Genitourinary Medicine

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This Journal, founded by the Medical Society for the Study of the Venereal Diseases, publishes original work on the investigation and treatment of genitourinary and allied disorders, and review articles, correspondence, and abstracts.

Advice to authors Papers for publication, which will be accepted on the understanding that they have not been and will not be published elsewhere and are subject to editorial revision, should be sent in duplicate to Dr A McMillan, Department of Genitourinary Medicine, Royal Infirmary, Lauriston Place, Edinburgh EH3 9YW. All authors must give signed consent to publication. The editor should be notified of any change of address of the corresponding author. Manuscripts will only be acknowledged if a stamped addressed postcard or international reply coupon is enclosed.

Full details of requirements for manuscripts in the Vancouver style (Br Med J 1982; 284:1766-70) are given in Uniform requirements for manuscripts submitted to biomedical journals, available from the Publishing Manager, British Medical Journal, BMA House (50p post free). Briefly details are as follows:

1. Scripts must be typewritten on one side of the paper in double spacing with ample margins. Two copies should be sent; if a paper is rejected, one copy will be retained.

2. Each script should include, in the following order: a brief summary, typed on a separate sheet, outlining the main observations and conclusions; the text divided into appropriate sections; acknowledgements; tables, each on a separate sheet; and legends for illustrations.

3. The title of the paper should be as brief as possible.

4. The number of authors should be kept to the minimum, and only their initials and family names used.

5. Only the institution(s) where work was done by each author should be stated.

6. SI units are preferred. If old fashioned units are used SI units should be given in parentheses or, for tables and figures, a conversion factor given as a footnote.

7. Only recognised abbreviations should be used.

8. Acknowledgements should be limited to workers whose courtesy or help extended beyond their paid work, and supporting organisations.

9. Figures should be numbered in the order in which they are first mentioned, referred to in the text, and provided with captions typed on a separate sheet. (Diagrams: use thick, white paper and insert lettering lightly in pencil.

Photographs: should be marked lightly on the back with the author’s name and indicating the top, and should not be attached by paper clips or pins. They should be trimmed to include only the relevant section (sizes 2½" or 5½" wide, maximum 5¼" x 7") to eliminate the need for reduction. Photomicrographs must have internal scale markers. X-ray films should be submitted as photographic prints, carefully prepared so that they bring out the exact point to be illustrated.

10. Tables should be numbered, have titles, and be typed on separate sheets. Please avoid large tables.

11. References should be numbered consecutively the first time they are cited and identified by arabic numbers in the text, tables, and legends to figures. Authors must take full responsibility for the accuracy of their references, and the list should be kept as short as practicable. It should be in the order in which references are first mentioned, and should include (in the following order), journals: author’s name and initials, title of paper, name of journal (in full or abbreviated according to the list in Index Medicus, year of publication, volume number, and first and last page numbers; books: author’s name and initials, full title, edition, place of publication, publisher, and year of publication. When a chapter in a book is referred to, the name and initials of the author of the chapter, title of the chapter, “In”: name and initials of the editor, and “ed” should precede book title, etc as above. In references to journals or books, when there are seven or more authors the names of the first three should be given followed by “et al.” Names of journals no longer published should be given in full — for example, British Journal of Venereal Diseases.

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Notices

Organisers of meetings who wish to insert notices should send details to the editor (address on the inside front cover at least eight months before the date of the meeting or six months before the closing date for applications.

Second world congress on sexually transmitted diseases (STDs)

The second world congress on sexually transmitted diseases (STDs) will be held at the Centre International de Congres de Paris (CIP), Porte Maillot, Paris, from 25 to 29 June 1986 under the patronage of the World Health Organisation and the International Union against Venereal Diseases and the Treponematoses. The general theme will be "STDs and their social and economic consequences".

For further information concerning registration, travel arrangements, hotels, etc. please contact the Commissariat General, 4 Villa d'Orleans, 75014 Paris, France.

Fourth international forum of andrology

The fourth international forum of andrology will be held on Thursday and Friday, 19 and 20 June 1986 at the Hotel Intercontinental, 3 rue de Castiglione, 75001 Paris, France.

