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 Ratnataunge; Dr Seaman; Dr George Csonka; 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 running both MSSVD and AGUM and for her care and support as a fellow human being. Her husband has agreed to a memorial, which will be in the form of a prize given to the best presentation from a district general hospital consultant at MSSVD Spring meetings.

The past year has seen an even more rapid pace of change resulting in the Honorary Secretary having difficulty keeping her head above water. Some major issues for the society have been identified.

The first of these is a review and implementation of the changes to the charitable governance of MSSVD. As incoming treasurer, Simon Barton investigated the duties and role of the Honorary Treasurer and after discussion with the officers, it was agreed that expert assistance would be required to undertake a comprehensive review of the society’s position. Mr Graham Tomlinson was appointed as an external consultant to support the officers, resulting in the clarification of the roles and responsibilities of the officers, council, and trustees of the charity. Clearer mechanisms for decision making, strategy, and development of business plans are in place for the future. The charitable governance will continue until December 2001 with his support. The Honorary Secretary and treasurer together with Mr Tomlinson have been developing an appropriate contract with the RSM to provide infrastructure and support services for the running of the society and refinement of the membership database. The contract will include a specification for secretarial and financial services, lines of accountability, an arrangement with the society for housing and lending of the MSSVD library books, and support for educational activities.

Educational initiatives

The Education Sub-Committee met on five occasions. Following discussion at the Education Sub-Committee, it was agreed that in 2000–1, one of the ordinary general meetings’ format would be altered to take into account adult learning theory; the meeting will be in March 2001 and run by the HPV Special Interest Group. The “Induction teaching steering group” has achieved its objective of producing an educational package suitable for non-consultant career grade doctors starting in the specialty and this will be launched at the start of this academic year. A skills course “Teaching the teachers” has been developed by the education officer Dr Jonathan Cartledge and education coordinator Sarah Chippindale, which will take place in November. Dr Jonathan Cartledge has completed his term of office as education officer and relinquished his post in December 2000. Sarah Chippindale was coopted 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 challenging the education subcommittee with 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.

The website has become an integral part of delivery of education to members of MSSVD. 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.

CME/CPD

A major change for doctors over the next 2 years will be the introduction of revalidation. The royal colleges have been working together with the GMC to coordinate the requirements for revalidation. The Royal College of Physicians has formalised a CME/CPD communiqué for communications between the 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 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 practising presentation skills, showed that our trainees continued to perform to a high standard. The prize was awarded to Dr Nelson David, for his presentation on “Zoon’s limits.”

MSSVD was host society for the Federation of Infection society meeting held in Manchester on 1–3 December 1999. This is the first time that the meeting has coincided with the Winter All and the meeting was very successful with the highest number of registrants recorded. Consequently, the VAT bill is larger than usual and the term “success” was confined to educational and social rather than financial! The debate trio of Drs Simon Barton, Colm O’Mahony, and Do- lores Hooker provided eye opening entertain- ment for our more reserved colleagues in other infection disciplines.

MSSVD continues to provide meetings in conjunction with other societies. These have included the SSSTDA/JUSTI meeting held in Soho, City, South Africa, and the joint BHIVA/MSSVD held on 8 October 1999. The MSSVD/ASTDA inaugural meeting was a resounding success. The society has been asked by the Section of Dermatology at the RSM to develop a joint meeting, which will take place on 8 June 2001.

NCCG meeting

The MSSVD NCCG meeting organised by Dr Jonathan Ross took place in September and was well received.

MSSVD National Continuing Professional Development course in GU Medicine/HIV/AIDS

This year the MSSVD took over the running of this course, previously known as BPMF, latterly the CPD course run by University College, London. The steering group is chaired by Dr Jackie Sherrard. This is a new and challenging venture for the society. The aim will be to offer a reduced price for MSSVD members on courses arranged by MSSVD. There has also been discussion about the need for a more basic course directed at primary care physicians, healthcare workers working in contraceptive services, and others providing sexual health services to complement the DFFP run by the Faculty of Family Planning and Reproductive Health Care (FFPRHC). Over the next year a core curriculum will be developed and the course piloted. The intention is to deliver this on a regional basis.

