MSSVD

Report of the Honorary Secretary to the 79th annual meeting of MSSVD held at the Royal Society of Medicine, Friday 27 October 2000

My final year as Honorary Secretary to MSSVD is now drawing to a close. The final challenge I set myself is to have circulated a summary of the main activities of the society including accounts and financial report in advance of the annual general meeting. It has required the hard work of the officers of the society, the secretariat and finance department at the RSM, and Graham Tomlinson, charitable governance adviser. The annual report was printed in November and circulated to members.

There are now 657 UK members of the society, with 101 overseas members and 31 honorary life members, 21 of whom are resident in the United Kingdom. There were 62 new members last year, of which 34 were nurses and health advisers. There are a number of MSSVD members to whom we paid tribute. These included Dr Ratnatunga; Dr Seaman; Dr George Conklin; Dr Christine Bakshi; Dr T Reed; Dr Andrew Crooks.

January 21 was a particularly sad occasion for the society when Maggie Godley sadly died following her two year illness. She will be remembered for all the work she put into the society and the RSM, and Graham Tomlinson, charitable governance adviser.

The website has become an integral part of the society's position. Mr Graham Tomlinson has completed his term of office as education officer and relinquished his post in December 2000. Sarah Chippindale was co-opted from her post as academic health adviser at Mortimer Market Centre and returned to her full time post in December 2000. On behalf of MSSVD members, I would like to thank them for their commitment and for their valuable contribution to the education programme. The future of further educational initiatives and support structures required to deliver these will be a priority for this coming year.

The website has become an integral part of the society. MSSVD as a specialist society will undertake a comprehensive review of the society's position. I would like to thank Mr Graham Tomlinson for the hard work of the officers of the society, and for the secretariat and finance department of the Royal Society of Medicine. The OGM meetings are now summarised and reported on the website. This initiative will be developed in the future as information technology at the RSM changes. There may be an opportunity to provide more webcasting similar to that at the MSSVD Spring meeting in Baltimore.

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CME/CPD
A major change for doctors over the next 2 years will be the introduction of revalidation.

The Royal College of Physicians has formalised a CME/CPD community for requirements between CME regional representatives and specialist societies. CME/CPD requirements will change and some assessment measures will be introduced. All doctors will be required to undertake CME/CPD and this will have substantial effects on clinics employing NCCG colleagues. MSSVD as a specialist society will be devising appropriate CME for its members in liaison with the RCP.

Meetings
Five ordinary general meetings were held in the Barnes Hall at the Royal Society of Medicine. The topics highlighted important advances in diagnosis and management. There were no key strategic issues for the specialty raised particularly in relation to medicolegal aspects and the needs of adolescents. The “Doctors in training” presentation meeting, which gives opportunity for presenting new ideas and engendering a critical look at our education and meeting programme. The future of further educational initiatives and support structures required to deliver these will be a priority for this coming year.

Other special interest groups
The six special interest groups have submitted business plans to the treasurer for their educational activities for 1999–2000. A proposal for a further special interest group of “Adolescent sexual health” has been accepted by council and will be submitting a business plan.

Doctors in training meeting
Last year the meeting was held in the president’s home city of Sheffield. Although the standard of hotels fell short of expectations, the scientific programme was well received and the skill workshops of personal image and communication skills provided direction to the consultants of tomorrow. The local cabaret of Karen Rogstad, David Daniels, Mary Stevenson, and Stephen Green, infectious disease consultant at Sheffield, entertained us on Saturday evening.

MSSVD undergraduate prize
This was awarded as follows: clinical prize to Dr Daniel Jary, “Why do young people still catch STIs?”

Other MSSVD activities
The changes in provision of medical care driven by government have made a significant impact on the day to day activities of all healthcare workers. Key issues that have been discussed at council have included charitable
Papulonecrotic tuberculide of the glans penis

Editor,—A 27 year old promiscuous, married man presented with recurrent episodes of ulceration of the penis of 12 years’ duration. Each episode began with a painful small raised lesion which got ulcerated and finally healed spontaneously in 2–3 months. The present episode of painful ulceration had been lasting for 6 months or so. In spite of various treatments received from various private practitioners, his genital sore did not respond.

