LETTERS TO THE EDITOR

Labial adhesions following severe primary genital herpes

EDITOR,—Labial adhesions following genital herpes infection have been described previously.1 To prevent their development various suggestions such as the use of early aciclovir,2 paraffin gauze, and saline bathing3 have been put forward. We believe nursing care is a significant factor in the prevention of this complication. Here we report two cases of severe genital herpes presenting at different sites, almost at the same time, both necessitating admission and developing labial adhesions.

CASE 1

A 27 year old insulin dependent female diabetic was admitted to the gynaecology ward with history of acute onset of vulval soreness, fever, and difficulty in micturation of 3 days’ duration. On examination she had a temperature of 38.2°C, oedematous tender vulva, and bilaterally enlarged tender inguinal lymph nodes. A presumptive diagnosis of cellulitis was made. The patient was catheterised and commenced on topical lignocaine gel, subcutaneous morphine, intravenous metronidazole, and cefuroxime, and insulin by sliding scale. Two days later she developed perineal and vulval ulcerations and intravenous aciclovir was added. In view of failure of clinical response the genitourinary department was asked to review the case. Examination revealed perineal and perianal ulcers. A diagnosis of primary HSV was made, intravenous antibiotics were stopped, and oral antivirals were started. The nursing staff were instructed to offer the patient a sitz bath twice daily in view of extensive discomfort and oedema. Swabs taken confirmed the diagnosis of HSV. The patient made gradual recovery and she was allowed home after 1 week in hospital. Two weeks later when she presented to the genitourinary medicine clinic, genital examination showed a thick band of adhesions between the middle halves of the labia minora, and new herpetic lesions (fig 1). She was prescribed oral valaciclovir, metronidazole, and lignocaine gel and advised to continue salt and water bathing at home. A follow up appointment was arranged for release of adhesions. Surprisingly, separation of adhesions was not needed.

COMMENT

These two cases illustrate that females with severe genital herpes can be admitted to different hospital departments other than genitourinary medicine, where the nursing staff may not be familiar with the management and complications of this infection. Patients should be encouraged to separate the labial folds; this can be facilitated by the liberal use of local anaesthetic agents with the assistance of the nursing staff. Frequent saline bathing of the genitalia should be encouraged to facilitate the removal of the fibrinous exudate, which is responsible for the formation of these adhesions.

GUM nurses and physicians should play an active part in the education and nursing care of such cases and lead the management especially when admitted to other specialties.

Contributors: EH managed case 1, JD managed case 2, while both authors wrote the manuscript.

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ACCEPTED FOR PUBLICATION 14 NOVEMBER 2000

Respiratory and cutaneous manifestations of disseminated cryptococcosis in AIDS

EDITOR,—A 26 year old, previously fit and well Afro-Caribbean man, presented with a 5 week history of a “flu-like” illness. Initially treated with antibiotics, the patient deteriorated, developing a cough, haemoptysis, progressive breathlessness, intermittent blurring of vision, and a rash. Investigations indicated he was HIV positive.

On examination, though orientated, he looked unwell and was febrile. He had an extensive papulonodular rash on his face, trunk, and limbs. Many of these lesions were centrally umbilicated with areas of associated haemorrhage (fig 1). Respiratory examination revealed decreased air entry in the right chest and coarse inspiratory bi-basal crackles. Funduscopy demonstrated retinal pallor, congested optic discs, and bilateral soft exudates associated with haemorrhages. He had no focal neurological signs.

Full blood count, urea and electrolytes, and clotting screen were normal. Arterial blood gases on 35% oxygen revealed a pH of 7.44, Pao$_2$ 9.4 kPa, Paco$_2$ 2.7 kPa, base excess –8.2. Chest radiograph demonstrated bilateral infiltrates with a right sided pleural effusion.

The patient had been treated for a presumed diagnosis of severe community acquired pneumonia and/or *Pneumocystis carinii* pneumonia plus *Molluscum contagiosum* of the skin. In view of the patient’s clinical findings, additional therapy was commenced with anticytomegalovirus (CMV) and anticytophococcal agents.

