Is bacterial vaginosis a sexually transmitted infection?

EDITOR—I have a concern about a reference used in the article "Is bacterial vaginosis a sexually transmitted infection?" in the February issue of STI.

I have a particular interest in BV, especially in the potential for BV to be sexually transmitted between women. In the recent article, the authors state that: "...past studies focusing on concordant BV infections within lesbian couples have failed to produce consistent results." To this statement there were two references. One supported concordant BV results in lesbian couples, but the second reference referred to an article about treating urethritis in men in developing countries. It is no wonder they didn’t find any evidence of BV transmission between women.

Previous studies have consistently demonstrated higher rates of BV in women who have sex with women. Further studies are needed to better understand the transmission dynamics of bacterial vaginosis between women.

KATH FETHERS
Alice Springs Sexual Health Unit, Alice Springs Australia
Correspondence to: Katherine.Fethers@nt.gov.au


Accepted for publication 10 May 2001

Dial 1097 (toll free)

EDITOR—Even as psychologists the world over ponder over whether computers can be good psychotherapists, computerised AIDS helplines are operating successfully in 35 Indian cities. The strategy behind these helplines is that as AIDS has no cure and prevention is its only remedy, "greater AIDS awareness" is akin to "greater AIDS prevention."

Chandigarh AIDS hotline is a computerised telecounselling service which is a joint venture of a non-government organisation (NGO) called "Servants of the People Society" and the State AIDS Control Society, Union Territory, Chandigarh. This helpline was started in January 1999 with the motive of "AIDS prevention" through "AIDS awareness." It is a 24-hour computerised interactive voice response service which is accessible on a 4-digit number (1097) by telephone. Confidentiality and anonymity of the caller are the hallmarks of this service. HIV/AIDS hotline is a toll-free service that provides information and counselling on HIV/AIDS-related issues in English, Hindi (national language), and Punjabi (regional language). The service consists of two parts—a prerecorded "standard question" option and a "specific inquiry" option. The prerecorded standard coded questions are:

- Code 1: What is HIV/AIDS?
- Code 2: How does it spread?
- Code 3: How is HIV not transmitted?
- Code 4: Prevention of HIV/AIDS
- Code 5: Symptoms of HIV/AIDS
- Code 6: Where is HIV testing done?
- Code 7: Relation of IV drug use and HIV
- Code 8: About STDs and HIV
- Code 9: Other specific queries on HIV/AIDS which are recorded and are replied to within 72 hours.

Details of the calls received from January 1999 to December 2000 are as follows:

- Total no of calls: 293,091
- Average calls per month: 12,212
- Average calls per day: 401
- "Language-wise" calls (%):
  - Hindi: 53.1
  - Punjabi: 30.3
  - English: 16.6
- "Code-wise" calls (%):
  - Code 1: 18
  - Code 2: 27.3

Accepted for publication 10 May 2001

Reply

EDITOR—I thank Dr Fethers for pointing out the discrepant reference in our paper.

The discussion paragraph referred to conflicting results from studies focusing on the transmission of bacterial vaginosis (BV) in lesbians. A cross-sectional prevalence study by Berger et al among monogamous sexual partners reported that of 11 index women with BV, eight (72.2%) had partners with BV. This compared with only one (10%) partner with BV of the 10 index women without infection. The high level of concordance was attributed to the probable sexual transmission of BV within lesbian couples.

The evidence against the sexual transmission of BV among lesbians should have referred to a paper by McCaffrey et al, though this was not among concordant partners. This study of sexual practices among women attending a specialist genitourinary medicine clinic in London reported that of 15 exclusively lesbian women, 40% had BV compared with 55% of the 76 women who were not exclusively lesbian. Therefore, the presence of BV did not appear related to sexual practices among lesbians.

I hope that the matter has now been clarified.

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Accepted for publication 10 May 2001


Rates of gonorrhoea and chlamydia in black ethnic groups

EDITOR—In their cross-sectional study of patients attending 11 clinics in London, Low et al report the incidence of both gonorrhoea and chlamydial infection to be higher in black Caribbean and black “other” ethnic groups than in black Africans. Neither the authors nor the writers of the accompanying editorial refer to similar findings in black men attending one of the clinics contributing to their study, which we published in 1999.

(Continued on following page)
We compared black African men with black Caribbean men and found that Caribbean men were less likely to be married (odds ratio (OR) = 0.03) and to have non-regular partners (OR = 0.09) but more likely to be from blue collar (OR = 250) or white collar (OR = 25) class and to be smokers (OR = 50). Caribbean men were more likely to have daily vaginal intercourse (OR = 33), begin intercourse before 16 years of age (OR = 50), and have gonorrhoea and/or chlamydial infection (OR = 12.5).

