Highlights from this issue

doi:10.1136/sextrans-2016-052919

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As we go to press, life feels very uncertain for many of our readers. The USA awaits the outcome of a presidential election in which one of the candidates promises a punitive and intolerant approach to the health consequences of migration and diaspora. In the UK, where the majority of our print subscribers are based – the seasons celebrated by the thump of STI journal on the doormat – our new government is widely seen as promoting xenophobia, even racism. And Syria burns.

It is at times like this it is important to remember the special place of venereology - now genitourinary medicine or sexual health - and its origins amidst the wreckage of war and migration.[1–3]

I recently visited a relative having a rough post-operative ride, and chatted to the physician checking her over. He asked what I specialised in, and when I told him he visibly shuddered. It's a while since I last met with a reaction like this from a colleague, and it reminded me of how important it is to tell our colleagues and the public about the value of our work. When I first started in genitourinary medicine as a clinical assistant, my consultant Dr Stephen Tchamouroff warned me that while people would thank a cardiologist at parties for operating on themselfor their aunt or father, no such thanks could be offered for treating their gonorrhoea. Our speciality emerged out of concern at the effects of syphilis and gonorrhoea on the war effort, at a time when the maimed sufferers of tertiary syphilis filled the mental asylums which would only begin to empty after the advent of penicillin. Venereal diseases were heavily stigmatised and carefully concealed while contemporary art and literature are shot through with the fear they evoked.

Migration, displacement by war or natural catastrophe, yearning to join family or beloved and for a better life – all these are and will always be at the heart of human experience. International aid efforts focus on nutrition, the care of life-threatening disease and (sometimes and where possible) HIV and STI prevention. The job of the STI clinician is of course to develop and support preventive and treatment services, many of which nowdays can be simple, cheap and even online. Our duty is also to provide a place of refuge and light for those whose journey through life has made them more vulnerable.

Over the coming year, we will be publishing with BASHH a print and online series to celebrate the centenary of venereology in the UK. Much has changed in the UK since 2017. Congenital syphilis is now a rare disease, antibiotics have revolutionized the treatment of gonorrhoea (for the time being), and HIV is currently treatable chronic condition once diagnosed. Yet as the world's most international STI journal, every issue we publish shows us that the vulnerabilities which created our speciality remain, and are often increasing, across the world. How can displaced women protect themselves against STI and HIV with condoms? Logie and colleagues address this question in a Haitian study.[4] How do minority ethnic groups access HIV care? This is explored by Nadol.[5] How do different groups of sex workers protect themselves.[6] Can we reduce the huge toll of congenital syphilis, and how?[7] It's true that recent communication technologies provide genuinely new challenges in prevention and surveillance.[8 9] New technologies for transferring gender have created novel patterns of risk[10 11] and clinical manifestations.[12] Novel diagnostic technologies and the discovery of new microbes really do change the landscape.[13 14] The science has changed, and new technologies such as HPV make a real difference to prevention that will transform the clinical landscape.

But as the political landscape darkens, we must remember who we are and where we came from. We must continue to stand up for global populations vulnerable to STIs and HIV, even as our political leaders create ignorance and fear.

Competing interests None.

Provenance and peer review Commissioned, not peer reviewed

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