Methicillin resistant \textit{Staphylococcus aureus} (MRSA) balanoposthitis in an insulin dependent diabetic male


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many non-consultant grades will be expected to pass it as part of higher training in the specialty in the United Kingdom. It would be interesting to have some figures on the number of candidates anticipated in the near future and how this will affect the examination mechanism.

The Apothecaries Diploma Board rejected viva voce examinations some time ago as being prone to bias. This is consistent with much current research on examination techniques. Oral examinations are regarded as being inherently biased and of poor inter-examiner reliability. How much, however, is this also a candidate number related phenomenon? With courses for small numbers, such as the Diploma in Venerology and Genito-urinary Medicine of Liverpool University, we find the viva a key mechanism to discriminate between candidates precisely because the examiner can adjust the level of difficulty of questions to the ability of each candidate. The viva is a good instrument to measure clinical thinking, ability to take a sexual history, and counselling. Role play need not be unique to the province of actors. The viva is particularly useful for borderline candidates—for example, those who are disadvantaged in essays which are notoriously dependent on proficiency in English (not to mention writing!). In order to reduce interexaminer variation inherent in the viva, all candidates for the Liverpool Diploma are viva’d independently by both sets of (two) examiners. Clearly, this would be extremely cumbersome and time consuming for the current and anticipated numbers taking the Apothecaries Diploma.

The venerable Apothecaries’ Hall is apparently “unsuitable” for projecting slides a convenient way of basing a clinical skills/data interpretation type examination for a large number of candidates—for example, MRCP Part 2 and many other postgraduate medical examinations. Will the examiners of the Apothecaries Diploma have to begin to think of more appropriate premises for their examination?

HUMPHREY BIRLEY
Department of GUM Royal Liverpool University Hospital, Liverpool L7 8XW, UK


Detection of chlamydia on meatal swabs

EDITOR,—The advent of ligase chain reaction (LCR) and other DNA technologies and their greater sensitivity has allowed the possibility of taking samples other than from the urethra in men, including urine samples. \(^2\) Although urine samples have the advantage of being collected non-invasively, the sensitiv-
ity of LCR tests on such samples is less than for urethral samples. \(^3\) This may be due to the presence of inhibitors in urine. \(^4\) The reduced sensitivity on urine samples may be unacceptable, particularly if testing populations with a high prevalence of chlamydia infection. Further processing of urine samples is more laborious. It is currently recommended that spec-

A pilot study was conducted to compare the sensitivity of LCR testing for genital chlamydial infection in men, taken from the meatus itself against the standard technique. All male patients attending the GUM clinic over a 3 month period were included in the study if they had symptoms or signs compat-
ible with chlamydia, or if a contact of a known case of chlamydia. A swab was taken from the urethra in the standard fashion. A second swab was taken from the meatus. After the sixth week of the study the order of the first and second swabs was changed, in order to evaluate any bias related to the order of the swabs. Specimens were processed using Abbott Laboratories LCx Chlamydia and handled according to the manufacturer’s guidelines.

Twenty five patients were asked to evaluate the swabs and to state which swab caused least discomfort or if there was no difference between them. A total of 208 men were recruited to the study. The overall prevalence of genital chlamydia infection in our popula-
tion was 25% (52/208). A confirmed diagno-
sis was made by both of the samples performed from the same man were positive for chlamydia, or if one sample was positive together with an equivocal result. There were no false positive tests using these criteria giv-
ing all methods a specificity of 100%.

There was no significant difference in detection rates between the subgroups where the order of swabs was changed.

There was no significant difference in the sensitivity of samples taken from the meatus (100%) or from deep within the urethra (96.2%). Of the 25 men questioned two (8%) felt that the meatal swab caused more discomfort; 23 (92%) had a strong preference for the meatal swab. Clearly, this would be extremely

difficult for projecting slides a convenient way of basing a clinical skills/data interpretation type examination for a large number of candidates—for example, MRCP Part 2 and many other postgraduate medical examinations. Will the examiners of the Apothecaries Diploma have to begin to think of more appropriate premises for their examination?

