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The performance of microscopic cervicitis for the detection of chlamydial infection

The diagnosis of chlamydial cervicitis by microscopy provides an opportunity for early treatment of infected patients and possible reduction in the incidence of pelvic inflammatory disease. Because of utilisation of insensitive methods for diagnosis of *Chlamydia trachomatis*, the conclusion of previous studies on the definition of chlamydial cervicitis has been inconsistent.

The aim of this study was to define the most sensitive and specific cut-off for polymorphonuclear cell (PMN) counts associated with chlamydial cervicitis diagnosed by a nucleic acid amplification test.

This was a prospective double blinded study on consecutive women older than 16 years and not menstruating attending the Department of GUM in Edinburgh for screening of sexually transmitted infections (STI) between May and September 2002. Patients were tested for *Neisseria gonorrhoeae* diagnosed by inoculation of ano-genital materials on modified New York City culture media (MNYYC) and for *C trachomatis* detected by testing endocervical material by ligase chain reaction (LCR). Gram stained and saline mount vaginal smears were utilised for the detection of bacterial vaginosis (BV) and *Trichomonas vaginalis* (TV) respectively. The diagnosis of BV was based on the modified Amsel’s criteria.

Cervical smears were examined by GB who was blinded to the outcome of the clinical and microbiological tests of patients. The median of PMN counts in five non-adjacent ×1000 microscopic fields in Gram stained endocervical smears was calculated. Slides with more than 100 squamous cells per slide or more than 100 bacteria per ×1000 microscopic fields were deemed contaminated with vaginal flora and were excluded from analysis.

χ² and Mann-Whitney U tests were conducted for categorical and non-parametric data respectively. A smear was positive only if it related to a positive LCR result.

Of the 138 consenting patients with valid cervical smears, 17 (12%) had chlamydial infections. None of the patients had infection with *N gonorrhoeae* or TV. Patients with chlamydial cervicitis had median PMN counts of 27 (interquartile range (4.5–54.5)) compared with that of 7 (1–18.5) among uninfected patients (P<0.04).

Table 1 shows the sensitivity and specificity of different PMN cut-offs in cervical smears for the detection of chlamydial infection. Limitation of cervical microscopy to women of 24 years or younger, those with BV, or women on oral contraceptive pill was not associated with better sensitivity or specificity of cervical smears (data not shown).

In our study, the prevalence of chlamydial infection among studied women was similar to that of reported elsewhere in United Kingdom. The sensitivity of cut-off of ≥5 PMN cells ×1000 microscopy field was higher than that reported by studies using enzyme immunoassay for diagnosis of *C trachomatis*. This could be due to the superior performance of LCR in diagnosis of chlamydial infection. Increasing the cut-off of chlamydial cervicitis improved the specificity at the expense of reduction in the sensitivity.

Although some studies have suggested an association between chlamydial cervicitis and pelvic inflammatory disease, leading to the suggestion that the high amino acid sequence homology between

## Table 1

The sensitivity and specificity of different PMN cut-offs in cervical smears for detection of chlamydial infection (total 138, prevalence of chlamydia 12.31%)

<table>
<thead>
<tr>
<th>PMN cut-off criteria</th>
<th>No of cervical smears</th>
<th>Positive chlamydial test</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>PPV (%)</th>
<th>NPV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥5 PMN/ hpf*</td>
<td>85</td>
<td>13</td>
<td>76</td>
<td>40</td>
<td>15</td>
<td>92</td>
</tr>
<tr>
<td>≥10 PMN/ hpf</td>
<td>56</td>
<td>10</td>
<td>59</td>
<td>62</td>
<td>18</td>
<td>91</td>
</tr>
<tr>
<td>≥15 PMN/ hpf</td>
<td>48</td>
<td>10</td>
<td>59</td>
<td>69</td>
<td>21</td>
<td>92</td>
</tr>
<tr>
<td>≥20 PMN/ hpf</td>
<td>39</td>
<td>9</td>
<td>53</td>
<td>75</td>
<td>23</td>
<td>92</td>
</tr>
<tr>
<td>≥25 PMN/ hpf</td>
<td>31</td>
<td>9</td>
<td>53</td>
<td>82</td>
<td>29</td>
<td>92</td>
</tr>
</tbody>
</table>

*High power field: ×1000 microscopy.
†Positive predictive value.
‡Negative predictive value.
Figure 1  
*Chlamydia trachomatis* IgG and chsP60 antibody responses in Dutch white women with different degrees of tubal pathology.

