

Genitourinary Medicine, while 17.3% specified an inadequate course. Dosage or duration could not be ascertained in 12.7% of responses. This suggests substantial improvement in the past few years,<sup>4</sup> although our study probably over-represents GPs already testing for chlamydia and may exaggerate the extent of good practice.

Our study suggests that GPs already willingly take on an important role in diagnosing and managing genital chlamydia infection. They agree overwhelmingly that partner notification is the main difficulty in managing these patients. However, there is little evidence of follow up strategies designed to minimise re-infection risk, as in previous studies.<sup>5,6</sup> and the majority of GPs consider that partner notification is not their role. The latter view probably explains why the majority manage partner notification by simply telling the patient to deal with it, without support or follow up.

If testing in primary care continues to increase without adequate support for partner notification, much of the resource used in testing women will be wasted. The announcement of pilot sites for chlamydia testing in primary care is to be welcomed.<sup>3</sup> However, support for GPs in partner notification should not wait for the roll out of a national programme, since many patients diagnosed in primary care are already at risk of re-infection and onward transmission.

#### Acknowledgements

We are grateful to NoCTeN and Trent Focus (primary care research networks) for facilitating the Chlamydia Partnership Project. Dr Jackie Cassell was supported on a Health Services Research Training Fellowship by the Wellcome Trust.

#### J A Cassell, M G Brook

Department of Sexually Transmitted Diseases, Royal Free and University College Medical School, Mortimer Market Centre, Off Copper Street, London WC1E 6AU, UK

#### R Slack, N James, A Hayward

Division of Public Health Sciences, University of Nottingham Medical School

#### A M Johnson

Centre for Infectious Disease Epidemiology, Department of Primary Care and Population Sciences and Department of Sexually Transmitted Diseases, University College London, London, UK

Correspondence to: Dr Jackie Cassell, Department of Sexually Transmitted Diseases, Royal Free and University College Medical School, Mortimer Market Centre, Off Copper Street, London WC1E 6AU, UK; jackiec@quadriverium.demon.co.uk

#### References

- 1 Shefrin J, Edmondson S, McNulty C. Countywide survey of the current practice of chlamydia detection in primary care. *J Family Plann Reprod Health Care* 2002;**28**:145-8.
- 2 Kufuji O, Slack R, Cassell JA, et al. Who is being tested for genital chlamydia in primary care? *Sex Transm Infect* 2003;**79**:234-6.
- 3 Department of Health. Action plan for the sexual health strategy for England. London: DoH, 2002. www.doh.gov.uk/sexualhealthanddiv
- 4 Stokes T, Bhaduri S, Schober P, et al. GPs' management of genital chlamydia: a survey of reported practice. *Fam Pract* 1997;**14**:455-60.
- 5 Mason D, Kerry S, Oakeshott P. Postal survey of management of cervical Chlamydia trachomatis infection in English and Welsh general practices. *BMJ* 1996;**313**:1193-4.
- 6 Ross JD, Sutherland S, Coia J. Genital Chlamydia trachomatis infections in primary care. *BMJ* 1996;**313**:1192-3.

Accepted for publication 8 January 2003

## Circumcision in genital warts—let us not forget!

Patients with genital warts present to the healthcare professional with two major problems of persistence and recurrence. These problems are attributable to the persistence of human papillomavirus in the keratinocytes, defective immune response in individuals with persistence and recurrence of warts, and the lack of specific antiviral therapy. Various treatments tried in the management of genital warts are topical podophyllin, podophyllotoxin, cryotherapy, electrosurgery, chemical cautery, carbon dioxide laser, 5-fluorouracil cream, topical imiquimod cream, and intralosomal interferon.<sup>1-3</sup> We wish to highlight the role of circumcision in extensive genital warts involving prepuce, which were refractory to the conventional treatment.

A 50 year old patient presented to us with genital warts for duration of 4 years. On examination, lesions were in the form of sessile, filliform, and papular keratotic verrucous lesions present involving both outer and undersurface of almost whole of the prepuce (fig 1). These lesions were treated by us and in the past by various doctors with topical podophyllin, trichloroacetic acid cautery, electrosurgery, etc, for periods ranging from weeks to months with only minimal response, with the lesions coming back. The patient had some difficulty in retraction of the prepuce and was psychologically disturbed. The patient otherwise was healthy with no evidence of any other disease. Considering the extensive insolvent of prepuce and refractory nature to various treatments, circumcision was performed. Histopathological examination of the excised tissue showed changes consistent with warts without any cellular atypia. Surgical wound healed well in a week with no complications.

