have both dyskaryosis and warts. A group with both dyskaryosis and warts is not included in the hypothetical example. If it had been, assuming that dyskaryosis and warts were independent risk factors for CIN, the relative risk for the group with both dyskaryosis and warts would be 16 × 4 = 64. This would imply that 100% of the outcome of dyskaryosis and warts would have CIN. The 2 × 2 table would now be:

<table>
<thead>
<tr>
<th></th>
<th>No CIN</th>
<th>CIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Warts</td>
<td>55</td>
<td>45</td>
</tr>
<tr>
<td>Warts</td>
<td>20</td>
<td>30</td>
</tr>
</tbody>
</table>

giving a relative risk of 1.83—more than 10 times the 0.17 obtained by Dr Renton and his colleagues from their inappropriate example.

We thank your correspondents for their combined interest in our paper.


National STD trends in Zambia 1987-89

In their review of national STD trends in Zambia, Matondo concludes that there has been a decline in STDs since 1987.1 This, it is stated, has occurred in spite of the increase in the number of STD clinics.

I wish to point out, however, that the data presented do not make a strong case for reaching this conclusion. The figures presented are absolute numbers of total cases and number of cases of each particular condition. This does not clearly show any shift in any direction as the data are influenced by various qualitative and quantitative factors. The assertion that because all clinics reported a decline suggests a genuine decline in STDs is not valid and needs clarification. This assertion can only be proved by establishing that a similar decline in outpatient attendances did not occur. It is known, for instance, that the economic situation in Zambia worsened during the period under study. This resulted, as expected, in a reduction in the resources allocated to health services. Consequently, there was a reduction in the availability of drugs and personnel with a subsequent decrease in hospital utilisation in some years. Health facility attendance for all conditions declined over the years though not uniformly. Although a decline in numbers of STD attendances did occur during the period in question, there was no decline if taken as a proportion of the total number of attendances. The decline reported is therefore an apparent decline and not a genuine one.

Individuals who do not seek medical care from health centres and hospitals go elsewhere, as Dr. Matondo rightly points out. It is necessary, therefore to study STD trends among private practitioners, traditional healers and other informal health workers before being conclusive of declines. It is possible that there is an inverse relationship between the number of people who attend hospitals and those seek treatment elsewhere.

Although the AIDS control programme in Zambia was established in 1986 and the STD programme in 1980, it was not until 1988 that massive health education campaigns were initiated. It is not likely that there were positive outcomes of these initiatives as early as 1988. As STD trends can be used as a surrogate marker for sexual behaviour change, trends in HIV infection also can be used as a proxy indicator for STD trends. Contrary to Matondo’s findings, HIV surveillance data have shown increases in sero-prevalence rates in antenatal clinic attenders and blood donors during that period.2

In a paper presented at the International Conference on AIDS in Africa, Kinshasa, we reviewed data from STDs in Zambia and were able to conclude that it was possible to infer wrongly that a decline had occurred if the data did not take account of various quantitative and qualitative factors.3 In addition we showed that when rates are calculated using outpatient attendances as denominators fluctuations, and not a steady decline in trends, is noted.

It is for this reason that the data presented should have considered rates and not absolute numbers. By calculating the rates, the total number of individuals attending a particular site for any reason should be taken as a denominator. This is so that the biases introduced by factors that affect health services utilisation and provision are considered.

I wish to suggest, therefore, that Matondo re-analyse his data and use outpatient attendances for each person as a denominator. This will allow comparisons of rates as opposed to absolute numbers. In addition we suggest that tests of significance are performed on the data to validate whether any changes in trends are statistically significant and present a genuine decline in STD trends.

GEORGE TEMBO
Epidemiologist AIDS Control Programme PO Box 6, Entebbe, Uganda


HIV infection in Tirupathi, India

I refer to the comments of Ravi Sockanathan, Genitourin Med, 1992;68:199. I must point out that vast numbers of non-Hindus also exist in Tirupathi and these include Muslims, Christians and others. It is therefore completely inappropriate to single out Hindus. Also, in a country with so much illiteracy as India, posters on sexual topics would be ill received. Television might help but what is really needed is education of the population as a whole. In the field of genitourinary medicine in particular much attention needs to be paid to differences between cultures.

STHARAKARAM
The Royal Infirmary
New Durham Road,
Sunderland SR2 7JE, UK

Sockanathan replies: I refer to the comments of Dr S Tharakaram and value his suggestions, indicating that TV programmes and education of the population as a whole would raise the public awareness of the prevalence of HIV infection in Tirupathi and South India. It is certainly not been appreciated that holiday makers from Europe who are unaware of the prevalence of the disease in these areas, will certainly be infected by health education campaigns. Radio and television programmes may be a source of information for the local population only. Therefore the lay press published in the western world indicating the prevalence of the disease in these areas will certainly increase the awareness amongst holiday makers and some pilgrims!

Iliteracy in India, should not form a barrier for health education programmes. A standard protocol for condom promotion and control of sexually transmitted diseases1 should be followed in the tropics and developing countries as recommended by the World Health Organisation.

Although the epidemiology health education programmes of sexually transmitted diseases in the tropics vary from that in the developing countries,1 it is well known that British yardsticks and methodology are used in many parts of the world including India.

RAVI SOCKANATHAN
Department of Genito-urinary Medicine
United Leeds Teaching Hospitals
Leeds General Infirmary
Leeds LS1 3EX, UK


Exophytic cervical warts—an indication for colposcopy?

In their recent paper, Evans et al conclude that external anogenital warts are not a risk for subclinical cervical HPV infection or for CIN and therefore not an indication for colposcopy.1 In contrast to external exophytic warts, cytological and histological evidence of cervical HPV infection was strongly associated with all grades of CIN. The authors suggest that external exophytic anogenital warts may in fact have a protective effect on the genesis of CIN. However, Evans et al make no comment on the relationship of exophytic cervical warts, as distinct from subclinical cervical HPV infection, to CIN.

Approximately 6% of women with genital warts may have exophytic cervical warts.2 The practice at this unit is to perform colposcopy on all women with clinically apparent exophytic cervical warts regardless of the result of cervical cytology. In a preliminary study we reviewed the cytological, colposcopic and histological findings of all patients who had colposcopy performed primarily for this indication. Thirty four patients were identified over a 6 month period, of whom 82.4% had concomitant vulval warts. Only four (11.7%) women had histological evidence of HPV infection. Dyskaryosis was found in 9/34 (26.5%). Twelve patients had normal cytology, two of whom had CIN (grade 2) on histology (negative predictive value 83%). Nineteen patients had low grade smears (inflammatory, borderline, wart virus infection, mild dyskaryosis) of whom four had CIN 1 and two CIN 2. Overall 9/34 (26.5%) women
HIV infection in Tirupathi, India.

S Tharakaram

_genitourin Med_ 1993;69:81
doi: 10.1136/sti.69.1.81-a

Updated information and services can be found at:
http://sti.bmj.com/content/69/1/81.2.citation

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/