Urgent blood and pleural fluid cryptococcal reactive antigen testing (CRAG) were strongly positive at a titre of 1:2048. Blood CMV PCR was negative. The patient could not tolerate a lumbar puncture. Despite initial improvement, he developed progressive respiratory failure and died. The post mortem revealed disseminated cryptococcal disease with involvement of brain, skin, lung, heart, liver, spleen, kidneys, pancreas, thyroid, bowel, adrenal glands, and testes.


Accepted for publication 14 November 2000
Disseminated cryptococcal infection has a >80% mortality when associated with respiratory failure. Cutaneous lesions occur in 5–10% of cases. These include subcutaneous nodules, ulcers, and cellulitis. These may mimic pyoderma gangrenosum, Kaposi’s sarcoma, and Molluscum contagiosum. Clinically, cryptococcal disease may be distinguished from Molluscum contagiosum by a more acute onset of numerous papules, which often have a central haemorrhagic crust.1

Our patient was unwell and had skin lesions that were too extensive for simple Molluscum contagiosum. While Pneumocystis carinii remains the commonest cause of severe respiratory disease in HIV infected individuals not on chemoprophylaxis, pleural effusions are rare in this condition. CMV would be unlikely to produce such acute systemic illness by itself. Hence, cryptococcal disease was a reasonable working diagnosis that required urgent treatment. A recent report has highlighted diagnostic delay as a major factor contributing to its high associated mortality. The CRAO test provides a rapid method of confirming the diagnosis of cryptococcosis. It will be positive in blood in infected individuals in up to 95% of cases. The result can then be verified on culture of suitable body fluids. We recommend early consideration of disseminated cryptococcosis in HIV positive patients with respiratory features suggestive of pneumonia or pleural effusion and atypical skin lesions. The use of rapid diagnostic tests may help to improve the poor outcome in this patient population.

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Accepted for publication 14 November 2000

Recurrent eczema herpeticum: an underrecognised condition

Editor,—We present a case of eczema herpeticum to highlight that herpes simplex can cause generalised infection in atopic individuals and should be considered in the differential diagnosis.

CASE REPORT

A 19 year old man presented with 2 day history of extensive painful pururulent eruptions of the hands, forearms, and chest. He also felt unwell and had fever. Fingers were stiff and could not be fully extended. He was seen in the local accident and emergency department and prescribed fluociclovir. On direct questioning he admitted that his illness started with painful penile ulcers followed 2 days later by eroded crops of blisters, which then became infected. Ten days before this he had unprotected sexual intercourse with a female friend in Ibiza. He had extensive atopic eczema during childhood, which is well controlled now but has been getting hay fever for the past few years.

Examination revealed symmetrical purulential eruptions on the hands, wrist, forearms, lower legs and chest, and a few vesicular eruptions on the hands typical of herpes. He also had multiple superficial penile ulcers. Axillary and inguinal lymph nodes were enlarged. There was also evidence of generalised eczema.

Herpes simplex was isolated from the penile ulcers. Screening for other STIs and HIV was negative. He was treated with aciclovir 200 mg five times a day for 5 days with very good response. Two months later he presented to our department with a similar episode that required treatment with aciclovir. Since then he has been seen on two occasions with recurrence in the past year, but the attacks were more localised to his hands and external genitalia (fig 1).

Eczema herpeticum is classically a disseminated herpes simplex infection of the skin occurring in patients with pre-existing active dermatitis. The disease may result from minor transient disease to a fulminating fatal disorder involving the viscera organs.1,2 The severity appears to be unrelated to the extent of cutaneous lesions. Active dermatitis is not necessary for the development of recurrent eczema herpeticum.

Atopic dermatitis typically begins in early infancy, and individuals with this disease frequently develop other atopic manifestations later in life such as hay fever, allergic rhinitis, and bronchial asthma.3 Eczema herpeticum has also been associated with seborrhoeic dermatitis, neurodermatitis, Darier’s disease, pemphigus, mycosis fungoides, Wiskott–Aldrich disease, congenital ichthyosiform erythroderma,4 and second degree burns.5

The presentation in our patient is fairly typical, lesions appearing in crops initially as tiny vesicles passing through pururulent and crusted phases associated with systemic symptoms. This condition is often misdiagnosed because the lesions are usually scratched and blistering is lost leaving raw punched out areas often with secondary infection. Diagnosis is based on patient history of atopic disease, presence of vesicular lesion, the striking tendency for the lesions to return to the same areas of the skin, and a positive result of viral culture for herpes simplex.