Topics will be: prostatitis, acute and chronic; male contraception; male sterility, hormonal causes; and what's new in andrology (posters). Final programme will be available in May 1986. Official languages are French and English (simultaneous translations).

For further information please contact Professor G Arvis, Department of Andrology and Urology, Hopital Saint-Antoine, 184 rue du Faubourg Saint-Antoine, F-75012 Paris, France. Tel: 434373 40 or ARVIS 250 303 Public Paris.

The 24th British congress of obstetrics and gynaecology

The 24th British congress of obstetrics and gynaecology will be held in Cardiff, United Kingdom from 15 to 18 April 1986. The scientific programme will comprise main sessions of invited contributions and selected papers, seminars of submitted papers, and subsidiary sessions of posters, films, and videos. A full and varied social programme is also planned.

The preliminary programme and registration and abstract forms may be obtained from the congress office. Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regent's Park, London, NW1 4RG.

First international conference on homosexuality and medicine

The first international conference on homosexuality and medicine will take place in London on 14 to 16 August 1986. Programmes, registration forms, and abstract forms may be obtained from the GMA Secretariat, c/o Caroline Roney Medical Conference Organisers, 100 Park Road, London NW1 4RN (tel: 01 723 6722).

Eighth international meeting of dermatological research

The eighth meeting devoted to dermatological research will be held under the auspices of the Société de Recherche Dermatologique in Nantes, France on 9 to 11 October 1986. The meeting will be organised by the department of dermatology, Centre Hospitalier Régional de Nantes. Hôtel-Dieu, Nantes, France (Director, Professor H Barrière). Further information, abstract forms, and application forms may be obtained from Dr J F Stalder, CARD Service de Dermatologie, CHU 44035 Nantes, France.
List of current publications

These selected abstracts and titles from the world literature are arranged in the following sections:

Syphilis and other treponematoses
Gonorrhoea
Non-specific genital infections and related disorders (chlamydial infections; mycoplasmal and ureaplasma infections; general)
Pelvic inflammatory disease
Reiter's disease
Trichomoniasis

Candidosis
Genital herpes
Genital warts
Acquired immune deficiency syndrome
Other sexually transmitted diseases
Genitourinary bacteriology
Public health and social aspects
Miscellaneous

Syphilis and other treponematoses

Cerebral gumma: case report

Congenital syphilis revisited

This report from the Centers for Disease Control (CDC), Atlanta, examines clinical, laboratory, and management findings in the 50 cases of early congenital syphilis reported to the State of Texas in 1982. It defines appropriate diagnostic criteria, treatment, and follow up and will be a useful reference for physicians in the United Kingdom where congenital syphilis is now rare.

Of the 50 neonates, 47 were born live but six of them subsequently died. Sixty two per cent were symptomatic at birth and the authors consider that asymptomatic cases may be under-reported. The commonest clinical manifestations were prematurity and low birth weight, cutaneous lesions, and hepatosplenomegaly. Venereal Disease Research laboratory (VDRL) or rapid plasma reagin (RPR) serum tests gave negative results at birth in five cases. Cerebrospinal fluid VDRL tests gave positive results in over half those tested, regardless of whether they were symptomatic or not, and half had radiographic evidence of osteochondritis. Dark field microscopy and serum IgM estimation were not performed in any of the cases. There was a huge variation in management. All were treated with penicillin, but there were 21 different regimens and only 28% were treated with the preparations, dose, and duration recommended by the CDC. Only 26% were followed up.

Recommendations for the investigation of suspected cases include: physical examination, taking the maternal history, quantitative serological tests for syphilis, measuring serum IgM concentration, examining cerebrospinal fluid, radiography of long bones, and dark field microscopy of external lesions. Treatment and follow up schedules are suggested, and the need to screen other members of the family is emphasised.

