LETTERS TO THE EDITOR

Labial adhesions following severe primary genital herpes

Editor,—Labial adhesions following genital herpes infection have been described previously. To prevent their development various suggestions such as the use of early aciclovir, paraffin gauze, and saline bathing 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 25 year old woman was admitted to the medical ward with severe vulval ulceration, generalised skin rash, and difficulty in micturation of 4 days’ duration. Clinical examination revealed target lesions, swollen labia, bilaterally enlarged tender inguinal lymphadenopathy with extensive vulval ulcerations. A clinical diagnosis of erythema multiforme secondary to herpes simplex virus (HSV) was made. However, swabs taken at admission for HSV culture were negative. The patient was commenced on oral aciclovir and metronidazole, and commenced on topical lignocaine gel, subcutaneous morphine, intravenous metronidazole, and cefuroxime, and inulin 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 a 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 present 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 crinkles. Funduscopy 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 anticytoccocal 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.
CASE REPORT
A 19 year old man presented with 2 day history of extensive painful purulat...
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 all isolates to the NRC for typing, susceptibility testing, and plasmid characterisation.

The NRC was incorporated into the WHO Gonococcal Antimicrobial Susceptibility Profiling (GASP) Project in 1993 and since then the methodology has been standardised.

From January 1993 to June 2000, the NRC determined the MICs of 1194 NG strains by the agar dilution method using pooling and individual testing (166 and 346, respectively) the cost saving was 52% compared with the 56% obtained using the mathematical formula. The main reason for this minor difference is that the formula does not take into account the inhibited and equivocal results requiring further sample testing.

Despite the low number of studies concerning urine pooling strategies, the results obtained so far suggest that pooling FCU specimens can be useful for epidemiological studies and for screening programmes.

This study was supported by the “Comissão de Fomento da Investigação em Cuidados de Saúde do Ministério da Saúde, Project 20/98” and by the “Instituto Nacional de Saúde”.

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Table 1 Distribution of positive samples

<table>
<thead>
<tr>
<th>+/− Pools</th>
<th>Equivocal pools</th>
<th>−/− Pools</th>
</tr>
</thead>
<tbody>
<tr>
<td>(12)</td>
<td>(4)</td>
<td>(50)</td>
</tr>
<tr>
<td>+/− Samples</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>−/− Samples</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

*Confirmed as positive pools.

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One NG strain, detected in 1996, showed a decrease susceptibility to ciprofloxacin. The isolate was submitted by a public hospital from Buenos Aires city.

The strain was β lactamase negative by nitrocefin discs and the MICs were penicillin 0.5 µg/ml, tetracycline 4 µg/ml, ciprofloxacin 0.125 µg/ml, spectinomycin 32 µg/ml, ceftriaxone 0.004 µg/ml, and azithromycin 0.25 µg/ml. The auxotype/serogroup class was proline requiring/WII-class.

In May 2000 the first NG strain with high level quinolone resistance (QRNG) was isolated. This strain was isolated in a private medical centre in Buenos Aires city and was submitted to the NRC; no inhibition zone was observed with a 5 µg ciprofloxacin disc.

CASE REPORT

The patient was a heterosexual man, aged 34 years, married, not a drug user, and he hadn’t travelled abroad during the past year. He had a 4 weeks course of doxycycline. The patient became asymptomatic 36 hours after the start of the treatment. Serological tests for VDRL, HIV, and hepatitis B and C were negative.

The strain was β lactamase negative and exhibited high level ciprofloxacin resistance (MIC 16 µg/ml) and low level tetracycline resistance (MIC 4 µg/ml) and was susceptible to the other antibiotics assayed. The MICs were penicillin 1 µg/ml, spectinomycin 32 µg/ml, ceftriaxone 0.004 µg/ml, and azithromycin 0.25 µg/ml. Phenotypic demonstrated a proline requiring auxotype and a WII/III serotype.

Both NG strains mentioned above displayed the same phenotypic characteristics: MICs (except for ciprofloxacin), auxotype, and serogroup.

Pulse field gel electrophoresis (PFGE) was performed with *NheI* and *SpeI*. There was no relation between the PFGE patterns of the two strains and neither showed genomic similarities to four other ciprofloxacin susceptible isolates belonging to the auxotype/serogroup class Pro/WII-III isolated in Buenos Aires at the same time.

The epidemiological data and laboratory characterization of this high level quinolone resistant strain suggest it 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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1 National Committee for Clinical Laboratory Standards 2000; Methods for dilution antimicrobial susceptibility tests for bacteria that grow aerobically. Approved standard. 5th ed. NCCLS document M7-A5;20(2).


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**Dorsal perforation of prepuce due to locally erosive 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. 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

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>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>T vaginalis self administered swab</td>
<td>552</td>
<td>2</td>
<td>554</td>
</tr>
<tr>
<td>Positive</td>
<td>100</td>
<td>21</td>
<td>121</td>
</tr>
<tr>
<td>Total</td>
<td>652</td>
<td>23</td>
<td>675</td>
</tr>
</tbody>
</table>

Kappa = 0.256.

insensitive for identification of trichomonads in women. Since only 5–10 organisms in a sample are necessary for a positive culture, 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.