Eczema herpeticum is now being seen with increasing frequency in adults and herpes simplex infection should be considered in the differential diagnosis of vesicular skin lesions occurring in atopic patients.

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Pooling urine samples for PCR screening of C trachomatis urogenital infection in women

Editor,—Selective or universal screening for Chlamydia trachomatis infections has been suggested by the World Health Organization as a primary prevention strategy.6

The improved sensitivity of the nucleic acid amplification assays for the detection of Chlamydia trachomatis allows the use of urine samples, suitable for screening programmes. However, these commercial assays are expensive, which make them disadvantageous for this purpose.

Therefore, some authors have recently evaluated the accuracy and cost saving of different urine pooling strategies using polymerase chain reaction (PCR) and ligase chain reaction (LCR) tests for the screening for genital C trachomatis infections, reporting very encouraging results.7,8 As the pooling strategies need individual retesting of each component of a positive pool, in order to identify the positive samples the cost saving inherent to these strategies is reflected to a pool size and pool size dependent. For this reason, pooling may be particularly suitable when applied to low prevalence populations. On the other hand, a high number of urine samples per pool may yield a decreased sensitivity because of the dilution effect associated with pooling. Peeling et al and Kacena et al have put forward a mathematical formula to estimate the number of pools that are likely to be positive given a selected pool size and population disease prevalence.9,10 Thus, it is possible to estimate the reduction on the number of tests required for a pooling strategy compared with individual testing.

The objective of this study was to develop a pooling urine samples strategy for screening urogenital chlamydial infection by PCR testing.

In all, 330 processed first catch urine samples (FCU) from women attending general practice clinics in Lisbon (from August 1999 to February 2000) were pooled by five into 66 pools. Pools and individual specimens were simultaneously tested using the Amplicor PCR test, according to the manufacturer's
Emergence of high level ciprofloxacin resistant Neisseria gonorrhoeae strain in Buenos Aires, Argentina

Editor—The surveillance programme of Neisseria gonorrhoeae (NG) antimicrobial susceptibility patterns was implemented in 1980 in the National Reference Centre for STI (NRC). Twenty-nine peripheral STI laboratories belonging to the National Network of Argentina, distributed throughout the country, routinely sent isolates to the NRC for typing, susceptibility testing, and plasmid characterisation.

The NRC was incorporated into the WHO Gonococcal Antimicrobial Susceptibility Surveillance Programme in 1989, and in 1993 an island-wide programme began. Serotypes were identified in the NRC using the polymerase chain reaction (PCR) method. Allelic sequence analysis was used to identify the porin Opa protein. The virulence plasmid was not found.

NG has become a major public health problem, particularly in young women and men who have sex with men (MSM). The incidence of NG in Argentina increased from 7.7 per 100 000 inhabitants in 1991 to 46 per 100 000 in 2003. The presence of high level quinolone resistance (QRNG) has been reported in Argentina and Latin American countries. The QRNG strain with high level quinolone resistance might have a foreign origin.

According to the literature reviewed no QRNG strain with high level quinolone resistance was reported in Latin American countries. We report here what we believe to be the first isolation of a strain with high level resistance to ciprofloxacin in Argentina.

Owing to the large scale use of quinolones in our country, where antibiotic use is difficult to control, a substantial increase of QRNG might be expected in the near future. If dissemination occurs, current first line therapy, a single 500 mg dose of ciprofloxacin, should be reviewed.*

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Dorsal perforation of prepuce due to locally eroded condylomata acuminata