M J Godley

Rheumatoid factor in syphilis

Biological false positives to serological tests for syphilis in herpes genitalis

Diagnostic considerations in intra-amniotic syphilis

Diagnosis of congenital syphilis by immunofluorescence following fetal death in utero

The outer membrane of Treponema pallidum: biological significance and biochemical properties

Detection of Treponema pallidum in lesion exudate with a pathogen-specific monoclonal antibody

Neonatal syphilis despite treatment of the mother with erythromycin

Penetration of oral doxycycline into the cerebrospinal fluid of patients with latent or neurosyphilis
List of current publications

**Gonorrhoea**

Gonococcal vulvovaginitis among female children in Malaysia
RI Smail, CK Toh, and YF Ng Eow (Kuala Lumpur, Malaysia). Sex Transm Dis 1985;12:114-6.

Gonococcal endocarditis during pregnancy: simultaneous cesarean section and aortic valve surgery

Localisation of gonococci in the anterior oral cavity – a possible reservoir of the gonococcal infection?

Conjunctivitis caused by β-lactamase-producing Neisseria gonorrhoeae

Destructive epidemic Neisseria gonorrhoeae keratoconjunctivitis in African adults

In an epidemic of Neisseria gonorrhoeae keratoconjunctivitis 16 patients were admitted to the Queen Elizabeth Central Hospital in Blantyre, Malawi, during a four month period in 1983. Simultaneously many other patients were seen in nearby hospitals with clinically similar infections. The patients studied comprised nine men and seven women (age range 18 to 60 years) with severe bilateral purulent keratoconjunctivitis. Because of shortage of culture media only five cases were confirmed by culture as being caused by N gonorrhoeae (all sensitive to penicillin), 10 were diagnosed by Gram stained smears, and the remaining case was diagnosed by the clinical appearance. All 16 patients had clinical “venereal” gonococcal infection. No chlamydial cultures were possible, but treatment included 1% tetracycline eye ointment with 1% atropine and crystalline penicillin eye drops plus procaine penicillin intramuscularly for nine days. Corneal melting and perforation with iris prolapse and endophthalmitis occurred in 10 eyes, of which five required enucleation. Thirteen additional eyes sustained severe visual loss secondary to corneal ulceration, leucoma, and healed corneal perforation.

No similar epidemic has occurred in this area, though sporadic cases were recorded. An annual seasonal epidemic of bilateral viral haemorrhagic conjunctivitis coincided with the epidemic and the gonococcal infection was possibly secondary to viral conjunctivitis. The route of transmission was probably by contamination from venereal infection through poor personal hygiene but also possibly through face washing in contaminated ground water during the rainy season. Contact tracing and detailed histories of sexual practices were not undertaken.

C Dixon

A community-based outbreak of infection with penicillin-resistant Neisseria gonorrhoeae not producing penicillinase (chromosomally mediated resistance)

Cohort trends in incidence of cervical cancer in Denmark in relation to gonorrhoeal infection

Penicillinase-producing Neisseria gonorrhoeae: epidemiology, antimicrobial susceptibility and plasmid types

Epidemiological characterization of Neisseria gonorrhoeae by lectins

Relationship between auxotype, plasmid pattern and susceptibility to antibiotics in penicillinase-producing Neisseria gonorrhoeae

Correlation of auxotype and protein I type with expression of disease due to Neisseria gonorrhoeae

Neisserial antigen H18 is immunogenic in patients with disseminated gonococcal and meningococcal infections

Gonococcal infection: a model of molecular pathogenesis

Role of anti-pilus antibodies in host defense against gonococcal infection studied with monoclonal anti-pilus antibodies

Effects of Mycoplasma hominis on in-vitro studies of Neisseria gonorrhoeae

Improved utility of Gonoscreen, a Limulus amoebocyte lysate assay, in the evaluation of urethral discharges in men

Evaluation of a one-hour test for the identification of Neisseria species

Rapid identification of penicillinase-producing Neisseria gonorrhoeae by detection of beta-lactamase in urethral exudates
In vitro activity of temocillin against Neisseria gonorrhoeae including penicillinase-producing strains

Single dose therapy with temocillin in acute gonorrhoea

Treatment of gonorrhoea with clavulanate-potentiated amoxicillin (Augmentin)

In vitro activity of Ro 15-8074, a new oral cephalosporin, against Neisseria gonorrhoeae