The prevalence of excessive alcohol consumption and the acceptability of brief advice in a sexual health clinic: cross sectional survey

Excessive alcohol consumption has been implicated in unsafe sex and the spread of sexually transmitted infections.1 Cross sectional surveys in sexual health clinics have shown that most patients drink alcohol regularly,2 but the proportion misusing alcohol has not been reported. Brief interventions for alcohol misuse have been shown to be beneficial across a range of medical settings,3 but their use in sexual health clinics has not been explored. We therefore examined the acceptability of offering brief advice to people identified as misusing alcohol in a sexual health clinic.

Two doctors (PCL, CB) set out to recruit consecutive attendees at walk-in clinics at the Jefferiss Wing Centre for Sexual Health at St Mary’s Hospital in London over a 3 month period. Consenting patients were interviewed using the Paddington Alcohol Test (PAT).4 Those drinking excessively were offered a self help leaflet, “Think about Drink,” and/or an appointment with an alcohol health worker (AHW). Acceptance of brief intervention was noted, and AHW records examined to find
out whether patients attended their appointment.

Three hundred and five people were invited to take part in the study, of whom 302 (99%) agreed. The sample comprised 210 women and 92 men, of whom 284 were heterosexual and 18 bisexual or homosexual. In all, 253 (84%) reported drinking alcohol and 98 (32%) were drinking excessively according to PAT. Men were more likely to be consuming excessive alcohol than women (46% compared to 27%, \( \chi^2 = 9.8, p = 0.001 \)). Thirty nine (39.8%) of those consuming excessive alcohol stated that their attendance in the clinic was related to alcohol. The most commonly stated reasons for this were either that being drunk led to sexual contact which would not otherwise have taken place or that alcohol consumption had resulted in sex without use of a condom.

Brief written advice was accepted by 91 (93%) of those drinking excessively. A further 30 (31%) accepted an appointment with an AHW. Those who stated they would accept an appointment with an AHW and only one person attended the clinic was related to alcohol. The most common time and place of convenience; when offered

those given an appointment other differences were found. Subsequent brief interventions in heavy drinkers. J Gen Intern Med 1997:12:274–83.

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References


Resolution of lymphocytic interstitial pneumonitis in an HIV infected adult after treatment with HAART

The optimal therapy for lymphocytic interstitial pneumonitis (LIP) in HIV infected adults is currently unknown. We describe an HIV patient with LIP who improved with protease inhibitor based highly active anti-retroviral therapy (HAART) without concurrent corticosteroids.

Case report

A 52 year old heterosexual African-American man, diagnosed with HIV infection 3 years before presentation, was hospitalised for an evaluation of an abnormal chest radiograph obtained during medical screening. His CD4 lymphocyte count was 198 cells \( \times 10^3/\mu l \), and plasma HIV-1 RNA level >290 000 copies/ml. He denied all symptoms, including cough, shortness of breath, chest pain, fever, and weight loss.

On admission, vital signs included temperature 37.1°C, respiratory rate 16 breaths/minute, and room air oxygen saturation 94%. Complete physical examination was unrewarding, including pulmonary examination. Laboratory data included white blood cell count 5800 \( \times 10^3/\mu l \), room air arterial blood gas: pH 7.42; pO2 38 mm Hg; pCO2 70 mm Hg. A chest high resolution computed tomography (HRCT) scan revealed diffuse micronodules and right lower lobe consolidation, without pleural effusions or intrathoracic lymphadenopathy (fig 1A). Pulmonary function tests (PFTs) revealed a mild restrictive ventilatory defect and a moderately reduced diffusing capacity (table 1).

Tuberculosis was considered; multiple induced sputum smears and cultures were negative for acid fast bacilli. Fibroepithelial bronchoconstriction was performed; bronchoalveolar lavage and transbronchial biopsy smears and cultures were negative for bacteria, fungi, and acid fast bacilli. Mature lymphoid infiltration and proliferation were seen and associated with germinal centre formation and focal invasion and destruction of the bronchial epithelium (fig 2). The histological features are characteristic of LIP.