Editor.—We recently reported five patients with sexually/non-sexually transmitted ulcerative diseases complicated by perforation on the dorsal surface of the prepuce.1 We found reports of only three similar cases in the indexed literature. During screening of our STD clinic files we found record of another patient with dorsal perforation of the prepuce; however, it was not due to genital ulcer disease, but to condylomata acuminata. This patient, a 22 year old man had unprotected sexual intercourse with a commercial sex worker about 6 months before reporting to our STD clinic in January 1994. About 1 month after sexual contact, he
developed small papular lesions on the glans penis. Lesions enlarged rapidly and started eroding the undersurface of the prepuce. Finally, 3 months later, the prepuce was perforated. Examination revealed a large, circular defect on the dorsal aspect of the prepuce through which multiple papulonodular, warty lesions were visible (fig 1). Warty lesions were also visible all around the prepuce opening. On retraction of the prepuce (which was difficult), the whole glans penis, corona, frenulum and undersurface of the prepuce were studed with multiple warts varying in size from 2 mm to 1.5 cm. The surface of the lesions was verrucous. Histopathological examination of one of the warty lesions showed features consistent with condyloma acuminatum. Serology for HIV and syphilis was negative.

In our earlier report all patients with dorsal preputial perforation had ulcerative diseases involving genitalia. Maite and Hay\(^1\) earlier reported a patient with genital warts treated with topical podophyllin, who presented later with perforation of the dorsal surface of prepuce. They considered it as delayed podophyllin damage. Our patient had not been treated before with podophyllin. The identical presentation in our and the reported patient suggests that warts themselves and not podophyllin are responsible for perforation. Condylomas particularly in immunocompromised individuals may attain a very large size and rarely become locally invasive and destructive.\(^1\) In our patient, however, condylomas were not very large and there was no evidence of immunosuppression.

Our patient had condylomas all over the glans, but perforation took place only on the dorsum of the prepuce, confirming that this site is more susceptible to this complication.

Incidentally, two more patients with perforation on the dorsal surface of the prepuce as a complication of chancre and genital herpes have been depicted in a colour atlas of AIDS in the tropics.\(^1\) Both patients were HIV seropositive. This suggests that this complication is not uncommon (though underreported), more so in tropics. HIV infection by altering the course and severity of genital lesions of sexually transmitted diseases probably makes this complication more frequent. Out of the 10 patients reported/published, half were HIV seropositive.

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**Table 1 Comparison of culture for T. vaginalis from centrifuged urine and self-collected vaginal swab in 675 women**

<table>
<thead>
<tr>
<th>T. vaginalis urine culture</th>
<th>Negative</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>T. vaginalis self administered vaginal swab</td>
<td>592</td>
<td>23</td>
</tr>
<tr>
<td>Positive</td>
<td>100</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>692</td>
<td>257</td>
</tr>
</tbody>
</table>

**Kappa** = 0.256

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EIDON.—Trichomonas vaginalis infection occurs worldwide with an incidence of over 200 million infections per year.\(^1\) Clinical disease in women ranges from asymptomatic to severe vaginitis, and has been associated with preterm delivery\(^2\) and an increased rate of HIV-1 transmission.\(^3\)

The magnitude of T. vaginalis associated morbidity, including risk of HIV-1 transmission, makes simple accurate diagnosis important especially in at-risk populations. Microscopic examination of a wet mount vaginal specimen is easy to perform but only identifies 40–60% of infections in comparison to culture. The In-pouch culture system (Biomed Inc, San Jose, CA, USA) is reported to be equally sensitive yet more practical than traditional culture methods.\(^4\) We found that cultured specimens from vaginal urethra of female patients for T. vaginalis might prove useful in population based screening programmes, field investigations, or individual circumstances when a patient might not want a genital examination. Therefore, we set out to determine the sensitivity of culturing urine from women in comparison with a self collected vaginal swab for identification of T. vaginalis.

We recruited subjects from a randomised community study that investigated the prevalence of sexually transmitted infections in women with and without access to female condoms.\(^5\) In this particular substudy we obtained specimens from participants in two study sites. Participants were instructed by one of the study nurses how to obtain a self collected vaginal swab and at the same time collect urine. Women were also instructed not to clean the genital area before providing both specimens. Immediately after collection the vaginal swab was inoculated into the In-pouch and urine was stored at −20°C for 10 minutes. After the supernatant was discarded, the sediment was agitated and pipetted directly into the In-pouch. Specimens were shipped at room temperature to the University of Nairobi and incubated at 37°C for up to 5 days according to manufacturer’s instructions. Daily microscopic examination was performed for identification of T. vaginalis. Random specimen coding ensured that laboratory staff remained blind to specimen source and pairing.