Non-specific genital infections and related disorders (chlamydial infections)

Recovery of Chlamydia trachomatis from the endometrium in infertile women with serum anticlamydial antibodies

Prevalence of Chlamydia trachomatis in the pregnant cervix

A prospective study of Chlamydia trachomatis in first trimester abortion

Comparative sensitivity of different serological tests for detecting chlamydial antibodies in perinatally infected newborn infants

Screening for Chlamydia trachomatis infection in an inner-city population: a comparison of diagnostic methods

Cryosurvival of Chlamydia trachomatis during cryopreservation of human spermatozoa

The declared aims of this study were to establish whether (1) direct monoclonal fluorescent antibody staining (using the MicroTrak system) detects Chlamydia trachomatis in infected human semen. (2) C trachomatis survives in semen after cryopreservation, and (3) the MicroTrak system could be used for routine screening of donated semen before cryobanking.

Ejaculates were obtained from five men participating in a semen donor programme. After liquefaction the samples were inoculated with C trachomatis to contain about 10⁶ inclusion forming units/ml. The infected specimens were diluted 1:10 with culture medium and then exposed to the cryoprotective agent, glycerol, by stepwise addition and mixing until a 10% concentration by volume was achieved. Straws were filled with about 0.4 ml of glycerolated semen to provide control (unfrozen) and experimental (frozen at –196°C for two hours or six months) samples. C trachomatis elementary bodies and inclusions with elementary bodies were detected by the monoclonal fluorescent antibody and culture techniques, respectively, in all unfrozen and frozen and thawed specimens. There was no evidence of interference by semen in the qualitative detection of chlamydial infection in the presence of the cryoprotective agent or cryopreservation.

Further clinical studies are required to assess whether a direct monoclonal fluorescent antibody technique would be valuable in the routine screening of donated semen. The dilution of infected semen with culture medium may also enhance the subsequent viability of the inoculated agent, and further studies omitting this stage are important.

RS Pattman

Human immune response and Chlamydia trachomatis infection

Rapid immunotyping of Chlamydia trachomatis with monoclonal antibodies in a solid-phase enzyme immunoassay

Pelvic inflammatory disease

Anatomic sites of upper genital tract infection

High failure rates in outpatient treatment of salpingitis with either tetracycline alone or penicillin/amoxicillin combination

Reiter's disease

An unusual case of Reiter's disease

Immunology of reactive arthritis and ankylosing spondylitis
GMÖLLER, ed. (Stockholm, Sweden). Immunological Reviews 1985;86.

Trichomoniasis

Trichomonas vaginalis infection in sexually abused girls

Candidosis

International symposium on vulvovaginal mycoses: June 1-3, 1984, Fort Lauderdale, Florida
List of current publications

Candida tropicalis vulvovaginitis

Effects of various antibiotics on gastrointestinal colonization and dissemination by Candida albicans

Unspecified numbers of mice were taken from the animal housing unit and placed in sterile covered cages. Members of one group were given water containing clindamycin, erythromycin, gentamicin, penicillin, or vancomycin. A control group was housed identically without antibiotic treatment. Three days later both groups received intragastric Candida albicans and were killed the following day. The caecal contents were removed, then the walls were washed and homogenised. Contents and walls were cultured for aerobic and facultative anaerobes and strict anaerobic organisms, in addition to C albicans. Spleen, kidney, and liver were cultured selectively for C albicans. Gastrointestinal and visceral organs were examined at 3, 12, and 24 hours for "the candida population levels". The results showed the dissemination of candida to the visceral organs in animals treated with antibiotics, but did not relate to any of the methods described previously and gave the impression that a section of the paper was missing. Results of the study described in the methodology text showed that penicillin, clindamycin, or vancomycin reduced the anaerobic population tenfold to 100-fold. As large numbers of organisms were being counted, these reductions did not seem to be exceptional. The enteric organisms were found to increase 10 000-fold. In contrast, in animals treated with gentamicin or erythromycin numbers of enteric and aerobic bacteria were reduced but anaerobes remained unchanged. The description of the bacteriology was very confusing and left an uncertain picture of what enteric bacilli were being cultured. The Gram stain was not helpful. In the mice treated with clindamycin, penicillin, or vancomycin large numbers of C albicans were found in the lumen and wall and candida was recovered from the visceral organs.