Figure 1 Dorsal perforation of the prepuce through which multiple papulonodular, warty lesions are visible.

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, circu-
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 prepul
t opening. On retraction of the prepuce (which was difficult), the whole glans penis, corona, and frenulum and undersurface of the prepuce were studied with multiple warts varying in size from 2 mm to 1.5 cm. The surface of the lesions was verrucous. His-
topathological 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
er earlier reported a patient with genital warts treated with topical podophyllin, who presented later with perforation of the dorsal surface of pre-
pucce. They considered it as delayed podophyl

lin damage. Our patient had not been treated before with podophyllin. The identi-
cal presentation in our and the reported patient suggests that warts themselves and not podophyllin are responsible for perfora-
tion. Condylomas particularly in immuno-
compromised 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 chancreoid and genital her-

pes have been depicted in A colour atlas of AIDS in the tropics.1 Both patients were HIV seropositive. This suggests that this complica-
tion is not uncommon (though underre-
ported), more so in tropics. HIV infection by altering the course and severity of genital lesions of sexually transmitted diseases prob-
ably makes this complication more frequent. Out of the 10 patients reported/published, half were HIV seropositive.

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1 Gupta S, Kumar B. Dorsal perforation of prepuce: a common end point of severe ulcer-

EDITOR.—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 delivery2 and an increased rate of HIV-1 transmission.3

The vaginitis of T vaginalis associated morbidity, including risk of HIV-1 transmis-
sion, makes simple accurate diagnosis impor-
tant especially in at-risk populations. Micro-
scopic examination of a wet mount vaginal specimen is easy to perform but only identifies 40–60% of infections in compar-
sion to culture. The In-pouch culture system (Biomed Inc, San Jose, CA, USA) is reported to be equally sensitive yet more practical than traditional culturing methods. If proved sensi-
tive, culturing of urine from female patients for T vaginalis might prove useful in popula-
tion based screening programmes, field inves-
tigations, or individual circumstances when a patient might not want a genital examination. Therefore, we set out to determine the sensi-
tivity of culturing urine from women in com-
parison with a self collected vaginal swab for identification of T vaginalis.

We recruited subjects from a randomised community study that investigated the preva-

cence of sexually transmitted infections in women with and without access to female condoms.4 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, which was not to be used to clean the genital area before providing both speci-

mens. Immediately after collection the vagi-

nal swab was inoculated into the In-pouch and urine was spun at 2000 g 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 instruc-
tions. Daily microscopic examination was performed for identification of T vaginalis. Random specimen coding ensured that labo-

ratory 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
Guidelines for serological testing for syphilis

**EDITOR**—In our area the high HIV prevalence has made the interpretation of syphilis tests particularly problematic. Coinfected patients do appear to reactivate their treponemal infection or possibly reinfection with a non-treponemal test. It is perhaps unfortunate that reference laboratories may have developed their algorithms in the face of conventional syphilis diagnosis—these do little to help with HIV coinfected patients.

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Sexually transmitted infections and risk behaviours in women who have sex with women

**EDITOR**—While it is comforting that some research is finally being carried out in depth on the risk of STIs among women who have sex with women (WSW), any conclusions about the dangers of inappropriate statements about STIs among women who have sex with women generally are not merited. The researchers themselves say their “clinical population . . . may not be representative of the WSW in the general community.” This is an understatement—and any reporting of this study must make very clear statements about the dangers of inappropriate conclusions about STIs among women who have sex with women generally.

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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 interrupted. 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 credible 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 drawings are used to very good effect. The overassiduous book critic might quibble with some the statements of management (e.g., only to be increased 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 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 gynaecologists working in non-specialist hospitals. 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 extraordinary how little we know about them. “Penis protectors” have come a long way since they were used in battle, cast to 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-
gent quality control and legal standards, has become a life saving device. The chapter on latex condom manufacture was fascinating and gives almost enough detail to allow you to try it at home!

Each year 8–10 billion condoms are used worldwide although an estimated 15 billion are required to protect adequately against HIV/STDs. The chapter outlining the effectiveness of condoms in preventing STIs was clearly set out with an excellent summary table outlining data and references. There was a fascinating chapter on how the commercial sector has risen to the challenge of global condom distribution through social marketing. By using pre-existing infrastructure, supplies to Africa have increased from 45.8 million in 1987 to 264.5 million in 1990. In Thailand by targeting commercial sex workers through “the 100% condom programme” usage rates have increased from 14% in 1982–9 to 93% in 1993 with STI cases in government clinics dropping from 237 000 to 39 000. In the chapter on condoms and commercial sex there was a fabulously table summarising different condom usage rates by CSWs in developing countries. 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 efforts to make them universally available should be promoted at every opportunity and every chance. I would highly recommend this book to anyone working in the field of sexual health.

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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.hcmf.org) has launched new guidelines on the management of herpesvirus infections in pregnancy. 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@spsp.sheridan.com).

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 7383 6856; 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 sent to: Joachim Kuhlmann AIDS Foundation, Bismarckstrasse 55, 45128 Essen, Germany.

Each of the submitted papers should contain a running title and may not indicate the names of the authors. An additional envelope containing 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, NBISC, 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@cpb.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).