We recruited 675 women for this substudy. T. vaginalis was detected by culture in 121 (17.9%) women per self collected swab and 23 (3.4%) women per centrifuged urine. In comparison with culture of self collected swab, culture of centrifuged urine yielded a sensitivity of only 17% and a specificity of 99.6% (table 1). We originally intended to recruit over 2000 women into the study, but discontinued recruitment when preliminary results clearly demonstrated the inadequacy of urine for culturing T. vaginalis in women.

In this large scale community study we found culture of centrifuged urine very insensitive for identification of trichomons in women. Since only 5–10 organisms in a sample are necessary for a positive culture,\(^6\) these findings were expected. We cannot fully explain why culture of urine for T. vaginalis in women proved so poor. Because of contamination of the external genitalia with vaginal fluid, a first void urine specimen might have proved a better sample.

Supported by the United States Agency for International Development, Family Health International and a grant from the National Institutes of Health (AI11448). Biomed Inc donated the In-pouch for this investigation.

Contributors: OAM helped design and oversee the study, assisted with analysis of the data, and drafted the manuscript; CRC designed the study protocol, analysed the data, and supervised preparation of the manuscript; DR assisted with the design and supervision of the study, and assisted with manuscript preparation; JO performed the culture of urine from female patients for T. vaginalis and assisted with manuscript preparation; MK assisted with the design and supervision of the study, and assisted with manuscript preparation; JO performed the culture of urine from female patients for T. vaginalis and assisted with manuscript preparation; JJB oversaw the laboratory aspects of the study, was co-principal investigator of the parent study, and assisted with manuscript preparation; MW was a co-investigator of the parent study, and assisted in manuscript preparation; PJF was the principal investigator of the parent study and assisted with manuscript preparation.

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3 Laga MA, Manohal A, Kivuru M, et al. Non- ulcerative sexually transmitted diseases as
Letters, Book reviews, CD-Rom reviews, Notices

BOOK REVIEWS


It is 6 years since the first edition of this book and the expansion in knowledge about lower genital tract precancer is reflected in the addition of an assistant and a contributing author, as well as an increase in the number of pages (from 254 in the first edition to 323 in the present one). The extra input and space has been used to maximal effect with the book losing none of its attractions of appearance, content, and even texture by its use of high quality paper.

I would have preferred chapter 5 (Cytology and screening for cervical precancer) to follow chapter 2 (HPV in the pathogenesis of lower genital tract neoplasia) and then the more practical aspects of colposcopy itself would not be introduced so early. This is a small criticism of an otherwise comprehensive and logical content.

The chapter on the management of cervical precancer is a delight to read and see, with the section devoted to HIV positive women reflecting most shades of reliable opinion in this developing field. HIV is again included in the chapter on VIN.

GU colposcopy will be particularly interested in the final chapters on infective conditions causing confusion in diagnosis of lower genital tract precancer. It is easy to quibble with some of the statements of management of the infections noted (cervical warts do not even merit a mention of treatment) but that is not the remit of the book.

The illustrations are gorgeous thorough and the line work provided to very good effect. The overabundant book critic might mention the data left on some colposcopic photographs, the venerable laser machine result from a cohort study.

Despite clearly a short production time an inevitable weakness is that new data have become available after going to press. To keep costs down there are few illustrations and a lot of text. However, tables are widely used and the text is well broken up. One third of the book is devoted to references, so all the text is strongly evidence based, and statements are not based on authors’ opinion but on published literature.

There is also an excellent introduction on the interaction between pregnancy, infection and a thorough discussion on maternal infections and their consequences.

This section ends with a review of the pitfalls and benefits of screening for antenatal infections including an excellent summary of potential biases involved in setting up and evaluating screening programmes.

The second section is a traditional whiz through the common infections in pregnancy. Highlights include Malm’s excellent chapter on herpes simplex infection, and Mandelbrot and Newell’s thorough review of vertical transmission of hepatitis viruses. I was disappointed to see no detailed discussion of HIV infection or a more detailed review of the role of perinatal infections in cerebral palsy.

