

MATTERS ARISING

Exophytic cervical warts—an indication for colposcopy?

The interesting letter from Murphy *et al*¹ on exophytic cervical warts and colposcopy has prompted us to report further analysis of our data on the relationship between CIN and specific STD. This is shown in the tables.

Our findings support Koutsky *et al*² in respect of gonorrhoea on univariate analysis (table 1), but no other significant associations appeared. Nevertheless, we agree that exophytic cervical warts should be an indication for colposcopy if only to ensure adequate treatment of the lesions as well as to detect the possible presence of squamous intraepithelial lesions (SIL) missed on cytological screening. Our experience with cytology was that 50% had HPV changes detected and 47% had dyskaryosis (17 mild and one moderate).

Entry of these additional STD variables into the stepwise logistic regression model (table 2) resulted in the appearance of oral contraception (RR 4.0), smoking more than 10 cigarettes a day (RR 2.5) and having had a baby (RR 3.3) as significant independent risk factors for CIN2 or 3.

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Table 1 Association with CIN: STD variables

STD	No CIN (n = 369)	CIN (n = 99)	p	CIN2/3 (n = 72)	p
Cervical HPV1	126	53	0.0007	34	<0.05
Anogenital warts	238	46	<0.001 (neg)	31	<0.001 (neg)
Cervical warts	31	7	0.82	4	0.43
Gonorrhoea	7	5	0.16	5	0.04
Chlamydial infection	38	14	0.37	7	1.00
NSU contact	18	6	0.83	4	1.00
Trichomoniasis	22	11	0.12	8	0.18
Bacterial vaginosis	9	3	0.90	3	0.56
Vaginal candidosis	141	35	0.69	22	0.27
Genital herpes	27	6	0.83	4	0.78

Table 2 Relative risks by stepwise logistic regression: CIN

Variables	All CIN			CIN 2/3		
	Step	RR	95% CI	Step	RR	95% CI
IUCD	1	14.2	3.7-54.1	1	15.3	3.0-76.8
Vulval warts	3	0.4	0.2-0.9	2	0.4	0.1-0.9
Coitarche <16	2	3.5	1.3-9.2	—	—	—
Oral contraception	4	3.0	1.1-8.6	4	4.0	1.0-15.5
Smoking >10/day	—	—	—	3	2.5	1.0-6.6
Baby	5	2.6	1.0-7.2	5	3.3	1.0-10.4

Pulmonary nocardiosis in a West African man with HIV-1 infection

We were interested to read the report of non-tuberculous cavitary disease due to nocardiosis in an Ivorian with AIDS.¹ We have also seen pulmonary nocardiosis in a 26 year old male from the Ivory Coast with advanced HIV disease. This man presented with a three month history of weight loss of 10 kg and shortness of breath, lassitude and fever for one week. He had lived in Europe for the last seven years and in the UK for the previous three months. On examination he was thin, febrile and had both pharyngeal candidiasis and signs of a respiratory infection. Initial investigations showed Hb 5.3 g/dl, WBC $4.2 \times 10^9/l$, platelets $187 \times 10^9/l$, reticulocytes $23 \times 10^9/l$; the blood film showed polychromasia, rouleaux, target cells; the direct Coombs tests negative, G-6PD assay 0.7 U/g Hb (normal 4.5—

13.6), normal blood urea levels, electrolytes and liver function tests were also normal. Antibodies were detected for HIV-1 but not for HIV-2. Further tests showed CD4 $30/mm^3$ (2%), normal cold agglutinins and clotting screen, bone marrow revealed myelodysplastic changes, with hypercellularity with no evidence of granuloma or lymphomatous infiltrate. Parvovirus antibodies were not detected. A chest radiograph initially showed collapse/consolidation of the left lower lobe. Sputum culture grew *Haemophilus influenzae* sensitive to amoxicillin, with which he was treated. The anaemia was thought to be directly related to HIV-1 infection rather than G-6PD deficiency and was treated with blood transfusion. Ten days later he had developed a left-sided pleural effusion which was drained. Bronchoscopy was normal. No pneumocysts were detected in bronchial washings stained by standard methods.

Specimens examined by microscopy from sputum, urine, stool, blood, bone marrow, pleural aspirate and bronchial washings were all negative for acid-fast bacilli as were subsequent cultures for *Mycobacterium tuberculosis*. Microscopy of specimens from bronchial washings stained by Gram's method showed small numbers of branching Gram-positive bacilli that were identified on culture as *Nocardia asteroides*. Intravenous co-trimoxazole was commenced but the patient developed progressive respiratory failure and died soon after, despite assisted ventilation.

Nocardiosis is rare in the UK but should be considered in HIV-positive patients with atypical radiographic lesions.² It may be that prophylaxis for *Pneumocystis carinii* pneumonia is masking the clinical presentation of nocardia in HIV-positive patients but co-trimoxazole does not confer complete protection.³ If nocardiosis were to be recognised as an AIDS indicator disease, more cases would undoubtedly be identified at an earlier stage than at present, and the poor prognosis currently observed when diagnosis is delayed³ would thereby be improved.

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This is a small collection which has not received any additions for many years, and it is clearly important that it should grow. Some funds may be available from the Society, and I would be glad to receive suggestions from members for possible additions to the collection. I would also like to suggest that members might consider donating books or conference proceedings; anything published before 1965 would be most welcome.

In these ways we could make our library a unique collection, of great value to present and future members of the MSSVD.

J D ORIEL
Honorary Librarian