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7 Abbott Diagnostics Division. Package Insert for LCx™ Chlamydia Accepted for publication 8 March 2001

HIV positive and negative homosexual men have adopted different strategies for reducing the risk of HIV transmission

EDITOR,—To reduce the risk of HIV trans-
mission, some homosexual men have adopted a strategy whereby they only have unpro-
tected anal intercourse (UAI) with a person of the same HIV status (‘homosexual consent UAI’). In London, homosexual men in a relationship are more likely to know the HIV status of their UAI partner than men not in a relationship and so establish concordance. However, this was not examined for HIV positive and negative men separately. A survey conducted in January-February 2000 among homosexual/bisexual men attending one of six gyms in central London, as part of an ongoing behavioural surveillance pro-
grame,\(^5\) has allowed risk reduction strategies to be considered by HIV status. A total of 792 homosexual men (median age 35 years) completed a confidential questionnaire (estimated response rate 50–60%\(^6\); 126 (16.0%) were HIV positive, 477 (60.2%) HIV negative; while 169 (21.3%) had never had an HIV test (data missing for 20 men). Just over half the men (55.2%) said they were currently in a relationship with another man; this did not differ significantly by HIV status (p=0.1).

Our analysis focused on sexual risk behaviour varied both by HIV as well as by relationship status. For HIV negative and positive men, UAI was classified as either concordant (UAI with a partner of the same HIV status) or non-concordant (UAI with a partner of unknown or discordant HIV status). Men reporting more than one UAI partner were classified as concordant only if all UAI partners were of the same HIV status as themselves. Men also indicated whether they had had UAI with a main partner only, casual partner(s), or both. One third of all men (32.9%, 259) reported UAI in the previous 3 months; HIV positive men 42.1% (53/ 126 HIV positive); HIV negative men 54.7% (246/457); data missing for two men) (p=0.1). Overall, concordant UAI was reported by 18.7% (89) of HIV negative and 21.4% (27) of HIV positive men (p=0.0), for HIV negative men, concordant UAI was predominantly reported by those in a relationship and rarely by men who were not (28.6% vs 5.0%, p<0.001) (table 1). Concordant UAI was usually with a main partner alone. By way of comparison, HIV positive men were just as likely to report
concordant UAI whether they were in a relation-ship or not (22.2%; 20.6%, p=0.9), often with a casual rather than main partner. The observation that HIV negative men were more likely to report concordant UAI in the context of a relationship while HIV positive men were just as likely to report concordant UAI whether they were in a relationship or not was confirmed in a multivariate model. With HIV status and relationship as independent variables and concordant UAI as the dependent variable, the only variable associated with HIV status and relationship was highly significant (p=0.001).

Seroconcordance among negative men can only be established with confidence if both men test for HIV together. For this reason it is difficult for HIV negative men to establish concordance with a casual partner. On the other hand, HIV positive men can establish concordance, be it with a casual or regular partner, simply by mutual disclosure. This requires no confirmatory test. Although seroconcordant UAI among positive men carries no risk of HIV transmission to an uninfected partner, there is the possibility of infection and drug resistance for the men themselves.

These data provide further evidence that HIV positive and negative homosexual men have both adopted HIV risk reduction strategies, with the less high risk sexual behaviour (that is, non-concordant UAI) was reported. Overall, non-concordant UAI was reported by 15.8% (75) of HIV negative men and 20.7% (26) of HIV positive men (p=0.2). No significant differences were seen when stratified by either relationship or HIV status (table 3). In the multivariate model there was no significant association between non-concordant HIV status and discordant HIV status. Non-concordant UAI was no more likely to report concordant UAI with a casual partner. HIV prevention programmes need to reinforce risk reduction strategies, tailored to a person’s HIV status, while simultaneously addressing high risk sexual behaviour. *

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Table 1: Unprotected anal intercourse (UAI) in the previous 3 months

<table>
<thead>
<tr>
<th>Type of partner for UAI</th>
<th>HIV negative men (n=477)</th>
<th>HIV positive men (n=126)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Main only</td>
<td>Casual†</td>
</tr>
<tr>
<td>Men in a relationship reporting</td>
<td>n=276</td>
<td>n=63</td>
</tr>
<tr>
<td>Concordant UAI</td>
<td>14.5 (40)</td>
<td>2.5 (5)</td>
</tr>
<tr>
<td>Non-concordant UAI</td>
<td>28.6 (79)</td>
<td>2.5 (5)</td>
</tr>
<tr>
<td>Total</td>
<td>35.1 (97)</td>
<td>8.0 (22)</td>
</tr>
</tbody>
</table>

Men not in a relationship reporting | n=199 | n=63 | n=262 | n=126 | n=36 | n=162 |
| Concordant UAI | 1.5 (3) | 2.5 (5) | 4.0 (10) | 1.5 (2) | 2.5 (5) | 4.0 (10) |
| Non-concordant UAI | 16.1 (32) | 5.0 (10) | 21.1 (54) | 9.0 (6) | 5.0 (10) | 14.0 (25) |
| Total | 18.6 (37) | 22.6 (45) | 41.2 (102) | 10.5 (7) | 22.6 (45) | 39.7 (67) |

*Data on UAI or relationship status missing for two HIV negative men.
†Men reporting UAI with a partner of unknown HIV status.