Two other criticisms could be a relative lack of assessments of cost effectiveness of screening programmes already in place and for the future. The introduction of new screening programmes and the retention of existing screening programmes—for example, syphilis and rubella, need to be increasingly driven by cost-benefit analysis. It would also be interesting to have had some speculation about why different infections have such different vertical transmission rates and have their impact at different stages of pregnancy. Overall, the strength of this book lies in its literature reviews. It is an extremely good summary of where we are at with perinatal infections in the year 2000. Who will find it useful? It is a postgraduate text, too detailed for undergraduates. It should be compulsory reading for obstetricians in training. I would recommend it to perinatologists, obstetricians and genetic counselling units.

It is a practical text with dosages, immunisation schedules, and treatment algorithms. It is reasonably priced. There are larger textbooks on perinatal infections costing £200, so this fills a gap in the market. Buy it and you won’t be disappointed.

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Considering we inquire about or promote the use of condoms with each and every patient we see in GU/HIV clinics, it’s extraordinarily how little we know about them. “Penis protectors” have come a long way since they were used in battle, cast size, and made from goat bladder, although “natural” condoms can still be obtained today from the caeca of New Zealand lambs. Thanks to Charles Goodyear, the birth control movement, and the HIV epidemic the condom has enjoyed a renaissance and with more strin-
The condom should probably receive more credit as a contraceptive device. Failure rates diminish with increasing experience and it may be a sound long term option for some women when combined with knowledge of fertile days and progesterone only emergency contraception. There were interesting discussions on the use of condoms for anal sex, the pros and cons of non-latex condoms, female condoms (becoming increasingly popular, especially in Zimbabwe), and recent developments in spermicides and viricides.

In summary, condoms are highly effective, cheap, and largely free of side effects. This book left me with a renewed belief that they should be promoted at every opportunity and should continue unabated. I would highly recommend this book to anyone working in the field of sexual health.

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CD-ROM REVIEW

Topics in International Health: HIV/AIDS. £30 for individuals, £20 or £45 for institutions in developing countries, and £120 for “first world” institutions, post inclusive with a 30 day money back guarantee. CD-Roms are not Apple Mac compatible. Oxon: CABI Publishing, 2000.

So the clinic’s not going well—you’ve too many patients and four students have all rolled up at once. Trouble is, they are all2000

ABSTRACTS

NOTICES

International Herpes Alliance and International Herpes Management Forum
The International Herpes Alliance has introduced a website (www.herasalliance.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@asp.sisp.harvard.edu).

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: +44 (0) 20 7383 6869; email: quality@bma.org.uk; website: www.quality.bmj.com).

Joachim Kuhlmann AIDS award 2001
The Joachim Kuhlmann AIDS Foundation, Essen, Germany, is awarding the above mentioned prize to investigators in the field of clinical and scientific HIV work. The prize is valued at 50 000 DM. Papers that have been published in 2000 or are accepted for publication can be submitted to the foundation for anonymous review. The submitted papers must be received by 31 March 2001. The award will be presented to the winner as part of the 8th German AIDS Congress in Berlin.

Submissions should contain seven copies of the paper and should be send to: Joachim Kuhlmann AIDS Foundation, Biimarckstrasse 55, 45128 Essen, Germany.

Each of the submitted papers should contain a running title and may not indicate the names of the authors. The abstract should contain the running title on the outside and information in the inside as follows: first name, last name, date of birth, address, professional position, as well as the running title and the complete title of the submitted paper.

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

International Congress of Sexually Transmitted Infections, 24–27 June 2001, Berlin, Germany
Further details: Congress Partner GmbH, Krausenstrasse 63, D-10117, Berlin, Germany (tel: +49-30-204 500 41; fax: +49-30-204 500 42; email: berlin@cpbd.de).

10th International Congress on Behcet’s Disease will be held in Berlin 27–29 June 2002
Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de).

20th World Congress of Dermatology, Paris, 1–5 July 2002
Further details: P Fournier, Colloquium, 12 rue de la Croix St Faubin, 75011 Paris, France (tel: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fournier@colloquium.fr; website: www.derm-wcd-2002.com).

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Letters, Book reviews, CD-Rom reviews, Notices

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