On physical examination, this moderately nourished individual had a single well defined ulcer on the glans penis near the urethral meatus, measuring 8 × 5 mm. The edge of the ulcer was undermined and its floor had necrotic slough. The ulcer had perforated deeply into the urethra, resulting in dribbling of urine through it (fig 1). Multiple puckered scars over the glans penis circumferentially, just distal to the coronal sulcus, were evidence of previous episodes of similar ulcerations. The inguinal lymph nodes were not significantly enlarged. His systemic examination was unremarkable.

Figure 1 Glans penis showing both ulcer and puckered scarring.

The haemogram revealed a raised erythrocyte sedimentation rate (64 mm in the first hour). The Mantoux test was strongly positive (20 × 20 mm). VDRL and HIV serology was non-reactive. Radiological investigations did not demonstrate any focus of tuberculosis in the chest or genitourinary system. Smear and culture of discharge from the ulcer and also of urine for acid fast bacilli were negative. Histopathological examination of the ulcer (glans penis) revealed ulcerated epidermis. In the deep dermis, by the side of the ulceration, there were caseating tuberculous granulomas along with perivascular inflammatory infiltrate with vessel wall thickening and endothelial cells swelling. Fite’s stain for acid fast bacilli was negative. These features were consistent with the diagnosis of papulonecrotic tuberculide. The patient was treated with a four drug regimen for antituberculous therapy to which he responded favourably. At the end of 2 months, the ulcer had healed completely.

Even though it is considered to be rare, tuberculids of the penis manifest as primary, secondary, or papulonecrotic tuberculide type. Clinically, it may present as superficial ulcers of the penis or tuberculous cavernosis. Papulonecrotic tuberculide, a form of cutaneous tuberculide, represents an allergic reaction to bursts of antigens reaching highly immune skin following haematogenous spread from an internal focus. The tuberculide is often not clinically active at the time of eruption as seen in our case. The diagnosis of papulonecrotic tuberculide in our case was based on the well laid down criteria.

Papulonecrotic tuberculides are mostly extragenital, but rarely genitalia may be involved. Sometimes, the glans penis alone may be involved as in our patient and then diagnosis becomes difficult. Under these circumstances, it needs to be differentiated from atypical soft sore, syphilis, recurrent herpetic simplex, and malignant ulcer. The diagnosis of such cases rests on biopsy, tuberculide testing and, in doubtful cases, a therapeutic test is usually decisive. The possibility of tuberculide as a cause of chronic ulcer on the penis has to be kept in mind especially in countries like India, where tuberculosis is still prevalent.

Table 1 Mean total and subscale scores for Attitudes to Lesbian and Gay Men (ATLQ) Questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Male (n=86)</th>
<th>Female (n=123)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATLQ mean (range)</td>
<td>69.0 (20–176)</td>
<td>56.0 (20–142)</td>
<td>0.003</td>
</tr>
<tr>
<td>ATLQ* mean (range)</td>
<td>40.9 (10–90)</td>
<td>31.8 (10–62)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ATLQ mean (range)</td>
<td>28.4 (10–90)</td>
<td>24.2 (10–80)</td>
<td>0.03</td>
</tr>
</tbody>
</table>

*ATL = Attitudes to Gay Men.
†ATL = Attitudes to Lesbians.
Questionnaires and postal research: more than just high response rates

EDITOR,—In the recent editorial by Bates and Rogstad the authors describe the problems associated with conducting postal research, including response rates, use of incentives, and ethical issues. We would like to comment on the importance of obtaining a high response rate to enhance the validity of the research findings.

The effectiveness of incentives to increase response rates remains controversial. Kalantar and Taylor recommend using a lottery incentive as it increases response rates after the first mailing. However, differences between groups were not large, and decreased during follow up and disappeared by the fourth mailing. Kosloski et al. found that the use of lottery tickets increase response rates, but may be limited when using them with long questionnaires (32 pages). Moreover, they compared the length of questionnaire (26 or 32 pages) which, while being different, did not reach statistical significance.