Chaperoning male patients

Editor,—I was delighted to see the letter by Fisk et al in the journal. My staff and I were becoming alarmed at the suggestion that male patients should have a chaperone when they are being examined by a male doctor. Was common sense finally leaving the special-ty? There are thousands of consultations taking place throughout the country, in both primary and secondary care, where sexual issues are discussed. These often include a genital examination, and just because there is a problem found with one or two individual patients or doctors it doesn’t mean the whole national service has to be turned upside down. Surely, the last thing an overworked, under pressure, genitourinary medicine service needs is to have another section of its skilled staff standing idly by in a room, while either a consultation or examination is taking place. I have never found any difficulty in taking the swabs on my own, and labelling the stuff myself, and have never felt the need for another person handing me things during a male examination. Indeed, I could easily see that interfering with the process at times, as there are some issues patients feel more com-fortable discussing on a one to one basis, and they can feel embarrassed and hindered if there is a chaperone present.

An occasional complaint is a small price to pay for the 99.9% otherwise effective consultations that occur. It’s lovely to see work like this published, as it becomes the evidence base that says we don’t need this.
kind of interference, and that basic common sense should prevail.

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Accepted for publication 15 February 2001

Lichen sclerosus of the glans is significantly associated with penile carcinoma

EDITOR,—We read with interest the article by the authors found no cases of malignancy.

We have previously reported a retrospective study on the incidence of cancer on 86 cases of PLS retrieved from our histopathological files over a 10 year period (1987–97).1 In that study, five cases showed malignant transformation—namely, squamous cell carcinoma (SCC) (three cases), in situ carcinoma (one case), and verrucous carcinoma (one case).

Since that report, we decided to interview all PLS patients in order to rule out any further malignancy that occurred over time. Of 86 patients identified, 60 were evaluated at our clinic. Among these, we found three additional patients treated with partial penectomy for invasive SCC at other institutions. Their medical records were obtained together with paraffin-embedded tissue samples to perform polymerase chain reaction (PCR) for human papillomavirus (HPV) testing. Clinical and laboratory information for these cases, together with previously reported patients, are summarised in table 1.

In this current study, eight (9.3%) out of 86 patients with PLS developed an epithelial malignancy. Data analysis using the t test confirmed in our series a statistically significant risk of malignant degeneration (p <0.05).

Clinically, the most common presentation of epithelial cancer arising with PLS was that of an infiltrated or ulcerated plaque followed, in decreasing order of frequency, by a nodular lesion or verrucous papules. The glans was the most commonly affected area. The average age of onset of PLS was 45 years, and that of development of cancer was 62 years. The average lag time from onset of PLS to cancer development was 18 years (range 10–34 years). This long latency time might explain the paucity of cases, mostly anecdotal, reported in the literature in the past 2 years (approximately 20)3,4 compared with our study, in which a long follow up disclosed 9.3% malignant degeneration in a series of 86 patients.

Also, the latency time was shorter in the HPV positive patients (average 15 years) compared with the HPV negative patients (average 23 years). The role of HPV in the pathogenesis of penile cancer is not fully understood. Some HPVs, such as type 16 and 18, are likely to play a part, but not all penile carcinomas are HPV positive, as shown in our study. Also, PLS is not commonly associated with HPV infection.1 In our study we found five patients positive for HPV 16 infection, and this may have hastened the progression towards cancer resulting in a shorter lag time. However, routine HPV testing on larger series is necessary in order to draw any definitive conclusion.

Similarly to vulvar lichen sclerosus, which has been observed to undergo malignant degeneration in 3–6% of women, a likely malignant evolution of PLS should be considered. Careful and systematic histopathological evaluation of any ulcerated or indurated plaques developing within PLS is therefore strongly recommended. The association between PLS and cancer may very well be underestimated and there is a need for further investigation that includes long term follow up and routine PCR analysis for HPV infection.