Extensive genital warts with evidence of keratinisation are often refractory to podophyllin, podophyllotoxin, and cryotherapy, etc, and are best dealt with surgically or by topical 5-fluorouracil cream. Scissor excision has been mentioned in the treatment of sessile lesions over the shaft of penis, labia majora, and perianal warts.<sup>3</sup> However, circumcision for extensive prepuce warts finds no place in the list of treatments for genital warts



Figure 1 Circumcised prepuce studded with extensive warts.

in men. In addition to the psychological morbidities, larger and more numerous warts can cause discomfort, and particularly involving prepuce can cause phimosis, secondary infection, and marital disharmony and considerable anxiety in the sexual partner. Globally, approximately 25% of the men are circumcised for religious, cultural, medical, or parental choice reasons. However, controversies surround its benefits and protective effects against STDs.<sup>4</sup> For genital warts, one study has reported a significant association with the lack of circumcision.<sup>5</sup>

Substantive evidence supports the premise that circumcision protects males from HIV infection, penile carcinoma, urinary tract infections, and ulcerative STDs.<sup>4</sup> Although it may be debatable to recommend circumcision to reduce the risk of acquiring any one of the other STDs/HIV infection in isolation, taken together however the psychological and sexual discomforts for the patients and their sexual partners with recurrent/persistent extensive prepuce warts, circumcision should be tried.

#### S Dogra, B Kumar

Department of Dermatology, Venereology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh, India

Correspondence to: Professor Bhushan Kumar, Department of Dermatology Venereology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh-160 012, India; kumarbhushan@hotmail.com

#### References

- 1 Clinical Effectiveness Group (Association of Genitourinary Medicine and the Medical Society for the Study of Venereal Diseases). National guidelines for the management of anogenital warts. *Sex Transm Infect* 1999;**75** (Suppl 1):S 71-5.
- 2 Beutner KR. Therapeutic approaches to genital warts. *Am J Med* 1997;**102**:28-37.
- 3 McMillan A. The management of difficult anogenital warts. *Sex Transm Infect* 1999;**75**:192-4.
- 4 Moses S, Bailey RC, Ronald AR. Male circumcision: assessment of health benefits and risks. *Sex Transm Infect* 1998;**74**:368-73.
- 5 US Bureau of the Census. Recent HIV seroprevalence levels by country: January 1998. Research Note No 24, January 1998.

Accepted for publication 16 January 2003

## Treatment of *Candida glabrata* using topical amphotericin B and flucytosine

We read with interest the article by White and colleagues on the treatment of *Candida glabrata* using topical amphotericin B and flucytosine because this infection can prove difficult to treat.<sup>1</sup> We have since used this treatment on a 28 year old woman with a 10 year history of recurrent candida.

The woman first attended our department complaining of a recurrent itchy white discharge. She had received numerous courses of antifungals including topical clotrimazole, oral itraconazole, and fluconazole with no relief. Vaginal swabs were positive for *C glabrata* and she was treated with nystatin pessaries 200 000 units at night for 14 nights. Culture was still positive for *C glabrata* at follow up 4 weeks later so she was advised to continue with nystatin pessaries for a further 4 weeks. On review she felt her symptoms were slightly better but she found the pessaries were not dissolving so she was switched to nystatin cream 200 000 units by

vagina for 28 nights. After this course of treatment she remained symptomatic and positive on culture for *C. glabrata*. Following the success with topical flucytosine and amphotericin B in the above article our pharmacist obtained this preparation. The patient was given amphotericin 100 mg plus flucytosine 1 g in Aquagel in a total 8 g dose, which was given by vaginal applicator nightly for 14 nights. She was reviewed 2 and 6 weeks after finishing treatment, her symptoms had greatly improved and cultures for yeast were negative on both occasions.

White's paper described the successful treatment of three patients with candidiasis using topical amphotericin B and flucytosine. Our patient makes up the fourth case of successful eradication of refractory vaginal *C. glabrata* using this combination which, like the other cases, was very well tolerated.

**S Shann, J Wilson**

Department of Genitourinary Medicine, Sunnybank Wing, Leeds General Infirmary, Great George Street, Leeds LS1 3EX, UK

Correspondence to: Dr S Shann, Department of Genitourinary Medicine, Sunnybank Wing, Leeds General Infirmary, Great George Street, Leeds LS1 3EX, UK; [siobhan.mcmyler@leedsth.nhs.uk](mailto:siobhan.mcmyler@leedsth.nhs.uk)

#### Reference

- 1 White DJ, Habib AR, Vanthuyne A, *et al.* Combined topical flucytosine and amphotericin B for refractory *Candida glabrata* infections. *Sex Transm Infect* 2001;**77**:212–13.