Treatment with corticosteroids and/or HAART was considered. Since the patient met criteria for initiating HAART, he was started on tenofovir disoproxil fumarate, lamivudine, and lopinavir plus ritonavir. Because he was asymptomatic, concurrent corticosteroids were withheld. After 1 month, his CD4+ lymphocyte count increased to 392 cells \( \times 10^3/\mu l \) with a concurrent 100-fold decrease in viral load, now currently undetectable. Repeat PFTs after 2 months on HAART showed significant improvement in all measurements (table 1). Follow up HRCT 3 months on HAART demonstrated marked improvement (fig 1B). At present, the patient remains on HAART without evidence of pulmonary disease.

Comment

LIP is a common complication of HIV infection in children but is uncommon in adults. Although the clinical, radiographic, and histopathological characteristics of LIP are relatively well described, the aetiology and pathogenesis remain unknown and the optimal treatment is undefined. We report a case of a patient with HIV and LIP who improved with HAART alone.
of infiltrating T lymphocytes which was significantly greater than that seen in HIV negative LIP and pulmonary MALT lymphomas. In light of the possible inflammatory and infectious pathogenesis underlying HIV related LIP, the use of corticosteroids and antiretroviral therapy appears reasonable. However, there are no randomised trials assessing the optimal therapy for LIP. Some patients have responded to corticosteroid treatment, although the optimal dose and duration of this therapy are unknown. Reports of AZT monotherapy have had mixed results; a case using combination nucleoside therapy was successful. This is the first case report of protease inhibitor based HAART therapy with significant improvement in his immune status, pulmonary physiology, and radiology. In HIV infected patients with LIP, especially if clinically stable, HAART alone may be an appropriate initial treatment.

### Key messages
- Lymphocytic interstitial pneumonitis (LIP) is a common complication of HIV infection in children but is uncommon in adults.
- The optimal therapy for LIP in HIV infected adults is currently unknown.
- Our patient responded to a protease inhibitor based HAART therapy with significant improvement in his immune status, pulmonary physiology, and radiology.
- In HIV infected patients with LIP, especially if clinically stable, HAART alone may be an appropriate initial treatment.

### Table 1 Pulmonary function tests

<table>
<thead>
<tr>
<th></th>
<th>Admission (pre-HAART)</th>
<th>After 2 months HAART</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Value</td>
<td>% Predicted</td>
</tr>
<tr>
<td>FVC (litres)</td>
<td>3.30</td>
<td>76%</td>
</tr>
<tr>
<td>FEV1 (litres)</td>
<td>2.65</td>
<td>72%</td>
</tr>
<tr>
<td>FEV1/FVC (%)</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>VC (litres)</td>
<td>3.14</td>
<td>79%</td>
</tr>
<tr>
<td>TLC (litres)</td>
<td>4.77</td>
<td>77%</td>
</tr>
<tr>
<td>DLCO (ml/min/mm Hg)</td>
<td>13.5</td>
<td>42%</td>
</tr>
<tr>
<td>pH</td>
<td>7.38</td>
<td></td>
</tr>
<tr>
<td>pCO2 (mm Hg)</td>
<td>38</td>
<td>43</td>
</tr>
<tr>
<td>PO2 (mm Hg)</td>
<td>70</td>
<td>89</td>
</tr>
<tr>
<td>A-a O2 gradient (mm Hg)</td>
<td>33</td>
<td>7</td>
</tr>
</tbody>
</table>

FVC, forced vital capacity; FEV1, forced expiratory volume in 1 second; VC, vital capacity; TLC, total lung capacity; DLCO, diffusing capacity for carbon monoxide.

### Figure 2

Histopathology showing changes consistent with LIP. (A) Dense lymphocytic infiltrates with widened interstitial septae (arrow). Inset: High magnification of a pink intranuclear inclusion, a so-called “Dutcherc body.” Bar = 100 μm. (B) High magnification of an airway in which the lymphoid infiltrate has focally invaded the airway epithelium (arrows) and focally disrupted the epithelium (arrowhead). Bar = 100 μm.

### References

### Oral sex and gum disease

Moderate gingivitis is present in at least 75% of the population. Although the strongest contributor to oral health is oral hygiene, there is a range of susceptibility caused by immune function and differences in plaque microflora. Pregnancy, oral contraceptive use, smoking, and diabetes are all associated with increased susceptibility to gum disease. Oral sex has been associated with oral sores in some populations, and can cause ulceration in the oral cavity. It may also spread infection from the oral cavity to the genital tract or vice versa, altering oral and genital microflora. The purpose of this study was to examine the association between sexual behaviour and self reported gum disease.