Special interest groups

The six special interest groups have submitted business plans to the treasurer for their educational activities for 2000–1. 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 Drs Carol Daniels, Mary Stevenson, and Stephen Green, infectious disease consultant at Sheffield, entertained us on Saturday evening. Pilsner kindly sponsored the event.

MSSVD undergraduate prize

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

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 lasted 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 × 9 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.

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 tuberculomas 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, tuberculosis of the penis can manifest as primary, secondary, or papulonecrotic tuberculide type.1 Clinically, it may present as superficial ulcers of the penis or tuberculous cavernositis.2 Papulonecrotic tuberculide, a form of cutaneous tuberculosis, represents an allergic reaction to bursts of antigens reaching highly immune skin following haematogenous spread from an internal focus. The tuberculous focus is often not clinically active in our case. The diagnosis of papulonecrotic tuberculide in our case was based on the well laid down criteria.3

Papulonecrotic tuberculides are mostly extragenital, but rarely genitalia may be involved.4 Sometimes, the glans penis alone may be involved.5 The diagnosis of such cases rests on biopsy, tuberculin test and, in doubtful cases, a therapeutic test is usually decisive.6 The possibility of tuberculosis 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>ATLG mean (range)</th>
<th>Female (n=123)</th>
<th>p Value</th>
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<tr>
<td>65.0 (20–142)</td>
<td>0.003</td>
<td></td>
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<tr>
<td>10.0 (9–10)</td>
<td>&lt;0.001</td>
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<tr>
<td>24.2 (10–80)</td>
<td>0.23</td>
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*ATG = Attitudes to Gay Men.
†ATL = Attitudes to Lesbians.
results are presented in table 1. The majority of the sample displayed positive attitudes to lesbians and homosexual men with female students exhibiting statistically more positive views especially in relation to homosexual men. However, a significant minority of men (11.8%) exhibited extremely negative attitudes to homosexual men.

We are encouraged by these results which are contrary to much of the published data on attitudes among physicians, nurses, and medical and non-medical students. However, we must continue to challenge negative attitudes as studies show that teaching and promoting tolerance can result in change. Occasionally difficulties with disclosure in medical settings will continue to impact on provision of health care to WSW and homosexual men and further hamper research in this area.

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, bias, mailing clinical specimens, and ethical issues. We would like to add that there are problems associated with conducting postal research.

Incentives to increase response rates

The effectiveness of incentives to increase response rates remains controversial. Kalantar and Talley 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. Koosloki 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 (20 vs 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 to the questionnaires will also influence the response rate 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 confidentially and this can improved 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 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 maintain increased response rates and higher quality questionnaire data.

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 vulval dystrophy 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.
Editor,—Those who have spent some time in genitourinary medicine will surely agree that the specialty has gone through vast changes but also the name of our specialty itself. The current terminology, with its emphasis on psychosexual health, has gone through a metamorphosis. Many gynaecologists will surely agree that the specialty has gone through vast changes. 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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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 UD clinics or specialist clinics to psychosexual health departments but also the name of our specialty itself has gone through a metamorphosis. 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.

Figure 2 Pelvic CT scan showing bilateral inguinal lymphadenopathy.

Vulval cancer accounts for 3–5% of female genital tract malignancies. Risk factors include lichen sclerosus, vulval intraepithelial neoplasia, and infection with oncogenic human papillomavirus (HPV) types. STDs other than HPV are also associated with an increase in the risk of developing vulval neoplasia. The presence of antibodies to HSV type 2 has been implicated as a risk for cervical pathology but a role for HSV in vulval neoplasia is unclear. Vulval basal cell carcinoma presenting as culture negative genital warts 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 herpetiform lesions which fail to respond to standard therapy.

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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 could not 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 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

Enron,—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.1–3 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.1,3 Focal mycobacterial lymphadenitis appears to be the commonest manifestation,1,3 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 seem tender to touch. Both have a pustular centre.