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Table 1
Clinical and histopathological features of eight cases of carcinoma on penile lichen sclerosus

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Age of onset of PLS (years)</th>
<th>Age of onset of Ca (years)</th>
<th>Lag time (years)</th>
<th>Site</th>
<th>Clinical aspect of malignancy on PLS</th>
<th>Histopathology</th>
<th>PCR testing for HPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>41</td>
<td>62</td>
<td>21</td>
<td>glans</td>
<td>fungating keratotic nodule with a white-yellowish hue slightly elevated verrucous papules</td>
<td>SCC, well differentiated</td>
<td>negative</td>
</tr>
<tr>
<td>2</td>
<td>36</td>
<td>59</td>
<td>23</td>
<td>glans</td>
<td>multiple erithymatous, indurated, and ulcerated plaques sharply circumscribed, erythematous, ulcerated plaque, oozing, and slightly infiltrated plaque</td>
<td>SCC, well differentiated</td>
<td>HPV 16</td>
</tr>
<tr>
<td>3</td>
<td>41</td>
<td>55</td>
<td>14</td>
<td>glans, corneal sulcus, glans, corneal sulcus, inner aspect of the foreskin</td>
<td>SCC, well differentiated</td>
<td>HPV 16</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>39</td>
<td>49</td>
<td>10</td>
<td>glans</td>
<td>exophytic verrucous whitish nodule sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>SCC, well differentiated</td>
<td>HPV 16</td>
</tr>
<tr>
<td>5</td>
<td>29</td>
<td>47</td>
<td>18</td>
<td>glans</td>
<td>sharply circumscribed, erythematous, eroded, crusted, and indurated plaque</td>
<td>SCC, well differentiated</td>
<td>HPV 16</td>
</tr>
<tr>
<td>6</td>
<td>75</td>
<td>85</td>
<td>10</td>
<td>glans</td>
<td>sharply circumscribed, erythematous, eroded, crusted, and indurated plaque</td>
<td>SCC, well differentiated</td>
<td>HPV 16</td>
</tr>
<tr>
<td>7</td>
<td>66</td>
<td>70</td>
<td>15</td>
<td>glans, corneal sulcus</td>
<td>SCC, well differentiated</td>
<td>HPV 16</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>33</td>
<td>67</td>
<td>34</td>
<td>glans, corneal sulcus</td>
<td>SCC, well differentiated</td>
<td>HPV 16</td>
<td></td>
</tr>
</tbody>
</table>

*Previously reported cases.1
PLS = penile lichen sclerosus; Ca = carcinoma; PCR = polymerase chain reaction; HPV = human papillomavirus; SCC = squamous cell carcinoma; VC = verrucous carcinoma.


Accepted for publication 22 March 2001

Third trimester screening or safer sex to prevent mother to child transmission of HIV

EDITOR,—Since 1992 Department of Health guidelines have recommended that HIV screening be offered to all pregnant women in high seroprevalence areas of high seroprevalence but implementation and uptake has been poor. In 1998 an intercollegiate working party recommended that HIV testing be integrated with antenatal screening for other infections and that the test should be offered and recommended to all pregnant women in high seroprevalence areas.1 In 1999 the Department of Health extended these recommendations to all regions aiming to reduce neonatal HIV infection by 80% by 2002.2 We present the case of an infant with symptomatic HIV infection, whose mother's antenatal HIV test was negative and discuss the implications.

A 3 month old female, born at term by spontaneous vaginal delivery and breastfed, presented with a 1 week history of increasing respiratory difficulty. Following further deterioration, she was transferred to St Mary's Hospital and ventilated. Pneumocystis carinii pneumonia (PCP) was diagnosed on bronchoalveolar lavage. Anti-HIV antibodies were present in serum and HIV infection was confirmed by the detection of HIV-DNA in peripheral blood mononuclear cells (PBMC) by PCR amplification. HIV-1 infection was confirmed in both parents. Her asymptomatic mother had received antenatal care from the 12th week of gestation and was HIV seronegative at 29 weeks. To investigate a
Table 1 Peripartum HIV test results