Among Caribbean men, the risk factors for gonorrhoea were being teenaged (OR = 9.5) and commencing intercourse before 16 years of age (OR = 3.3) and for chlamydial infection having had multiple partners (OR = 10.5).

Our conclusion was that the problem should be addressed by the setting up of more ethically acceptable clinical services before the appearance of HIV infection.

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KEN MacRAE
Postgraduate Medical School, University of Surrey, Guildford

Correspondence to Dr B A Evans

2 Zeinman JM, Shahmanesh M, Winter AJ. Ethnicity and STIs: more than black and white. Sex Transm Inf 2001;77:2–5.

Accepted for publication 22 May 2001

Human papillomavirus PCR direct sequencing study of cervical precancerous lesions in Quebec children

Editor,—Similarly to adult pathology, human papillomavirus (HPV) infection is the most common sexually transmitted disease in adolescent girls, whose prevalence is 16% according to one US study.1 However, little or no HPV sequencing data from paediatric specimens are available. We used our two-tier polymerase chain reaction (PCR) direct sequencing (PCR-DS) approach2 to study cervical biopsies from 44 adolescent Quebec girls (14–17 year old) who originated from various social and ethnic groups, as well as geographically distinct areas of Quebec. Written informed consent about the use of the specimens was obtained from the ethics committee of this institution. All biopsies were analysed for histological changes and presence of HPV specific DNA. Most of them (n = 36) were diagnosed as cervical intraepithelial neoplasia (CIN), seven as inflammatory changes, and one as “nil.” Among the 36 CIN, 33 (92%) tested HPV positive, including all CIN-II and CIN-III samples.

Sixteen HPV types were detected, four of them in more than two samples: HPV6 (n = 8), HPV16 (n = 7), HPV11 (n = 3), and HPV13 (n = 3). In the group of cervical biopsies from adolescent girls with CIN (n = 36, age 14–17), as well as in the larger control group of adult women (n = 487, age 18–72), the percentage of high risk HPV types increased, and the low risk HPV types decreased with the progression from low grade (CIN-I) to high grade (CIN-II and III) precancerous lesions. High risk HPV represented all but one HPV type (33/34) identified in CIN-III lesions from adult women, and all HPV types from 14–17 year old girls with CIN-III (fig 1).

The informative value of HPV testing in CIN, hence its clinical relevance, depends on whether there is an increase of the high risk HPV types in more advanced grades of precancerous lesions. The currently available data are conflicting. Some groups reported an increased frequency of high risk HPV from CIN-I to CIN-III, at the expense of the low risk HPV types,3 but others insisted that the high risk HPV rates in CIN-I, CIN-II, and CIN-III were similar.4 Our results indicate that the high risk HPV types are significantly increased from less than 50% in CIN-I to almost 100% in CIN-II and III, and this is valid for the adolescent and adult patients alike (fig 1). We hypothesise that the reasons for the discrepancies in the detection rate of various HPV types in CIN-I, CIN-II, and CIN-III may be due to the fact that some groups used the method of PCR with single pair of primers, MY09/11, which may be underrepresenting the most frequent low risk HPV types, up to a complete lack of detection for HPV6 and HPV11.5

This study indicates that a mass prophylactic HPV vaccine should be targeted at cohorts younger than 14–17 years, because at that age some girls already develop high grade precancerous cervical lesions with possible long term integration of the viral oncogenes in the host cell genome. We believe that a PCR direct sequencing approach to HPV testing will provide treating physicians and pathologists with precise HPV typing information, and may be used in vaccine design, application, and monitoring in children and adults.

Supported in part by the Canadian Institutes of Health Research (CIHR), grant number MOP-37874, Les Fonds de la recherche en santé du Québec (FRSQ), and La Fondation de l’Hôpital Ste-Justine (to WVY). WVY is a chercheur-boursier (scholar) of the FRSQ.

Corresponding author: WVY, wotovw@ere.umontreal.ca


Accepted for publication 7 June 2001

Substantial increase in gonorrhoea among homosexual men attending an STD centre in Toulouse, France

Editor,—A substantial increase in cases of gonorrhoea in an STD centre in Toulouse, France, was noted between October 1999 and September 2000. It was associated both with predominant transmission in a homosexual

www.sextransinf.com
A recent increase in gonococcal infections was also noted in England and Wales, the Netherlands, and France. The rise in cases among homosexual men and women was noted in the Netherlands and France. Our results suggest that the predominant mode of transmission is the practice of “safer sex” in a homosexual population, participating in only oral sex practices with occasional partners. Asymptomatic pharyngeal carriage may facilitate this epidemic course. High HIV seroprevalence in homosexual patients with gonorrhoea became a real problem during the last year of the serosurvey. All knew their serostatus, no one was found to be positive at the first visit, but 10 patients (50%) refused the HIV test. Among seropositive men, all participated in only oral sex practices, suggesting that they thought they were having safe sex.

