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 prematurity 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 five 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 total county population (which includes Leicester central district) being HIV positive. Forty seven of 771 181 white people and 10 of 77 537 Asians in the Leicestershire 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 HIV1 in the United Kingdom, 3.3% were black Caribbeans, 49% were black African, with 33% being white, and 2.3% were Asian.

In 1999, the Communicable Disease Report 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 23.7% of the total population of the city (Leicester City Council, 1991 census figures, 2000, personal communication). However, the Asian figure is not that high pro rata, possibly because cultural factors prohibit sex outside marriage.

Quinn et al2 have shown recently that viral load is the chief predictor of the risk of heterosexual transmission of HIV-1, and that transmission is rare among people with levels of less than 1500 copies of HIV-1 RNA per ml.

It may be that HAART (highly active antiretroviral therapy) for HIV infected people has caused transmission to be low in the United Kingdom but, as Cohen says, such a theory has not been proved.

The viral subtype dominant in parts of Africa (clade C), has unique properties that favour sexual transmission.3 Other factors that make Africans more susceptible to HIV than those who live in more developed countries include lack of host factors that reduce infection risk; the plasma HIV-1 RNA level in seropositive people being higher in sub-Saharan Africans; the lack of mutations in the gene for chemokine receptor 5; circumcision status, with most men in Africa being uncircumcised; and the high prevalence of ulcerative sexually transmitted diseases.4 Some of these factors will operate for Asian patients born in Africa.

Thus, ethnicity and country of acquisition of HIV in Leicester as elsewhere, is a reflection of interwoven, genetic, environmental and behavioural, political, and geographical factors. Therefore, we cannot just examine nationality in isolation when considering HIV epidemiology. Travellers from Britain to Thailand, the Philippines, India, and Africa especially should be forewarned of the risks of sex and healthcare needle exposure and/or blood transfusions in all travel medicine consultations.

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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>2 (3%)</td>
<td>6 (3%)</td>
<td>100%</td>
</tr>
<tr>
<td>Africa</td>
<td>2 (3%)</td>
<td>2 (3%)</td>
<td>19 (25%)</td>
<td>21 (25%)</td>
<td>100%</td>
</tr>
<tr>
<td>UK</td>
<td>3 (3%)</td>
<td>1 (3%)</td>
<td>12 (15%)</td>
<td>16 (20%)</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>9%</td>
<td>31%</td>
<td>45 (54%)</td>
<td>60%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Thailand.


Accepted for publication on 15 January 2000.
Detection of 14-3-3 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.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, leucoencephalopathy, 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 x10⁹/l, who underwent lumbar puncture for investigation of HADC (six patients), staging of lymphoma (five patients), or investigation of other conditions (six patients): intracranial hypertension (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 Memo rial 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 at −20°C and stored for subsequent 14-3-3 protein analysis.

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 Hirsch et al,4 modified to use anti-14-3-3-γ 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 extraneuraxial 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 provides 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 cerebellar degeneration1 makes it difficult to ascribe the finding to a paraneoplastic process.

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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) vary 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.3,4 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 associations nine characteristics were significantly associated with HBV vaccination—age; educational status; knowledge of hepatitis; HBV 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

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>3</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>No</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.
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 committee. 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 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 Diseases 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, Venerology and Leprosy, PGIMER, Chandigarh – 160 012, India (tel: (+91) (0172) 745330; fax: +91 (0172) 744401; 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 (Maoritanaivery 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 Cancer (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 Union and Refresher Course on Sexual Health, Lee Garden Plaza Hotel, Hat Yai, Thailand 24–26 November 2000

Further details: Hat Yai Secretariat, Dr Verapol Chandyeng, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cverapol@rattree.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).

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Further details: Hat Yai Secretariat, Dr Verapol Chandyeng, Dept of OB-GYN, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkla 90110, Thailand (fax: (66-74) 446 361; email: cverapol@rattree.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, RSM London, 7–8 December 2000

The RSM in London, UK, and the NIH in Bethesda, Maryland, US, are organising an international conference to be held at the RSM on “New trends in HIV management and research.” Further details: Victoria Boswell, Academic Conference Assistant, Royal Society of Medicine (tel: (+44) (0)20 72920 2965; fax: +44 (0)20 7292 2977; email: victoria.boswell@roy socmed.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, British Medical Association, WC1H 9JP, UK (tel: +44 (0) 20 7383 6409; fax: +44 (0) 20 7383 6869; email: quality@bma.org.uk; website: www.quality.bmjgroup.com).