From 1999 to 2001, the Feminine Hygiene Study interviewed 411 African-American women seeking routine gynecological care at two New York hospitals about their hygiene habits and health behaviours. Sexual practices were assessed, including “Within the last 3 months, how often have you received oral sex in which your partner’s mouth or tongue was touching your vulva/ vagina?” and “Within the last 3 months, how often do you give oral sex in which you...
and receiving oral sex, it would be more likely that giving oral sex was created by multiplying frequency of intercourse times a reported frequency of oral sex (1 for always, 0.75 for often, 0.5 for half the time, and 0.25 for occasionally). In addition, women were asked if they had been diagnosed with gum disease, if their gums bled when they brushed their teeth, and if they had bad breath. 

Table 1: Associations between oral sex and indicators of gum disease in a cohort of 411 African-American women, New York City

<table>
<thead>
<tr>
<th>Sex in past 3 months included</th>
<th>Bleeding gums (often/always)</th>
<th>Bad breath (often/always)</th>
<th>History of gum disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude</td>
<td>Adjusted</td>
<td>Crude</td>
</tr>
<tr>
<td></td>
<td>No % OR 95% CI</td>
<td>OR 95% CI</td>
<td>OR 95% CI</td>
</tr>
<tr>
<td>Giving oral sex:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;half time or more seldom/never</td>
<td>54 13 2.8 (0.8 to 9.7) 3.5*  (1.0 to 12.4)</td>
<td>2.9 (0.8 to 11.2) .59†  (1.3 to 27.5)</td>
<td>2.9 (0.7 to 21.1) .71†  (0.3 to 13.2)</td>
</tr>
<tr>
<td>Receiving oral sex:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;half time or more seldom/never</td>
<td>355 87 1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Giving oral sex:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;half time a week</td>
<td>105 36 1.8 (0.8 to 4.0) 0.9*  (0.3 to 2.9)</td>
<td>1.4 (0.5 to 3.8) .27†  (0.6 to 12.7)</td>
<td>1.4 (0.5 to 3.5) .8†  (0.2 to 4.3)</td>
</tr>
<tr>
<td>one time a week</td>
<td>304 74 1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&lt;one time per month</td>
<td>44 11 2.8 (1.0 to 7.5) 3.33*  (0.9 to 11.9)</td>
<td>1.2 (0.3 to 5.8) .95†  (0.2 to 6.8)</td>
<td>1.5 (0.4 to 5.4) 2.3**  (0.4 to 13.5)</td>
</tr>
<tr>
<td></td>
<td>68 17 1.1 (0.3 to 3.3) 1.2  (0.4 to 4.0)</td>
<td>1.6 (0.5 to 5.1) .9  (0.1 to 4.7)</td>
<td>1.3 (0.4 to 4.0) 1.5  (0.3 to 6.9)</td>
</tr>
<tr>
<td></td>
<td>296 73 1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

All adjusted estimates based on models that include both giving and receiving oral sex. Logistic regression controlling for: education; income, education, new sex partner; alcohol use, income, frequency of douching, new sexual partner, and parity; giving oral sex, education; giving oral sex, age, money, education, frequency of douching, new sexual partner; *getting oral sex, age, frequency of douching, new sexual partner, and marital status.

There are limitations to the observed data. The number of subjects with oral problems was small, the oral problems were self-reported, and we did not collect information on oral hygiene practices. Although we controlled statistically for socioeconomic status and a number of other risk factors, residual confounding by oral hygiene may still have influenced the result. Secondly, we asked about giving oral sex followed by vaginal intercourse rather than simply giving oral sex. The question was worded in order to assess possible transmission of bacteria to the vagina. Although this might misclassify some women who gave oral sex without vaginal intercourse, the prevalence of reported oral sex in our study was similar to other studies, and it is difficult to imagine why women who had oral sex alone would have different oral health. Because of the increased prevalence of oral sex in the general population, the current interest in periodontal disease as a risk factor for chronic disease, and the high prevalence of gingivitis and periodontitis generally, more studies on this issue are warranted.

Contributors
EWH analysed the data and wrote the paper; IZ contributed to the design and data management of the study; MCH contributed to the design and the conduct of the study; all authors assisted with conceiving this analysis and reviewing drafts of the paper.

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References

Acute urinary retention following self treatment of genital warts with imiquimod 5% cream

A 17 year old woman attended the accident and emergency department at our hospital in acute urinary retention. Examination revealed a palpable bladder and painful ulceration of the skin around the vaginal introitus. A urinary catheter was inserted and she was admitted to the urology ward. There was concern that the genitai ulceration might be due to herpes simplex virus infection and we were asked to review the patient.

