urogenital discharge was noted. Microscopy of a Gram stained urethral specimen revealed Gram negative, intracellular diplococci for which he was treated immediately with a dose of 400 mg of ofloxacin. A provisional diagnosis of first episode of herpes simplex virus infection of the oropharyngeal cavity was made, and he was advised to take aciclovir 200 mg × 5 for 5 days.

The patient reported to have always practiced homosexual urogenital sex and had never practised anal sex. The sexual history of the recent casual partner was not known. He admitted to having had a similar sexual contact with another male partner 10 weeks earlier. This was his previous regular partner for 5 years who had no known history of genital herpes.

He returned after 10 days when he was reported to be well and asymptomatic. On examination the oropharyngeal ulcers were noted to be almost healed. A test of cure for N. gonorrhoeae from a urethral specimen was reported negative on microscopy. A blood sample was sent for a repeat estimation of HSV antibody.

Herpes simplex virus type 1 (HSV-1) was isolated from the specimen from oropharyngeal ulcers in cell culture. The serum HSV-1 antibody level showed a significant rise from less than 1 in 10 during the first visit to more than 1 in 40 on the tenth day during the follow up visit. This rise in HSV-1 antibody level was consistent with seroconversion for HSV-1.

Microscopy result of N. gonorrhoeae from the urethra on his first visit was confirmed on culture. A pharyngeal specimen did not grow N. gonorrhoeae.

Protection of a high proportion of HSV-1 among women with first episode of genital HSV infection was first reported from Sheffield. Since then an annually increasing prevalence of HSV-1 in female genitourinary herpes has been reported by others. The practice of cunnilingus has been proposed as one of the possible causes of such a trend. It seems reasonable to assume that such sexual activity could similarly lead to a transmission of HSV from the genital area to the oropharyngeal cavity. In the present case, the occurrence of herpetic lesions in the oropharyngeal cavity within 1 week of unprotected genitourinary contact suggests possible transmission of HSV-1 from the genital area to the oropharynx. A first episode of genital HSV-1 infection almost always indicates a true primary infection with HSV. Thus, seroconversion for HSV-1 in the present case suggests primary infection with this virus and also substantiates the possibility of transmission of HSV from recent genitourinary contact.

The incidence of sexually acquired oropharyngeal herpes due to HSV may increase as a result of increased prevalence of urogenital sexual activity. Because of the risk of transmission of HSV from asymptomatic viral shedding, the prevalence of HSV carriage and shedding from the oropharynx of sexually active adults needs to be investigated. During counselling, the possibility of acquisition of HSV from oropharyngeal cavity from the anogenital region, and vice versa, should be discussed.

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Syndromic management of sexually transmitted diseases

The WHO has recently recommended the syndromic approach for management of various sexually transmitted diseases. This is being adapted as an increasing number of countries as it is easy, adaptable, safe, and efficacious. However it has also received some criticisms.

In the Sultanate of Oman, STD prevalence is estimated to be around 121/100 000 and the predominant STDs are gonococcal urethritis, non-specific urethritis, and syphilis (particularly latent syphilis). Infections like granuloma inguinale and lymphogranuloma venereum are common.

In Oman, the syndromic approach for management has recently been adapted as part of the national STD control programme. A national STD manual has also been released and has been made available to all healthcare providers. However, we have made certain modifications to adapt it to the prevailing local conditions, after consideration of the various comments made about the approach reported in the literature. We highlight these modifications to show how the approach can be successfully adapted to local conditions.

One well meaning criticism is that the WHO recommendations do not include mandatory testing for VDRL and HIV infection. This is particularly relevant in view of the well established link between HIV infection and other STDs. Since facilities for the transport of blood samples do not exist in Oman, we have made it a mandatory requirement for all cases of STD to be investigated with VDRL and ELISA for HIV infection. This will help in detecting latent syphilis/HIV infection.

Another valid criticism is that, with the syndromic approach, data collection and statistical analysis of individual STDs, becomes impossible and would affect future planning. To overcome this, we have introduced a monthly STD form (in addition to tally sheets for syndromic approach), to be completed by all healthcare providers. However, this form is not available in all healthcare facilities. This is an important. We have included a special section on interpretation of VDRL in our STD manual, for this purpose.

As can be seen, our syndromic approach provides a simple model which can be adopted quite easily to the regional situation. We hope our letter will stimulate similar modifications elsewhere.

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Decline in the incidence of HIV test requests in general practices in Amsterdam after 1992

I wish to report an interesting trend in HIV test seeking behaviour in Amsterdam, where half of all AIDS cases in the Netherlands have occurred. To assess trends in HIV test seeking behaviour and HIV prevalence in the
Syndromic management of sexually transmitted diseases.

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