Further details: ECEAR ‘2001 Conference Secretary, Division of Retrovirology, NIBSC, Blanche Lane, South Mimms, Potters Bar, Herts, EN6 3QG, UK.
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>Ethnic group:</th>
<th>Male sexual orientation:</th>
<th>Female sexual orientation:</th>
<th>Age group:</th>
<th>Number not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Heterosexual</td>
<td>Heterosexual</td>
<td>13–15</td>
<td>438 (10)</td>
</tr>
<tr>
<td></td>
<td>Heterosexual</td>
<td>Heterosexual</td>
<td>16–19</td>
<td>359 (11)</td>
</tr>
<tr>
<td></td>
<td>Heterosexual</td>
<td>Heterosexual</td>
<td>20–24</td>
<td>278 (22)</td>
</tr>
<tr>
<td></td>
<td>Heterosexual</td>
<td>Heterosexual</td>
<td>25–34</td>
<td>245 (21)</td>
</tr>
<tr>
<td></td>
<td>Heterosexual</td>
<td>Heterosexual</td>
<td>35–39</td>
<td>109 (1)</td>
</tr>
<tr>
<td></td>
<td>Male sexual orientation:</td>
<td>Heterosexual</td>
<td>13–15</td>
<td>438 (10)</td>
</tr>
<tr>
<td></td>
<td>Male sexual orientation:</td>
<td>Heterosexual</td>
<td>16–19</td>
<td>359 (11)</td>
</tr>
<tr>
<td></td>
<td>Male sexual orientation:</td>
<td>Heterosexual</td>
<td>20–24</td>
<td>278 (22)</td>
</tr>
<tr>
<td></td>
<td>Male sexual orientation:</td>
<td>Heterosexual</td>
<td>25–34</td>
<td>245 (21)</td>
</tr>
<tr>
<td></td>
<td>Male sexual orientation:</td>
<td>Heterosexual</td>
<td>35–39</td>
<td>109 (1)</td>
</tr>
</tbody>
</table>

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></td>
<td>3320</td>
<td>(6.46)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>3101</td>
<td>(6.04)</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>1184</td>
<td>(2.30)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>957</td>
<td>(1.86)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>233</td>
<td>(0.45)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>187</td>
<td>(0.36)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>(0.05)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>(0.04)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>(0.04)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>(0.02)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>(0.02)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>(0.00)</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td></td>
<td>42 297</td>
<td>(82.34)</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Total 51 371 (100)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chlamydia

Duration of untreated genital infections with Chlamydia trachomatis—a review of the literature.


Urogenital Chlamydia trachomatis serovars in men and women with a symptomatic or asymptomatic infection: an association with clinical manifestations?


Relationship of hormonal contraception and cervical ectopy as measured by computerized planimetry to chlamydial infection in adolescents.


Pooling cervical swabs and testing by ligase chain reaction are accurate and cost-saving strategies for diagnosis of Chlamydia trachomatis.


Reproducibility problems with the Abbott Laboratories LCx assay for Chlamydia trachomatis and Neisseria gonorrhoeae.

AM GROMOFSKI, S COPPER, D BARTOLO, PR MURRAY. J Clin Microbiol 2000;38:2416–8

An important proportion of genital samples submitted for Chlamydia trachomatis detection by PCR contain small amounts of cellular DNA as measured by β-globin gene amplification.


Priming with Chlamydia trachomatis major outer membrane protein (MOMP) DNA followed by MOMP ISCOM boosting enhances protection and is associated with increased immunoglobulin A and Th1 cellular immune responses.


Genetic differences in the Chlamydia trachomatis tryptophan synthase α-subunit can explain variations in serovar pathogenesis.


Role of hyphal formation in interactions of Candida albicans with endothelial cells.


Measurement of T-cell-derived antigen binding molecules and immunoglobulin G specific to Candida albicans mannan in sera of patients with vaginal candidal candidiasis.


Evidence for mating of the ‘asexual’ yeast Candida albicans in a mammalian host.

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Bacterial vaginosis

The Papanicolaou smear: inadequate screening test for bacterial vaginosis during pregnancy.


Trichomoniasis

A randomized trial of intravaginal nooxynol 9 versus oral metronidazole in the treatment of vaginal trichomoniasis.

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Host and tissue specificity of Trichomonas vaginalis is not mediated by its known adhesion proteins.


18S ribosomal DNA-based PCR for diagnosis of Trichomonas vaginalis.


Syphilis and other treponematoses

Tracing a syphilis outbreak through cyberspace.


Strategies for syphilis prevention—findings from surveys in a high-incidence area.

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JG WASSERSTEIN. Sex Transm Dis 2000;27:311–2

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Comparison of the Serodia Trepomema pallidum particle agglutination, Captia syphilis-G and Spiroket Reagin II tests with standard test techniques for diagnosis of syphilis.


Trepomema pallidum subsp pertenue displays pathogenic properties different from those of T pallidum subsp pallidum.


Hepatitis

Detection of hepatitis C virus in the semen of infected men.


JG FELDMAN, M MINKOFF, L LANDESMAN, J DEHOPVITZ. Sex Transm Dis 2000;27:338–42

The natural history of hepatitis C virus infection—host, viral and environmental factors.


Herpes

Herpes simplex virus in the human cornea.

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Further evidence from a murine infection model that farnesilic acid interferes with the establishment of HSV-1 latent infections.

AM THACKRAY, H FIELD. J Antimicrob Chemother 2000;45:825–34

Comparison of virus isolation and various polymerase chain reaction methods in the diagnosis of mucocutaneous herpesvirus infection.


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