Similar prospective studies in cohorts of patients with persistent generalised lymphadenopathy in the United States have reported rates of progression from 6% to 19% during median follow up times from 12·9 to 22 months.[1] The rates of progression in cohorts of patients infected with HIV with and without lymphadenopathy ranged from 8% to 34% over three years.[2] In a cohort of 1835 infected homosexual men followed up for a median of 15 months the annual incidence of AIDS in asymptomatic men compared with that in men with lymphadenopathy was not significantly different.[3] Prognostic markers for disease progression include clinical features such as fever and weight loss, oral candida, and leucoplakia, haematological and immunological abnormalities such as anaemia, cytopenias, particularly progressive depletion of T helper lymphocytes, increased serum IgA concentrations, impaired in vitro γ-interferon production, lymphocyte responses to pokeweed mitogen, and perhaps specific cellular responses to HIV.[3,4] More recently, a decline in the titre or the disappearance of anti-P24 (the antibody to HIV core protein) has been shown to predate the development of the full blown syndrome by up to 27 months.[5]

Many complex tests are not widely available to the general physician, and our study shows that a clinical examination and simple haematological measurements are useful in determining the risk of progression.

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A forgotten factor in pelvic inflammatory disease: infection in the male partner

Infection by *Chlamydia trachomatis* has been increasingly implicated in pelvic inflammatory disease in women.[1,2] While we recognise that pelvic inflammatory disease is often sexually transmitted, we know little about the sexual partners of women with the disease. *C trachomatis* has been isolated in up to half of all men with non-gonococcal urethritis.[3] Because some of these patients are asymptomatic they may fail to seek medical treatment and therefore spread the infection.

Methods and results

We studied women who presented at a sexually transmitted disease clinic with features of pelvic inflammatory disease. Their sexual partners in the previous three months were asked to attend for investigation.

All patients were seen by the duty doctor. A full clinical and sexual history was taken. Routine screening for *Neisseria gonorrhoeae*, *Trichomonas vaginalis*, yeasts, and syphilis was performed for all women.[4] For technical reasons *C trachomatis* culture could not be carried out for all the women. Each patient underwent bimanual pelvic examination. The criteria for diagnosing pelvic inflammatory disease were[5]: (*a*) lower abdominal pain with or without vaginal discharge, (*b*) adnexal tenderness with or without adnexal mass, and (*c*) positive cervical excitation.

Ultrasonography and laparoscopy were performed in three patients because of severe or equivocal physical signs.

Tests on the male contacts were performed only if they had held their urine for over four hours. Non-gonococcal urethritis was diagnosed if a Gram stained urethral smear contained 10 or more polymorphonuclear cells per field (1000 magnification) and microscopy and culture failed to show *N gonorrhoeae*.[4] Chlamydia cultures were taken from most of the male contacts.

Statistical comparisons were by the χ^2 test (with Yates's correction where indicated).

Fifty eight women were diagnosed as having pelvic inflammatory disease. Of the 45 in whom chlamydia cultures were taken, 16 (36%) gave positive results. One male contact for each of the 58 women was seen. Forty six of these men had non-gonoccocal urethritis, of whom 36 were symptom free. The remainder complained of slight urethral discharge or dysuria. *C trachomatis* was isolated from 10 of the 36 cultured, seven of whom were asymptomatic.

Six women admitted to having had a second male partner in the previous three months but these could not be traced. In addition, 11 men admitted to having had another female partner. There appeared to be no relation between concurrent sexually transmitted disease and pelvic infection or non-gonococcal urethritis.

Eleven of the patients with positive chlamydia cultures were taking oral contraceptives in contrast to seven of the 29 with negative chlamydia cultures ($\chi^2=40·07$, $p<0·001$). Only four patients were using an intrauterine contraceptive device.

Comment

The isolation of *C trachomatis* from the cervixes of 36% of women with pelvic inflammatory disease confirmed studies from Scandinavia and the United Kingdom which showed a 30-40% rate in pelvic infection diagnosed at laparoscopy.[1,2] The present study emphasises the high incidence of non-gonococcal urethritis among the male partners of women with pelvic inflammatory disease, over three quarters of whom were asymptomatic. Kinghorn *et al* studied women with more severe pelvic inflammatory disease than those reported here and showed that 56% of their male contacts had asymptomatic non-gonococcal urethritis.[2] Our study highlights the need to trace the sexual contacts of all women with pelvic inflammatory disease.

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Adverse reactions to drugs in children

Most studies of adverse reactions to drugs in children have observed those who received drugs in hospital or at home shortly before admission.[1-3] As the use of drugs in hospital is considerably different from that outside[2,4,5] the incidence and nature of adverse reactions might also be expected to vary.

We aimed to discover the incidence and nature of adverse reactions to drugs in a large group of children considered to be representative of the total child population.

Subjects, methods, and results

We surveyed 1590 children over two periods of 13 weeks in the summer and winter of 1984-5. They were pupils or siblings of pupils attending 19 infant care or educational establishments around Birmingham. Parents were asked to record on a weekly questionnaire the drugs being taken by their children, both prescribed and non-prescribed, and whether adverse reactions to the drugs had been seen.