The most important aspect of postal research is the questionnaire itself. While high response rates are desirable, it is critical that the information provided by participants is of high quality. The quality of the data may differ between short and long questionnaires and to our knowledge this has never been validated. When participants fill out a long questionnaire they may rush or mark incorrect responses purely because they have lost interest because of the length of the questionnaire. Conversely, if a questionnaire is too short, it may be deemed “unimportant” and not worth completing.

The real question is, is there any real difference in the size of the length of the questionnaires used in this study? In comparison with a four or 10 page questionnaire they are still long. Studies are lacking which highlight the threshold or optimal length of questionnaires.

Figure 1 shows a theoretical model of how response rate may perform according to questionnaire length. Part A represents low response rates due to questionnaires of short length; part B is the optimal questionnaire length giving the best response rate; and part C shows the poor response rate due to questionnaires of excessive length.

The presentation of the questionnaires will also influence the response rates to postal surveys. Questionnaires that are professionally printed and designed are more likely to be taken seriously by participants compared with two pages stapled together.

Other reasons for an increased response rate include the importance of assuring participants of their confidentiality and this can improve even further if the steps taken to keep subject data confidential is explained. Respondents may want or expect their answers to be treated strictly in confidence, especially if the topic area is threatening or embarrassing. The researcher should not promise greater confidentiality than he/she can provide remembering that coders and data processors may have access to the information.

Ethics of repeated follow ups is of concern. Some individuals do not like receiving multiple mailouts and this can be a problem if they complain. The respondents’ privacy and dignity should be respected. A dilemma may sometimes arise when the need for the researcher to obtain the “informed” consent of respondents conflicts with the need for respondents not to know so much that the results are biased.

One thing is certain; the greater the number of follow ups completed the higher the response rate will be. There can be problems associated with undertaking multiple follow ups, particularly when individuals complain about the number of letters and/or questionnaires they receive. However, this can easily be solved by stating on the initial cover letter if they do not wish to be contacted further, to contact the researcher and tell them so they can be removed from the mailing list. By using some of these techniques researchers should be able to obtain increased response rates and higher quality questionnaire data.

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Figure 1 A theoretical model of how response rate may perform according to questionnaire length

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Genital herpes may mask underlying neoplasia

EDITOR,—Lesions that fail to heal despite appropriate therapy should always be biopsied to look for an underlying diagnosis. We have seen a 44 year old woman who presented with genital ulceration and lichen sclerosus and was culture positive for herpes simplex virus (HSV) type 1. After treatment with two courses of oral aciclovir there was some reduction in ulceration and resolution of symptoms. However, in view of the persisting solitary ulcer and the presence of lichen sclerosus (fig 1) a biopsy was performed. Histology was reported as showing poorly differentiated invasive squamous cell carcinoma with dysplasia but no features of wart virus infection. She was promptly referred to the gynaecological oncology department where local radiotherapy and chemotherapy were the initial treatments of choice as the tumour extended close to the anal margin. The immediate response was encouraging but subsequently vaginal adhesions and difficulty with micturition developed. A pelvic CT scan showed bilateral inguinal node involvement (fig 2). Radical block dissection was subsequently performed but lymphoedema and local skin nodules developed and she died 2 years after diagnosis.

Figure 1 Appearance of the vulva—ulceration remains despite therapy for HSV Note white plaques, small haemorrhages, and lichenoid reaction typical of lichen sclerosus.

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Sexually shared infections

Editor,—Those who have spent some time in genitourinary medicine will surely agree that the specialty has gone through vast changes over the years. Not only the nomenclature of our clinics from VD clinics or specialists clinics to sex clinics but also the name of our specialty itself has gone through a metamorphosis. The presence of antibodies to HSV type 2 has been implicated as a risk for cervical neoplasia is unclear. Vulval basal cell carcinoma presenting as culture negative genital herpes has been reported. In our case the carcinoma was culture positive for HSV; this may have been due to new infection or to reactivation of pre-existing HSV in the presence of malignancy. This case highlights the need for biopsy of herpetic lesions which fail to respond to standard therapy.

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Accepted for publication 12 January 2001

Sexually shared infections

Editor,—I was therefore interested to note the term “sexually shared infections” suggested by Hopwood et al and wondered what message it would project to our patients, sorry our “clients.” Hence, I decided to test this new term in my clinic and would like to share the results with the readers of STI.