Based on these results the authors concluded that mice treated with clindamycin, penicillin, or vancomycin had decreased levels of strictly anaerobic bacteria and increased total enteric bacilli, which allowed C albicans to colonise and disseminate from the gastrointestinal tract. They suggested that strict anaerobes have an inhibitory effect on the enteric bacteria as well as on C albicans. This is an interesting theory, though I do not feel that it is backed by strong scientific evidence. The antibiotics used (penicillin, vancomycin, and clindamycin) have an effect on bacteria other than "strict anaerobes", and I think that an agent effective against anaerobes only (such as metronidazole) should have been investigated in this study.

MS Sprott

Ecology of Candida albicans gut colonization: inhibition of Candida adhesion, colonization and dissemination from the gastrointestinal tract by bacterial antagonism

Recurrent and persistent vulvovaginal candidiasis: treatment with ketoconazole

A new vaginal antifungal agent — butoconazole nitrate

Genital herps

Disseminated neonatal herpes simplex virus infection acquired from the father

Genital herps in pregnancy: risk factors associated with recurrences and asymptomatic viral shedding

Neutralising antibody against type I and type 2 herpes simplex virus in cervical mucus of women with cervical intra-epithelial neoplasia

Alpha-interferon and normal killer activity of lymphocytes in genital herpes and the influence of specific vaccine and interferon therapy on them

Antitherpeptic activity of xylure

Recurrent genital herpes suppressed by oral acyclovir: a multicentre double blind trial

Genital warts

Condyloma acuminatum of the bladder and associated urothelial malignancy

A black heterosexual man aged 33 presented with gross haematuria, weight loss of 13·6 kg, suprapubic discomfort, passing hard material in the urine, and other bladder symptoms of three months' duration. He was cachectic and had an enlarged smooth liver and multiple penile condylomata. Ten years before he had developed external genital condylomata acuminata, which were treated mainly with topical podophyllin. He had then developed urethral condylomata, which were treated with instillations of 5% 5-fluorouracil. He was lost to follow up, but three years later was seen with loin pain when a condyloma of the right bladder wall causing right hydronephrosis was found. A biopsy specimen showed condylomata acuminata without atypia or invasion.

Investigations disclosed raised liver enzyme activity, multiple liver and lung metastatic nodules, condylomata along the entire urethra with a urethrocutean fistula, a non-functioning hydronephrotic right kidney, and condylomata in the distal portion of the left ureter. Cystourethroscopy showed a soft fleshy growth of the bladder wall, which contained a hard mass deep within it and obstructed the right ureteric orifice. Histological examination of superficial and deep biopsy specimens showed condylomata acuminata and undifferentiated carcinoma, respectively.
Immunoperoxidase staining for papillomavirus gave positive results in the condylomata and negative results in the carcinoma. The patient showed no energy or immunodeficiency. Despite combination chemotherapy he succumbed to diffuse carcinomatosis, but a necropsy could not be undertaken.

Condylomata acuminata of the urethra occurs in about 5% of patients with genital condylomata, but bladder condylomata are extremely rare, especially in men, and this is the third case reported. In view of the possibility of iatrogenic seeding of the bladder during cystourethroscopy, the authors suggest anterior urethroscopic examination alone for mental condylomata.

KM Saravanamutti

Latent papillomavirus and recurring genital warts

Human papillomavirus types 16 and 18 sequences in carcinoma cell lines of the cervix

Interferon for the therapy of condyloma acuminatum

Acquired immune deficiency syndrome

Revision of the case definition of acquired immunodeficiency syndrome for national reporting - United States

Slim disease: a new disease in Uganda and its association with HTLV-III infection

Minimal change nephropathy in the acquired immune deficiency syndrome

Cryptococcosis in the acquired immunodeficiency syndrome

Retrovirus and malignant lymphoma in homosexual men

Transient antibody to lymphadenopathy-associated virus/human T-lymphotropic virus III and T-lymphocyte abnormalities in the wife of a man who developed the acquired immunodeficiency syndrome

Persistent noncytopathic infection of normal T lymphocytes with AIDS-associated retrovirus

Human T-lymphotropic retroviruses

Isolation of human T-lymphotropic virus type III from the tears of a patient with the acquired immunodeficiency syndrome
LS Fujikawa, Ss Salahuddin, and AG Palestine (Bethesda, USA). Lancet 1985;i:529-30.

