Labial adhesions following severe primary genital herpes

EDITOR,—Labial adhesions following genital herpes infection have been described previously.1 2 To prevent their development various suggestions such as the use of early aciclovir,3 paraffin gauze,4 and saline bathing5 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 advised to use topical lignocaine gel; she admitted, however, to being afraid to touch her genitalia. The patient made a slow recovery and was allowed home after 8 days in hospital. At follow up (GUM) 2 weeks later, she presented with a history of her abnormal urinary stream “urine splashing all over the place.” Examination of the external genitalia revealed two bands of adhesions between the labia minora. The bands were separated using a knife after infiltration with lignocaine 2% and gauze dressing dispensed. Surprisingly, separation of the bands was not needed. The patient made a slow gradual recovery and 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 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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LETTERS TO THE EDITOR

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, Pao2 9.4 kPa, Paco2 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 Mucor species contamination of the skin. In view of the patient’s clinical findings, additional therapy was commenced with anticytomegalovirus (CMV) and anticytomegalovirus 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.

Figure 1 Cryptococcal skin lesions associated with disseminated disease.
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 lesions that were too extensive for simple laboratory failure.

A recent report has highlighted diagnostic delay as a major factor contributing to its high associated mortality. The CRAO test provides a rapid and sensitive method for confirming the diagnosis of cryptococcosis.1 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. Our patient was unwell and had skin lesions that were too extensive for simple Molluscum contagiosum, and should be considered in the differential diagnosis of vesicular skin lesions occurring in patients with pre-existing active disease.1

The presentation in our patient is fairly typical, lesions appearing in crops initially as tiny vesicles passing through pustular and typical, lesions appearing in crops initially as tiny vesicles passing through pustular eruptions on the hands, wrists, forearms, and chest. 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 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 condition may arise from minor transient disease to a fulminating fatal disorder involving the visceral organs.1,3 The severity appears to be unrelated to the extent of eczematous 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.2 Eczema herpeticum has also been associated with seborrhoeic dermatitis, neurodermatitis, Darier’s disease, pemphigus, mycosis fungoides, Wiskott–Aldrich disease, congenital ichthyosiform erythroderma,2,4 and second degree burns.5

The presentation in our patient is fairly typical, lesions appearing in crops initially as tiny vesicles passing through pustular 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.5


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 pustular 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 flucloxacillin. On direct questioning he admitted that his illness started with painful penile ulcers followed 2 days later by more localised crops of blisters, which then became infected. Ten days before this he had unprotected sexual intercourse with a casual 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 pustular eruptions on the hands, wrists, 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 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).

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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.2 Eczema herpeticum has also been associated with seborrhoeic dermatitis, neurodermatitis, Darier’s disease, pemphigus, mycosis fungoides, Wiskott–Aldrich disease, congenital ichthyosiform erythroderma,2,4 and second degree burns.5

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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.5


Accepted for publication 14 November 2000

Poolling 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.1

The improved sensitivity of the nucleic acid amplification assays for the detection of C 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.2,3 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 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.1,4 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 evaluate 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 Profiling (WASP) project in 1998 and in 1999 the Caribbean had been enrolled within the programme. For epidemiological studies and for screening programmes, the WASP project had started contributing to antimicrobial susceptibility patterns for NG isolates using the Amplicor PCR test (both 100%) and also solved the problem of PCR inhibitory substances in urine specimens (0% compared with 3.6% of individual testing). One FCU specimen was repeatedly inhibited and was excluded.

The choice for a 5× size pool model was based on the highest potential cost saving for the estimated prevalence of the studied population, according to Peeling et al and Kacena et al. According to the number of tests required 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 samples can be useful for epidemiological studies and for screening programmes.

<table>
<thead>
<tr>
<th><em>÷</em> Samples</th>
<th>Equivocal pools</th>
<th><em>÷</em> Pools</th>
<th>4</th>
<th>0</th>
</tr>
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<tbody>
<tr>
<td>13</td>
<td>14</td>
<td>17</td>
<td></td>
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</table>

*Confirmed as positive pools.

The results are summarised in table 1. The calculated prevalence was 5.2% (17/329). The dilution effect associated with the pooling strategy did not have any effect on either the sensitivity or specificity of the Amplicor PCR test (both 100%) and also solved the problem of PCR inhibitory substances in urine specimens (0% compared with 3.6% of individual testing). One FCU specimen was repeatedly inhibited and was excluded.

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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 preputial 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. 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\textsuperscript{2} earlier reported a patient with genital warts treated with topical podophyllin, who presented later with perforation of the dorsal surface of the 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.\textsuperscript{3} 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 chancroid and genital herpes have been depicted in A colour atlas of AIDS in the tropics.\textsuperscript{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,\textsuperscript{1,3} 6 were HIV seropositive.

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>
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</thead>
<tbody>
<tr>
<td>T vaginalis self administered vaginal 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

In this large scale community study we found culture of centrifuged urine very insensitive for identification of trichomonads in women. Since only 5–10 organisms in a sample are necessary for a positive culture, these findings were unexpected. 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 (AI111438). Biomed Inc donated the In-pouch for this investigation.

Correspondence: 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 microscopical examinations, and assisted in manuscript preparation; MK assisted with the design and supervision of the study, and assisted with manuscript preparation; JJB overview 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; PFJ was the principal investigator of the parent study and assisted with manuscript preparation.

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5. Laga MA, Manohla A, Kivurro M, et al. Non-ulcerative sexually transmitted diseases as...

It is 6 years since the first edition of this book and the expansion in knowledge about lower genital tract precancer 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 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 is used to very good effect. The overall book critic might mention the data left on some colposcopic photographs, the venerable laser machine showed on page 171 and whether the specimen is correctly placed on page 36, but not at all. This is a “must buy.” It’s a big book (in size, content, and price) which should form the nucleus of the colposcopist’s library.

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I liked this book. An alternative title could be “An evidence based review of prevention, diagnosis, and treatment of congenital and perinatal infection.” The editors, both recognised experts in perinatal infection, persuaded an international panel to provide up to date reviews of particular perinatal infections with key references up to 1999/2000. 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 an excellent introduction on the interaction between pregnancy, immunity and 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 the potential biases involved in setting up and evaluating screening programmes.

The second section is a traditional whizz through the standard common infections in pregnancy. Highlights include recent Baumann’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 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 gynecologists in training.

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 fabulous 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 sensible, 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 virucides.

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 underfunded African hospitals. That this academic, not just the treatment options open to AIDS patients, is awarding the above mentioned award 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, 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 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

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.HIMF.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@isp.sheridan.com).

INTERNATIONAL SYMPOSIUM ON DISORDERS OF THE PROSTATE, 21–23 March 2001, Castle, 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.

NOTICES