Accepted for publication 27 February 2003

## BOOK REVIEW

**Immunotherapy for Infectious Diseases.** Ed by Jeffrey M Jacobson. Pp 331; \$125. New Jersey: Humana Press, 2002, ISBN 0896036693.

I judge this is a jewel of a book, although you would not think so from my comments in the next paragraph.

My initial reaction was one of intense irritation. The preface stated that the intention was to "review the state of the art . . . of this rapidly emerging . . . field."

A bold promise for which tight editorial time lines and up to date references would be essential. Yet, even though the book was published in 2002, there were very few references from 2001 or even from 2000 in some chapters. To take as one particularly bad example, the chapter dealing with the immunotherapy of HIV had only one reference as recent as 2000, and all the rest were from the last millennium.

It is a credit to the book's other talents that my bad humour was rapidly dissipated. The introductory chapters were, quite simply, a pleasure. The basis of humoral immunity was a clear rendition of the area, and the chapter on the principles of cellular immunology was as good, and as enjoyable an introduction to the field as you could get. The final introductory chapter, on mucosal defences, maintains the high standards set by the first two.

The remainder of the book is divided into three sections covering the molecular basis for immunotherapy, immunotherapy for HIV infection, and immunotherapy for other infectious diseases. Each of these three sections provides a good review of the major issues. The molecular basis of for immunotherapy contains an excellent chapter on the role of dendritic cells, and usefully explains how their crucial role in immune defences might be utilised for immune therapy. The chapter on cytokines sheds light on an area which is too complex or obtuse for many.

The section on immunotherapy for HIV infection covers in turn the basis for immunotherapeutic HIV vaccines, passive immunotherapy, and gene therapy. There are some notable omissions dictated by the presumed delay between the research for each chapter, and publication of the book. For instance, RNA interference, sometimes known as post-transcriptional gene silencing, is currently being investigated as a possible major therapeutic strategy for the future. True, the problem of delivery to the target cells still has to be solved, but for RNA interference to be left out dates the book already. Similarly many of the viral and bacterial vectors for vaccine delivery worked on the past few years, such as adenovirus, and salmonella, to name just two, are not included. Even those that are, such as canarypox, are not included in the index. Which leads to my final criticism before summing up—the index is entirely inadequate and mitigates strongly against using this as a book of reference.

So in conclusion, this book represents a flawed gem. Viewed from a certain light it is illuminating, a joy to behold. From other angles, the imperfections are all too obvious. None the less, for a physician or scientist working in the field of infectious diseases or related areas such as STDs or HIV, it provides an introduction to the field of immunotherapy which is both accessible and enjoyable. Read it within the next couple of years before it begins to date further and it will be time well invested. For a specialist in the field it has limited value, except to recommend to trainees or newcomers.

If the editor decides to bring out another edition, he should somehow do the near impossible for multi-authored texts, and en-

sure they are all up to date. Oh, and also invest in a professional indexing service. Then, there really will be a precious jewel.

**Barry S Peters**

## NOTICES

### International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a web site ([www.herpesalliance.org](http://www.herpesalliance.org)) where patient information leaflets can be downloaded. Its sister organisation the International Herpes Management Forum (web site: [www.IHMF.org](http://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.

### Pan-American Health Organization, regional office of the World Health Organization

A catalogue of publications is available online ([www.paho.org](http://www.paho.org)). The monthly journal of PAHO, the *Pan American Journal of Public Health*, is also available (subscriptions: [pubsvic@tsp.sheridan.com](mailto:pubsvic@tsp.sheridan.com)).

### Australasian Sexual Health Conference: Tango down South—2003!

4–7 June 2003, Christchurch Convention Centre, New Zealand  
Further details: Dart Associates (tel: +02 9418 9396/97; email: [dartconv@mpx.com.au](mailto:dartconv@mpx.com.au); web site: <http://www.acshp.org.au>).

### 7th European Society of Contraception Seminar

12–13 September 2003, Budapest, Hungary.  
The 7th ESC Seminar on contraceptive practice in Europe: differences in availability and accessibility, will be held in Budapest Hungary. The main themes are availability and accessibility of: (1) contraceptive methods, (2) emergency contraception, (3) testing and treatment of sexually transmitted infections, and (4) abortions.

Further details: ESC Central Office, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 0852; fax: +32 2 582 5515; email: [esccentraloffice@contraception-esc.com](mailto:esccentraloffice@contraception-esc.com); website: [www.contraception-esc.com](http://www.contraception-esc.com)).