Firstly, I saw a young girl who had primary presentation of genital warts. I suggested that she might have “shared” this infection with her partner to which she replied, “Look doctor, I know HE gave it to me because he is the one who was sleeping around.”

The next one was a young man who presented with acute gonorrhoea. When I said he might have shared this infection with the one night stand he had in Manchester he replied, “Look doctor, I am no fool. I was so drunk that night that I couldn’t perform but she went ahead anyway then this happened.”

The third one was a chlamydia re-infection. The young girl was found to be positive and received a single dose regimen. Her boyfriend was referred to a GUM clinic but by the time he attended they had had protected sex but the condom split and the girl was reinfected.

When I mentioned the “shared” element she fumed, “It was him who gave me this in the first place and he wouldn’t get treatment himself because he felt OK.”

English is not my first language but I always thought that you “share” something that is nice. Like sharing the tender moments, sharing your cake, British Airways share offer when it floated on stock market, etc.

Sharing an STI to me sounds a bit awkward.

In my opinion people transmit the infections knowingly or unknowingly because of their high risk sexual behaviour. It does not matter if we try to play this down and make it acceptable. There always will be some stigma attached to STIs but we should ensure awareness, patient education, and partner notification. I believe this should be done by professionals in a confidential setting in a genitourinary medicine clinic. Changing the terminology about the mode of transmission will not eliminate the stigma attached to STIs but the more open we are about infections the better it will be for our patients.

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Deterioration of disseminated cutaneous Mycobacterium avium complex infection with a leukaemoid reaction following institution of highly active antiretroviral therapy

Editor,—The impact of highly active antiretroviral therapy (HAART) on the incidence of opportunistic infections (OI) in HIV infected patients has been well documented. HAART also frequently alters the clinical course of OI. Increasingly, immune reconstitution disease is recognised after starting HAART in patients with latent or established OI. Despite the marked reduction in incidence of disease due to Mycobacterium avium complex (MAC) in the HIV infected population over the past 5 years, this OI is often implicated in immune reconstitution disease and may be difficult to treat. Focal mycobacterial lymphadenitis appears to be the commonest manifestation, but other organs may be involved.

A 40 year old white HIV positive man presented with Staphylococcus aureus tricuspid valve endocarditis; blood cultures also grew MAC. He had a history of cutaneous Kaposi’s sarcoma and oesophageal candidiasis. After inpatient treatment of the endocarditis he defaulted from outpatient follow up. Five months later he re-presented with a 3 month history of fever, cough, malaise, and painless skin lesions on both arms and legs. Examination showed multiple dermal papules and nodules. A skin biopsy has been performed on the right shin. (B) Five days after re-presentation. Medial aspect of left ankle. There are two erythematous lesions, which were tender to touch. Both have a pustular centre.
Inappropriate or inadequate treatment, low rates of partner notification, and lack of referral to genitourinary medicine (GUM) clinic described were similar to the observations made in two recent studies. An investigation in Merseyside family planning clinics (FPC) showed that of 80 infected patients identified (n = 958) only 34% were treated within 1 month of diagnosis, 24% had no proof of treatment, and 13% never found out they were infected. Similarly, a study of 112 women diagnosed with Chlamydia trachomatis attending FPCs showed that only 48% were known to have been treated 3 months after the test had been carried out. If diagnosis does not result in immediate treatment, patients can be lost to follow up. In turn, this result in poor rates of partner notification, an increased likelihood of further transmission, a reduction in the impact of testing on disease incidence, and an increased risk of complications. In GUM clinics, diagnosis generally results in treatment and consequently surveillance data derived from this setting, the KC60 dataset, can be used as a measure of treatment success. In contrast, the above studies suggest that a proportion of diagnoses made in primary care may not be treated. This questions the validity of using diagnosed infection as an outcome measure for evaluating sexual health interventions in primary care. It also emphasises the significant role of clinical audit in the improvement of the quality of patient management.

