taken.¹ They also, however, noted a rise in the number of cases of homosexually acquired gonorrhoea in 1990, with a rate of rectal infection of 6-9%.

In the three genitourinary medicine clinics in Riverside Health Authority 59 episodes of confirmed anorectal gonococcal infection occurred in 57 homosexual or bisexual men attending between 30 March and 8 October this year. Of these 57 men, 17 were known to be HIV seropositive and 19 HIV seronegative and 21 were untested for HIV antibodies. Thus while the rate of detection of rectal gonorrhoea in homosexual and bisexual men attending genitourinary medicine departments in this area is much lower than in the era before AIDS, there are no grounds for complacency as these men, regardless of their HIV status, are presumably continuing to have unprotected anal sex or failure of barrier methods.

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EDITOR,—D J Jones and B P Goorney's article on sexually transmitted diseases and anal papillomas contains many inaccuracies.¹

The incidence of sexually transmitted diseases affecting the anorectal region is not increasing in Britain^{2,3} or the United States.⁴ The authors state that "about one quarter of homosexual men attending screening clinics have anorectal gonorrhoea." A recent countrywide survey by the British Co-operative Clinical Group found between 3-4% and 2-7% of homosexual men had gonorrhoea (site unspecified).⁵ Our own (unpublished) data suggest that just over one third of these infections will be rectal, giving a prevalence of anorectal gonorrhoea among gay men attending a sexually transmitted disease clinic of not 25% but 1%.

The inguinal adenopathy in both primary and secondary syphilis is painless. The first serological test to yield a positive result in syphilis is the fluorescent treponemal antibody absorption test⁶ and not, as implied, the Venereal Disease Research Laboratory test. Condylomata lata, as manifestations of secondary (systemic) syphilis, are independent of the site of the primary chancre and may therefore represent infection acquired heterosexually, a more common occurrence in Britain today.⁷ A foul discharge is not characteristic of condylomata lata.

The authors confuse the clinical manifestations of the oculogenital strains of *Chlamydia trachomatis* (serotypes D to K, and commonly found in non-gonococcal urethritis) and those of the tropical disease lymphogranuloma venereum (serotypes L1 to L3). Lymphadenopathy (which may be painful) is associated only with lymphogranuloma venereum. It is not true that many people who practise anoreceptive intercourse harbour sub-clinical infections. Non-lymphogranuloma venereum *C trachomatis* was isolated from the rectums of only six of 150 homosexual men in one study,⁸ none of whom had any symptoms referable to the disease. Rectal stricture is a late complication of lymphogranuloma venereum, found predominantly in women and homosexual men. It is extremely rare in Britain.

Herpes simplex virus infection is an important complication, rather than manifestation, of HIV infection. Chronic mucocutaneous herpes simplex virus infection is not diagnostic of AIDS. Herpetic ulcers, with definitive identification of the virus,

persisting for at least one month in someone with a positive HIV antibody test result or evidence of immune deficiency (in the absence of any other cause) is an AIDS defining illness.⁹ The picture used shows herpes simplex virus infection of the buttock, not the anus. Diagnosing herpes simplex virus by cytological examination lacks sensitivity; culture of the virus is the usual method of diagnosis.¹⁰ The authors' description of an ulcerating proctitis is not characteristic of herpes simplex virus infection in immunocompetent patients, pronounced erythema being typical.

Cryptosporidiosis causes a profuse and watery (secretory) diarrhoea, which is not haemorrhagic.¹¹ Although oocytes may be found in rectal biopsy specimens, diagnosis is usually made by examination of the stool. Centers for Disease Control stage III refers to persistent generalised lymphadenopathy, patients being otherwise asymptomatic and well—we see no reason why they should be denied anorectal surgery.

Condylomata acuminata (viral warts) are caused by human papillomavirus. Proctoscopy may show lesions not only within the anal canal but also in the distal rectum. Polyps outside the anal canal may respond to application of podophyllin only if they are of viral aetiology. Cryotherapy and use of a laser, both useful methods of treatment, are not mentioned. Finally, it is surprising that there is no discussion of anal intraepithelial neoplasia and malignant change.

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AUTHOR'S REPLY,—Our article was intended to raise clinicians' awareness of the sexually transmitted diseases and anal papillomas that may present in the colorectal and anal region. We were unable to elaborate on such details as lymphogranuloma venereum causing rectal strictures as opposed to oculogenital strains of *Chlamydia trachomatis*. But several of the points raised by J Sherrard and colleagues deserve clarification.

Firstly, regarding the prevalence of rectal gonorrhoea in Britain, we meant to say that one quarter of homosexual men with gonorrhoea have rectal disease. We do not disagree with Sherrard and colleagues' data concerning gonorrhoea in homosexuals.

In the section on syphilis and the serological

tests used the Venereal Disease Research Laboratory test was discussed first in the context of patients presenting with a clinical lesion suggestive of early syphilis. We were not suggesting that it is the first test to show seroconversion after the acquisition of syphilis, which is the fluorescent treponemal antibody absorption test.

In the section on herpes the opening sentence mentions the infection in association with HIV infection; the assumption that we were referring to chronic mucocutaneous herpes simplex in an immunocompetent person is incorrect. Persistent or continuous mucocutaneous herpes with positive culture of the virus, particularly the aggressive and ulcerative variety, in a person with HIV infection (and in the absence of other cellular immunodeficiency) does indicate advanced HIV disease and, if of more than a month's duration, is an AIDS indicator diagnosis.¹

Although cryptosporidiosis and isosporiasis mainly cause a secretory diarrhoea, a haemorrhagic colitis has been described,² which responds promptly to cotrimoxazole.

We did not imply that otherwise well patients with Centers for Disease Control stage III disease, persistent generalised lymphadenopathy, should be denied anorectal surgery. The presence of important constitutional symptoms such as fever and weight loss also needs to be considered. As with any operation, the final decision to operate has to be based on the person's disease and condition.

Finally, with regard to anal warts and pre-malignant change, I would refer Sherrard and colleagues to the article on anal cancer in the ABC series.

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- 1 Wexner SD. Sexually transmitted disease of the colon, rectum and anus. *Dis Colon Rectum* 1990;33:1048-62.

Health checks for people over 75

EDITOR,—Like Andrew Barker and colleagues¹ I am disappointed that so many general practitioners fail to take the opportunity that the annual health check for people over 75 provides to assess dementia. In March 1990 the Alzheimer's Disease Society circulated all 35 000 general practitioners in the United Kingdom with an information pack containing a copy of the abbreviated mental test score.² The society would be pleased to supply, free of charge, a copy of the test to any general practitioner who did not receive one or has mislaid it. The society will also make available its publication on managing dementia.³

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EDITOR,—Few people doubt the utility of mental test scores when used as clinical instruments or research tools. Andrew Harris¹ and Andrew Barker and colleagues² suggest that community screening for cognitive impairment in older people with these scores may be useful; this seems optimistic in the light of problems with interpreting the results.³ The Folstein mini-mental state examination was recently selected as one of two questionnaires with the most robust scientific background.⁴ Its positive predictive value for organic brain disease in community screening was, however, only 55% at the