Isolation of AIDS-associated retroviruses from cerebrospinal fluid and brain of patients with neurological symptoms

Isolation of AIDS virus from cell-free breast milk of three healthy virus carriers

Resistance of AIDS virus at room temperature

Disinfection and inactivation of the human T lymphotropic virus type III/lymphadenopathy-associated virus

Monoclonal antibodies specific for p24, the major core protein of human T-cell leukaemia virus type III

Activated interferon system in healthy homosexual men

Unexplained lymphadenopathy in homosexual men: a longitudinal study

The acquired immunodeficiency syndrome in a cohort of homosexual men: a six-year follow-up study

Isolation of infectious human-T-cell leukaemia/lymphotropic virus type III (HTLV/III) from patients with acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC) and from health carriers: a study of risk groups and tissue sources

Heterosexual transmission of the acquired immunodeficiency syndrome (AIDS)

Female prostitutes: a risk group for infection with human T-cell lymphotropic virus type III

Absence of antibodies to HTLV-III in health workers after hepatitis B vaccination

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List of current publications

Some problems in the prediction of future numbers of cases of the acquired immunodeficiency syndrome in the UK

Variation in human T lymphotropic virus III (HTLV-III) antibodies in homosexual men: decline before onset of illness related to acquired immune deficiency syndrome (AIDS)

Immunological changes in lymphadenopathy virus positive and negative symptomless male homosexuals: two years of observation

Which anti-HTLV III/LAV assays for screening and confirmatory testing?

Diagnosis of Pneumocystis carinii pneumonia by cytological examination of bronchial washings

Immunopotentiation of impaired lymphocyte functions in vitro by isoriposine in prodomal subjects and AIDS patients

Effects of suramin on HTLV-III/LAV infection presenting as Kaposi's sarcoma or AIDS-related complex: clinical pharmacology and suppression of virus replication in vivo

Vincristine therapy for Kaposi's sarcoma in the acquired immunodeficiency syndrome

9-(1,3-dihydroxy-2-propoxymethyl) guanine for cytomegalovirus infections in patients with the acquired immunodeficiency syndrome

Other sexually transmitted diseases

An outbreak of chancroid in Orange County, California: descriptive epidemiology and disease control measures

Trimethoprim sulphonamide in the treatment of chancroid. Comparison of two single dose treatment regimens with a five day regimen

The comparative in-vitro activity of twelve 4-quinolone antimicrobials against Haemophilus ducreyi

Prognostic value of quantitative HBsAg determination in acute hepatitis B

The effect of levamisole on the course of chronic cytomegalovirus infection in women

Genitourinary bacteriology

Qualitative and quantitative changes of the vaginal microbial flora during the menstrual cycle

Vaginal redox potential in bacterial vaginosis (nonspecific vaginitis)

In-vitro and in-vivo activity of metronidazole against Gardnerella vaginalis, Bacteroides spp, and Mobiluncus spp in bacterial vaginosis

Comparison of single-dose vs one-week course of metronidazole for symptomatic bacterial vaginosis

The treatment of Gardnerella vaginalis vaginosis: a randomized comparison of pivampicillin with metronidazole

Public health and social aspects

Sexually transmitted diseases in females in a juvenile detention center
TA Bell, JA Farrow, WE Stamm, CW Critchlow, and KK Holmes (Seattle, USA). Sex Transm Dis 1985;12:140-4.

Miscellaneous

Quantification of vaginal discharge in healthy volunteers
Treatment of vaginitis with benzydamine: preliminary results of a randomized study
A BREMOND, D ANDRÉ, L DUCRET, ET AL

Benzydamine for the topical treatment of vulvovaginitis in children and adolescents