<table>
<thead>
<tr>
<th>Time (in weeks of gestation)</th>
<th>1 T = 12 weeks (“Booking blood”)</th>
<th>2 T = 29 weeks</th>
<th>3 T = 13 weeks (“Booking blood”)</th>
<th>4 T = 13 weeks post partum (child presents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital where blood taken</td>
<td>X Blood was stored and retrospectively tested</td>
<td>Y Index antenatal test (serum not available for repeat retrospective testing)</td>
<td>Y Blood was stored and retrospectively tested</td>
<td>St Mary’s Postnatal test. Blood stored</td>
</tr>
<tr>
<td>HIV antibody screening tests</td>
<td>Clear negative / Detect-HIV&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Weak positive / Abbot Assay HIV 1/2&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Clear negative / Detect-HIV&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Strong positive / Abbott Assay HIV 1/2&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>HIV specific antibody tests (CPHLS in-house EIA(s))</td>
<td>Clear negative, (OD/CO) HIV IgG=49.4, IgM=0.36, IgA=0.44</td>
<td>Strong positives, (OD/CO) HIV IgG=12.34, IgM=10.94, IgA=5.28</td>
<td>Strong positives for IgG and IgA: weak positive IgM (OD/CO) HIV IgG=15.41, IgM=3.14, IgA=4.18</td>
<td>HIV1 p17+, p24++, p55+, p31++, p51++, p65++, env gp160+, gp120+, gp160++</td>
</tr>
<tr>
<td>HIV western blot&lt;sup&gt;b&lt;/sup&gt;</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>HIV2 gp36- 41377 Quaniplex HIV-1 RNA 3.0&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>HIV RNA (copies/ml)</td>
<td>Not detected (&lt; Limit of detection) Cobas Amplicor HIV-1 Monitor v1.5&lt;sup&gt;d&lt;/sup&gt;</td>
<td>—</td>
<td>—</td>
<td>82400 Cobas Amplicor HIV-1 Monitor v1.5&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Enzyme immunoassay (EIA) for detection of antibody to HIV-1 and 2. Biochem Immunosystems Inc Montreal, Quebec, Canada.

<sup>b</sup>EIA for detection of antibody to HIV-1 (Abbott Murex). Murex Biotech Ltd, Dartford, UK.

<sup>c</sup>EIA for detection of antibodies to HIV-1 and 2. Abbott Laboratories, IL, USA.

<sup>d</sup>EIA for detection of antibodies to HIV-1 and 2 (Abbott Murex). Murex Biotech Ltd, Dartford, UK.

<sup>e</sup>Passive particle agglutination test for detection of antibodies to HIV-1 and 2 Fujirebio Inc, Tokyo, Japan.

<sup>f</sup>Western blot for detection of antibodies to HIV antigens. GeneLab Diagnostics, Singapore.

<sup>g</sup>Polymerase chain reaction (PCR) for quantitative detection of HIV-1 RNA. Roche Diagnostics, Branchburg, NJ, USA.

<sup>h</sup>Signal amplification nucleic acid probe assay for quantitative detection of HIV-1 RNA. Chiron Corp Emeryville, CA, USA.

possible false negative result, other sera stored at various times were retrieved and tested. The results, which show seroconversion late in pregnancy, are summarised in table 1.

The HIV antibody test is usually performed at the booking visit with other routine antenatal screens. This allows the parents time to adjust to the diagnosis before delivery, to consider family planning issues and interventions to minimise the risk of mother to child transmission. In addition, mothers with advanced immunosuppression benefit from antiretroviral therapy. Although rarely reported, an HIV seronegative mother whose partner has undiagnosed HIV infection is at continued risk of infection during lactation and the infected male may benefit from early diagnosis [19].

Repeat antenatal screening late in pregnancy, as is recommended for syphilis in the United States, would identify some primary HIV infections during gestation. However, if maternal infection is not prevented transmission during lactation would remain a risk and there would be significant logistic and cost implications. The extension of testing for HIV (and other infections) to the partners of pregnant women is appealing as both maternal and infant infections could be prevented (and the infected male may benefit from earlier diagnosis and treatment) but would require a fundamental change to antenatal care. A practical approach, which may prevent maternal and neonatal infection (but not identify the infected male) is to use the opportunity, when giving negative HIV, hepatitis B, and syphilis results to the mother, to discuss the sexual transmission of infections, to emphasise that the negative results cannot be extrapolated to the partner, and advocate safer sex which is commonly abandoned following conception.

Contributors: PG obtained samples and results, monitored virology and immunology, wrote and amended paper; RW monitored virology and immunology, amendments to paper; JP monitored PHLS Colindale tests, amendments to paper; GT was involved in clinical management of child, helped write and amend paper.