Ultimately the effectiveness of intervention should be measured in terms of a reduced prevalence of pelvic inflammatory disease and associated sequelae. However, other more pragmatic outcome measures may need to be used. The UK NHS G trachomatis screening pilot is evaluating the feasibility and acceptability of opportunistic screening in primary and secondary healthcare settings in two health authorities. Three of the primary outcome measures that are being evaluated are the number of positive diagnoses, the proportion of the positive diagnoses treated, and the rate of patient or provider led partner notification. In the pilot, patient management has been improved by recalling positive patients by the community office staffed by GUM health advisers. Preliminary data indicate that out of 900 positive patients identified through the Wirral arm of the pilot, treatment was achieved in 40 (4.4%) patients. Separate studies in Liverpool are also evaluating how patient management could be enhanced by GUM health advisers working in outreach sessions in a community FPC (AMCW) and a department of obstetrics and gynaecology (submitted to British Journal of Family Planning). Results from these studies will provide further evidence to guide the development of patient management and the outcome measures that could be used to assess future intervention strategies.

Detection or treatment: which outcome measure?

Editor,—The report by Rogstad et al is a timely description of the problems associated with the management of patients diagnosed with genital chlamydial infection within and between established healthcare settings. The ineffectiveness or inadequate treatment, low rates of partner notification, and lack of referral to genitourinary medicine (GUM) clinic described were similar to the observations made in two recent studies. An investigation in Merseyside family planning clinics (FPC) showed that of 80 infected patients identified (n = 958) only 34% were treated within 1 month of diagnosis, 24% had no proof of treatment, and 13% never found out they were infected. Similarly, a study of 112 women diagnosed with Chlamydia trachomatis attending FPCs showed that only 48% were known to have been treated 3 months after the test had been carried out. If diagnosis does not result in immediate treatment, patients can be lost to follow up. In turn, this result in poor rates of partner notification, an increased likelihood of further transmission, a reduction in the impact of testing on disease incidence, and an increased risk of complications. In GUM clinics, diagnosis generally results in treatment and consequently surveillance data derived from this setting, the KC60 dataset, can be used as a measure of treatment success. In contrast, the above studies suggest that a proportion of diagnoses made in primary care may not be treated. This questions the validity of using diagnosed infection as an outcome measure for evaluating sexual health interventions in primary care. It also emphasises the significant role of clinical audit in the improvement of the quality of patient management.

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The findings confirm those of Freud, Kinsey et al as well as Masters and Johnson and make it clear that men not only need to take the clitoris seriously but to ensure that its function is more regularly fulfilled whatever the form of sexual congress.

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International Herpes Alliance and International Herpes Management Forum
The International Herpes Alliance has introduced a website (www.herpessalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

1st Asia Pacific Forum on Quality Improvement in Health Care
The 1st Asia Pacific Forum on Quality Improvement in Health Care will be held from 19–21 September 2001 in Sydney, Australia. Presented by the BMJ Publishing Group (London, UK) and Institute for Healthcare Improvement (Boston, USA), with the support of the Commonwealth Department of Health and Aged Care (Australia), Safety and...
Quality Council (Australia), NSW Health (Australia) and Ministry of Health (New Zealand). Further details: quality@bma.org.uk; fax +44 (0) 7383 6869.

41st St Andrew’s Day Festival Symposium on Therapeutics
The 41st St Andrew’s Day Festival Symposium on Therapeutics will be held on 6–7 December 2001 at the Royal College of Physicians of Edinburgh. Further details: Ms Eileen Strawn, Symposium Co-ordinator (tel: 0131 225 7324; fax: 0131 220 4393; email: e.strawn@rcpe.ac.uk; website: www.rcpe.ac.uk).

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

5th World Congress of Perinatal Medicine, 23–27 September 2001, Palau de Congressos de Barcelona - Avda Maria Cristina s/n, Barcelona, Spain
Further details: Dr Francesc Figueras, Congress Promotion Secretary (fax: +34.93.451.74 38; www.perinatology2001.com).

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Second International Conference on Sexual Health, to be held in Bangkok, Thailand on 23–28 February 2002. Calls for abstracts deadline 1 September 2001
Further details: European Secretariat, Dr Richard Burack (tel: +44 (0) 20 8599 8029; email: siamcare@aol.com).

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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