The patient was known to us, having presented to the genitourinary medicine (GUM) clinic 4 months earlier with a first episode genital warts. A full screen (including an HIV test) had shown no other sexually transmitted infections and podophyllotoxin cream 0.15% had been prescribed for self treatment. After three monthly cycles the response was disappointing and treatment had been changed to imiquimod 5%. Four days after the imiquimod was prescribed, the patient returned to the GUM clinic complaining of marked discomfort at the site of application. She was advised to...
Knowledge of post exposure prophylaxis (PEP) for HIV among general practitioners in northern Sydney

Post exposure prophylaxis (PEP) for HIV has been shown to significantly reduce the transmission of HIV in both occupational exposures and vertical transmission; however, its role in non-occupational sexual exposures has been harder to define.1 2 In 1988 the New South Wales (NSW) health department released guidelines for PEP use in non-occupational exposures, including sexual exposures, based on recommendations from the Centre for Disease Control and Prevention.3 4 Eligibility depends upon risk, time since exposure and negotiated risk versus benefit.1 4

In Sydney, campaigns raising awareness of PEP have focused on the gay community, impacting upon inner city GPs with higher numbers of HIV positive clients. Little is known about the experience or knowledge of HIV PEP among GPs who do not practise in areas of higher HIV prevalence and have lower or no HIV case loads. GP studies have shown that limited HIV experience and training may affect the ability to effectively assess, advise, and treat patients.1 4

We focused on GPs in northern Sydney, an area that comprises approximately 12% of the NSW population. From March to July 2002 a questionnaire was submitted to GPs from the northern suburbs of Sydney via mailout and also distributed at regular GP education meetings. We collected demographic information and GPs were asked what they knew about the availability of HIV PEP, its uses, prescribing time restrictions, and access.

We received 202 GP responses in total: 162 from education sessions, a 68.6% response rate, and 40 responses from the mailout questionnaire, a 6.2% response rate. Most respondents were female (114/202, 56.2%). Women were generally younger (median age: 46 years, range: 28–71 years) and were more likely to work part time (67/114, 57.8%) compared to their male counterparts (median age 54 years, range 27–86 years. Full time work: 65/85, 81.3%).

While 68.5% (139/202) of those surveyed were aware of the availability of HIV PEP for high risk occupational exposures, only half of those (69/139), or 35.1% of all doctors (71/202: p<0.0001) were aware of the availability of HIV PEP for sexual exposures. Of all surveyed, 24.6% (50/202) were aware of the 72 hour time restrictions with 28.1% (56/202) offering explanations of how to access HIV PEP. Of doctors aware of the availability of HIV PEP for sexual exposures, 42.3% (30/71: p<0.0001) were aware of time restrictions with 46.5% (33/71: p<0.0001) offering explanations of access.

Low levels of awareness and knowledge of HIV PEP may translate to missed opportunities for access to PEP, and potential HIV infection. Limited knowledge may reflect the recent introduction of PEP into Australia and/or unfamiliarity with HIV infection and patients. Limitations of this study include the small sample of self selected doctors who, it may be argued, were more motivated learners, or more interested in HIV PEP. Education aimed at increasing GP awareness of basic HIV PEP principles may be beneficial for those in low HIV case load areas for patients missed by campaigns targeted at high risk communities.

References


A notice of ‘redundant publication’

A notice of ‘redundant publication’ appeared in the August issue of Sexually Transmitted Infections (2004;80:254). In their reply Dr Underhill and her co-authors suggested that they submitted the duplicate paper to the Journal of Family Planning and Reproductive Health Care after discussion with me. While I clearly cannot recall the exact content of our conversation, I would like to stress that it would have been most improper, and therefore highly unlikely, for me, as editor of Sexually Transmitted Infections, to suggest that they submit a duplicate publication to another journal. I would, therefore, like to correct any erroneous impression that might have been suggested to the reader.

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HIV in black Caribbeans

We read with interest the paper by Dougan et al regarding the epidemiology of HIV infection in black Caribbean adults in England, Wales, and Northern Ireland.

In our clinic setting, a district general hospital in north west London with a large black population (fig 1), diagnosis of HIV in


3 Low N. HIV infection in black Caribbeans in the united Kingdom. Sex Transm Infect 2004;80:2–3.