com).

6th European Congress of Experimental AIDS Research (ECEAR ‘2001), 23–26 June 2001, Herriott-Watt University, Edinburgh, UK

Further details: ECEAR ‘2001 Conference Secretary, Division of Virology, NIBSC, Blanche Lane, South Mimms, Potters Bar, Herts, EN6 3QG, UK.

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Letters, Notices, Correction, Current publications
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, Sheffield (%)</th>
<th>St Thomas’s, London (%)</th>
<th>Mortimer Market Centre (MMC), London (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total attenders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>20 334 (1)</td>
<td>15 155 (1)</td>
</tr>
<tr>
<td>Female</td>
<td>10 314 (1)</td>
<td>7 186 (1)</td>
</tr>
<tr>
<td>Total attenders</td>
<td>30 648 (1)</td>
<td>22 341 (1)</td>
</tr>
<tr>
<td>Age group:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13–15</td>
<td>189 (1)</td>
<td>189 (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>Total attenders</td>
<td>20 334 (1)</td>
<td>15 155 (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>Homo/bisexual</td>
<td>800 (8)</td>
<td>1 174 (15)</td>
</tr>
<tr>
<td>Total attenders</td>
<td>9 981 (90)</td>
<td>7 918 (80)</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>Asian</td>
<td>483 (2)</td>
<td>496 (3)</td>
</tr>
<tr>
<td>Total attenders</td>
<td>19 535 (97)</td>
<td>13 342 (84)</td>
</tr>
<tr>
<td>Presenting diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital warts6</td>
<td>1 976 (10)</td>
<td>963 (6)</td>
</tr>
<tr>
<td>Genital HSV5</td>
<td>548 (3)</td>
<td>433 (3)</td>
</tr>
<tr>
<td>Gonorrhoea6</td>
<td>389 (2)</td>
<td>559 (4)</td>
</tr>
<tr>
<td>Chlamydia6</td>
<td>2 175 (11)</td>
<td>752 (5)</td>
</tr>
<tr>
<td>Number of recorded (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>3 046 (15)</td>
<td>2 802 (20)</td>
</tr>
<tr>
<td>Total attenders</td>
<td>18 406 (92)</td>
<td>13 642 (84)</td>
</tr>
<tr>
<td>Previous STI:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5 791 (28)</td>
<td>5 807 (38)</td>
</tr>
<tr>
<td>No recorded</td>
<td>13 (1)</td>
<td>159 (1)</td>
</tr>
<tr>
<td>Total attenders</td>
<td>6 615 (31)</td>
<td>6 966 (43)</td>
</tr>
<tr>
<td>Ever injected drugs:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>361 (2)</td>
<td>228 (2)</td>
</tr>
<tr>
<td>No recorded</td>
<td>12 (1)</td>
<td>7 486 (47)</td>
</tr>
<tr>
<td>Total attenders</td>
<td>373 (2)</td>
<td>7 794 (43)</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>No recorded</td>
<td>15 155 (100)</td>
<td>7 641 (48)</td>
</tr>
<tr>
<td>Total attenders</td>
<td>20 698 (100)</td>
<td>15 826 (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 (0.46)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>3101</td>
<td>6 (0.46)</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>1184</td>
<td>2 (0.30)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>957</td>
<td>1 (0.86)</td>
<td>−</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>233</td>
<td>0 (0.43)</td>
<td>−</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>187</td>
<td>0 (0.36)</td>
<td>+</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>28</td>
<td>0 (0.05)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>21</td>
<td>0 (0.04)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>21</td>
<td>0 (0.04)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>11</td>
<td>0 (0.05)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>9</td>
<td>0 (0.02)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>5</td>
<td>0 (0.01)</td>
<td>+</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>42 297</td>
<td>82 (0.34)</td>
<td>−</td>
<td>−</td>
<td>+</td>
</tr>
<tr>
<td>Total 51 371</td>
<td>(100)</td>
<td>−</td>
<td>−</td>
<td>+</td>
</tr>
</tbody>
</table>

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CURRENT PUBLICATIONS

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

Gonorrhoea
Chlamydia
Candidiasis
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, J A CARDINALE, VL CLARK, DK THOMPSON, CD DEAL, CA ISON, HM PALNER, JP LEENING, A TURNER.

Amultiplex polymerase chain reaction to differentiate β-lactamase plasmids of Neisseria gonorrhoeae. A comparison of β-lactamase plasmids of Neisseria gonorrhoeae. Homo/bisexual 800 (8) 1 174 (15) 1 751 (22)

J Infect Dis 2000;181:2080–2

A typing system for Neisseria gonorrhoeae based on blinjinkelated oligonucleotide probes to PIB gene variable regions.

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