In New York City a longitudinal incidence study conducted in one of the STD clinics identified a history of gonorrhoea as a predictor of HIV seroconversion and recent features suggest that oral sex is an independent risk factor of HIV transmission.

Our study represents only a few cases in a limited cohort of patients attending an STD centre. It may not reflect the tendency in the general population but may shed light on a new epidemic mode of transmission of gonococcal disease in a core group of highly HIV positive homosexual men practising oral safe sex. More studies must be done to determine if gonococcal asymptomatic carriage in oral sex can facilitate HIV oro-genital transmission with follow up for HIV serology in seronegative patients.

Adverse reaction to antymmocobacterials administered as a combination tablet with no reaction to the same drugs in isolation

**Letters, Books, Notices**

**Figure 1** Cases of gonorrhoea.

<table>
<thead>
<tr>
<th>Year of diagnosis</th>
<th>Number of episodes</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>1990</td>
<td>4</td>
<td>12</td>
</tr>
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<td>1991</td>
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<tr>
<td>2000</td>
<td>4</td>
<td>12</td>
</tr>
</tbody>
</table>

**Letters, Books, Notices**

**Figure 1** Cases of gonorrhoea.

**Letters, Books, Notices**

**Figure 1** Cases of gonorrhoea.

**Letters, Books, Notices**

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**Letters, Books, Notices**

**Figure 1** Cases of gonorrhoea.

**Letters, Books, Notices**

**Figure 1** Cases of gonorrhoea.
Increasing HIV prevalence in STD clinic attendees in Delhi, India: 6 year (1995–2000) hospital based study results

EDITOR.—The association between the occurrence of HIV infection and the presence of other STDs has been strongly established. STDs act as important co-factors that promote HIV transmission. The trend of HIV infection in STD clinic attendees, one of the high risk groups, may reflect the trends of HIV epidemic in the community. To estimate the frequency of HIV infection among various STD patients over a period of 6 years from January 1995 to December 2000 and to observe the interrelation between HIV infection and different other STDs, we analysed the HIV status of 1504 STD clinic attendees (M:F ratio 1:0.1, average age of 25.2 years) in Dr RML Hospital, a centrally located major tertiary care centre in Delhi. The breakdown in the number of STD attendees tested for HIV voluntarily out of total STD attendees was as follows: 180 out of 407 (44%) in 1995, 261 out of 513 (51%) in 1996, 245 out of 414 (59%), in 1997, 280 out of 363 (77%) in 1999; and 261 out of 513 (51%) in 1998 and 2000, respectively, among STD Delhi show 1.6% and 3.2% HIV infection in

1.7% HIV positivity among non-ulcerative patients with GUDs, in contrast with only
2.1% in 1997, 2.5% in 1998, 2.7% in 1999, 3.4% in 2000. The cumulative prevalence (1.7% in 1995, 2.2% in 1996, 2.1% in 1997, 2.5% in 1998, 2.7% in 1999, and 3.4% in 2000). These data as well as ours are comparable and support the belief that Delhi is still in a low level epidemic category.

From the experience of the Mwanza trial in Tanzania and the Rakai trial in Uganda, it is speculated that the effect of STD control on HIV transmission may decrease with the maturation of the HIV epidemic. Therefore, it is high time to extend vigorous intervention programmes in all high risk groups as well as the general population of this city which is still in the early epidemic phase to ensure this cost effective opportunity is not missed.

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The discrepancy in total number of patients in both groups is due to the presence of more than one STD in some patients.

Table 1 Frequency of HIV seropositivity in different sexually transmitted diseases

<table>
<thead>
<tr>
<th>Type of STDs</th>
<th>No of patients having same STD</th>
<th>No of patients found HIV seropositive</th>
<th>Seropositivity rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group I, ulcerated STDs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td>222</td>
<td>10</td>
<td>4.5</td>
</tr>
<tr>
<td>Chancroid</td>
<td>200</td>
<td>10</td>
<td>5.0</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>162</td>
<td>7</td>
<td>4.3</td>
</tr>
<tr>
<td>Donovonosis</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lymphogranuloma venerum</td>
<td>17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All ulcerative STDs</td>
<td>605*</td>
<td>27</td>
<td>4.5</td>
</tr>
<tr>
<td>Group II, non-ulcerative STDs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-gonococcal urethritis</td>
<td>102</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Condylomata acuminate</td>
<td>291</td>
<td>7</td>
<td>2.4</td>
</tr>
<tr>
<td>Gonococcal urethritis</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vaginosis</td>
<td>77</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Balanoposthitis</td>
<td>226</td>
<td>9</td>
<td>2.0</td>
</tr>
<tr>
<td>All non-ulcerative STDs</td>
<td>89*</td>
<td>15</td>
<td>1.7</td>
</tr>
<tr>
<td>All STDs</td>
<td>1504*</td>
<td>42</td>
<td>2.8</td>
</tr>
</tbody>
</table>

*The discrepancy in total number of patients in both groups is due to the presence of more than one STD in some patients.