1 Hopwood J, Mallinson H, Wellstead S. Canary and ethambutol alone, after 6 weeks when fast bacilli (AFB) were seen and MAC was poorly formed granulomata; numerous acid copies/ml. Skin biopsy revealed multiple × 10/l and the HIV viral load 202 300 copies/ml. Skin biopsy revealed multiple poorly formed granulomata; numerous acid fast bacilli (AFB) were seen and MAC was subsequently cultured from skin, sputum, urine, and blood. He was treated with rifabutin, clarithromycin, ethambutol, and isoniazid; treatment was reduced to clarithromycin and ethambutol alone, after 6 weeks when the mycobacterium was speciated. HAART,
EDITOR,—The obituaries of three physicians, Ambrose King, Eric Dunlop, and David Oriel, appeared in quick succession in your columns.

By the time I started training in venereology, as it was then called (not a bad name incidentally because it means the science of the act of love which encompasses STIs, colposcopy, HIV disease, and sexual dysfunction) at the Whitechapel Clinic of the London Hospital in 1973 Ambrose King was already on his way left. However, the clinic still sparkled (not physically you understand) from his inspirational radiance and he was spoken of in hushed, reverential tones.

Eric Dunlop was the senior physician at that time. To a very junior doctor he was literally an awe inspiring figure. By today’s standards he did not educate or teach. Rather you were well aware that he had laid a “golden egg” and that there was a touch of colour and brilliance in his research work and lectures. I was taught basic day to day venereology by the senior charge nurses at that department. Eric Dunlop’s lucidiousness was legendary. We took nine specimens from each woman to screen for Chlamydia trachomatis (including three cervical curettages) and had a very high number of correctly identified positives. This meticulousness transferred itself to one’s own attitude to research, and many of us also aspired to achieve Eric Dunlop’s larger than life persona and facility for logical reasoning by the senior charge nurses at that department.

I later worked for David Oriel. He made advances by quietly yet relentlessly pushing forward at the broad front of research and clinical practice. He pioneered some of the earliest uses of potent antiretroviral therapy on the management of patients with HIV disease and sexual dysfunctions. He was also evaluating how patient management and consequently surveillance data can be used as a measure of treatment success. In contrast, the above studies incriminating ART and concomitant opportunistic infections were shown to be appropriate or inadequate treatment, low rate of partner notification, and lack of referral to genitourinary medicine (GUM) clinics. The inappropriate treatment and consequences were shown to be 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 FPC 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 can 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 C 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 and the community clinics are 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 490 (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.

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5 Accepted for publication 29 January 2001

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 inappropriate or inadequate treatment, low rate 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 FPC 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 can 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.

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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.

R S MORTON

Over the years, many books on the use of antimicrobials in the treatment of infectious disease have been written. Although few of these books have a subtitle implying that resistance will be specifically dealt with (as with this book), most of them by necessity write about this topic. I approached this book with a degree of cynicism, expecting to find the same tales retold in the same formulaic way. The first part of the book was not what I expected and I was pleasantly surprised. The first seven chapters dealt with the science of resistance generally, and then with specific examples, in a way that was informative and relevant to many clinicians. These early chapters also information on epidemiology, public health measures, and vaccination that are relevant to managing the problems of resistant organisms. Although this is a multi-author book, there seemed to be more consistency in approach and writing in these early chapters than those found later. The latter part of the book was little more than the systems based summary of antimicrobial use found in so many books.

As is to be expected with a book written by American authors, there are differences in practice from that in the United Kingdom: recommendations for treatment of community acquired pneumonia differ from those of the British Thoracic Society; recommendations for the treatment of infective endocarditis differ from those of the ESCC Working Party. Although generic drugs, some of these are different (although comparable) from those we would use in the United Kingdom. The authors frequently recommend the use of trimethoprim-sulfamethoxazole; because of the risk of sulphonamide toxicity, the CSM only recommends the use of this combination for specific indications in the United Kingdom. The chapter on meningitis the authors do not recommend the immediate use of penicillin in clinical suspicion (UK guidance).

The controversy of use of antibiotics in the treatment of infective diarrhoea is not discussed. Most importantly, the adverse effects of using antibiotics in shigellosis in children and EHEC infection are not mentioned.

The chapters on the treatment of sexually transmitted infections and HIV are short for a specialist reader, and there really should have been a separate chapter on hepatitis. I doubt there is much in this book that the established GUM clinician or scientist will find helpful. The trainee GUM physician may be confused or misled.

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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).

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).

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).

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