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Accepted for publication 3 April 2001.

Economic advantages of ligase chain reaction for diagnosis of genital Chlamydia trachomatis infection in GUM clinic attenders

EDITOR.—Genital infection with Chlamydia trachomatis is highly prevalent and recognised as a major threat to public health. There is now a wealth of evidence to demonstrate the superiority of DNA amplification techniques over antigen detection and culture. Only one large study has directly compared ligase chain reaction (LCR) with enzyme immunoassay (EIA) on identical clinical material and no studies have analysed the health economic impact of LCR in a genitourinary medicine (GUM) clinic population.

We studied the diagnostic effectiveness and cost of LCR compared with EIA.

All GUM attendees undergoing sexual health screening were offered the opportunity to participate. Men presenting with dysuria or urethral discharge were defined as symptomatic. Swabs were collected in a pre-randomised order from the cervix in female patients and 4–5 cm proximal to the urethral meatus in male patients. Urethral specimens in male patients were evaluated for evidence of urethritis (defined by ≥4 polymorphs per high powered field).

LCR was performed using a standard immunoassay technique (Organon Chlamydia-Tek), with confirmation of reactive tests by microdot DIF. LCR (LCX system, Abbott Laboratories) was also performed on every specimen. Specimens

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testing positive by LCR alone were retyped by an alternative PCR assay for DNA sequences coding for the major outer membrane protein (MOMP) of Chlamydia trachomatis.

A total of 148 male and 153 female patients were tested; 23/148 (16%) swabs from male patients were positive for Chlamydia trachomatis by LCR (see fig 1). The sensitivity, specificity, negative and positive predictive values, and cost/test of LCR and EIA, respectively, were 100%, 100%, 100%, 100%, £5.64 and 58%, 100%, 95%, 100%, £4.05.

Of 33 cases of chlamydial infection, 15 cases (12 (92.2%) in men and two (20.0%) in women) would have remained undetected if EIA had been used alone. Although EIA tests cost less than LCR, the inferior detection rate for EIA (17 patients need to be screened per case detected) compared with LCR (nine patients screened per case detected) was also included in analysis of the results. The cost per case of chlamydial infection detected using EIA in this population was £65, compared with £50 for LCR.

In a hypothetical cohort of 100 GUM attendees, with an 11% prevalence of chlamydial infection (as in the present study), testing with EIA would cost £405 and would detect 6.4% of the 11 cases. Testing the cohort with LCR would cost £564 and detect all 11 cases. The additional cost of LCR is thus £199. The additional benefit is 4.6 additional cases detected. The additional cost of LCR per additional case detected is £34.

The clinic in which the study was conducted sees 6000 new attendees annually. Had EIA been used alone, 276 cases of chlamydial infection would have been missed in a one year period, at an estimated cost of over £82 000. A full economic evaluation would require that these long term health and resource costs be more thoroughly quantified as resources.

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NOTICES

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.HMIF.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: pbvsbc@tps.sheridan.com).


Further details: ECEAR 2001 Conference Secretary, Division of Human Virology, 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@cpb.de).

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 6069.

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 Behcet’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.perinatal2001.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).

International Conference on HIV/AIDS 16–19 December 2001, Mumbai, India

Further details: Dr Chander P Puri, President, Indian Society for Study of Reproduction and Fertility, Institute for Research in Reproduction, Jehangir Merwanji Street, Parel, Mumbai 400012, India (Tel: 4137730 (Direct), 4132111-2-6-7; fax: 091-022-495853 or 091-022-4139412; e-mail: vichin@bom4.vsnl.net.in OR dirirr@vsnl.com).

10th International Symposium on Human Chlamydial Infection, 16–21 June 2002, in Antalya, Turkey

The scientific programme will encompass the breadth of chlamydial research from clinical and epidemiological studies to molecular and cell biology of all species of Chlamydia. Further details: Professor A Demir Serter, Department of Clinical Microbiology and Infectious Diseases, Ege University, Faculty of Medicine, 35100 Bornova, Izmir, Turkey (Fax: 90 232 343 71 30; e-mail: ISHCICX@itsa.ucsf.edu).

20th World Congress of Dermatology, Paris, 1–5 July 2002

Further details: P Fournier, Colloquium, 12 rue de la Croix St Faustin, 75011 Paris, France (tel: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fournier@colloquium.com; website: www.derm-wcd-2002.com).