Figure 1 A Prince Albert ring inserted through the external urethra and glans penis.
Safer sex in HIV infected patients in London: practices and risks

EDITOR.—Recent figures from the Public Health Laboratory Service (PHLS) report1 have shown the largest number ever of new cases of HIV infection (2968 cases) occurring 2000 in the United Kingdom. The majority of HIV infected individuals attending clinics for their treatment and care will have been counselled and strongly advised to practise safer sex. Specific risks of unsafe sex will be summarised, including the risk of transmission of HIV to their partners, as well as their own risk of acquiring new sexually transmitted diseases and the spectre of multirisk resistant HIV variants.

The overall effect of such safer sex messages were called into question by Dodds et al who recently reported evidence of an increasing incidence of high risk sexual behaviour among homosexual men in London. The accompanying editorial by Grulich2 called for improved data on risk behaviours, specifically in HIV infected individuals. We can present data on this from a questionnaire survey of patients attending the largest HIV outpatient centre in London. The questionnaire was distributed to 500 consecutive individuals attending the Kobler HIV outpatient clinic at the Chelsea and Westminster Hospital during spring 2000. The confidential questionnaire could be returned anonymously or with written consent. A total of 494 legible questionnaires were suitable for analysis. Anonymised questionnaires were received from 240 respondents, whereas 254 (50.8%) disclosed their identity, and 35 (7%) were female. Although 317 patients (64%) reported engaging in any unprotected sex in the previous 12 months, 173 (35%) individuals had unprotected vaginal and anal intercourse in a sample of homosexual men which reported a prevalence of 38%.3 On further analysis of this group, it was revealed that a substantially higher proportion, 93 (54%), had unprotected sex with more than five partners, of which 40% had more than 10 sexual partners in the past 12 months.

Only 252 patients had a sexual health check up in the past year. There was a significant association between having a check up and reporting having unprotected sex. However, of those who had unprotected penetrative sex in the past year, 67 (39%) did not have a sexual health screen. A sexually transmitted infection had been diagnosed in 41% of respondents in the past year, which was significantly associated with their increasing numbers of sexual partners.

We believe that major efforts to encourage sexual health check ups must be targeted to the key population of HIV infected individuals. The majority (76.2%) of our patients who had a sexual health check up in the last year, did so at the GU medicine clinic in the same building, contrary to the popular belief that HIV patients do not use local services for sexual health check ups.

Oral sex causing HIV transmission is biologically plausible though it is considered a less risky activity compared with unprotected vaginal and anal intercourse. However, the frequency of its occurrence may serve to increase its relative contribution to overall HIV transmission, especially in those with a check up in the past year. There was a significant association between having a check up in the past year. There was a significant association between having a check up and reporting having unprotected sex. However, of those who had unprotected penetrative sex in the past year, 67 (39%) did not have a sexual health screen. A sexually transmitted infection had been diagnosed in 41% of respondents in the past year, which was significantly associated with their increasing numbers of sexual partners.

Six per cent of our studied population believed they acquired HIV infection through unprotected oral intercourse only. On reviewing the notes of the identifiable patients we concluded that five out of these 15 patients had no other risk factor other than unprotected oral sex recorded at any time during their counselling or management records, which we can account for their HIV transmission. The remaining 10 patients’ notes did not have enough evidence to support their claim that they acquired HIV disease through oral sex only. Three out of five of these patients had never engaged in anal sex and the remaining two always used protection.

Following this observation we have further identified six patients who have probably acquired HIV through unprotected oral sex, and we can summarise data from all 11 patients. They were all homosexual men. Eight out of 11 never practised anal sex and the remaining three always used protection. Five of them were living with long term HIV positive partners and were fully aware of safer sex issues. However, all of the five considered unprotected oral sex as a safer activity. Six out of 11 were reported to have recurrent infections of the mouth; two had pharyngeal gonorrhoea, one had herpes simplex stomatitis, two had idiopathic ulcerative stomatitis, and the remaining one had his tongue pierced 10 weeks before his seroconversion. Although oral sex is a lower risk activity for HIV transmission, in compromising situations where the mucosal barrier of the mouth is not intact, it can play a larger part in HIV transmission and can possibly be the sole cause of transmission.

Despite the recent EAGA report, while such uncertainties about the contribution of oral sex to new HIV transmission exist, the delivery of clear safer sex messages to this and other groups will remain difficult to implement.

Our department is now developing a fast track service to enable HIV infected individuals to more easily combine sexual health screening with their HIV outpatient appointment. Efforts by both statutory services and advocacy and support organisations for HIV infected people need to be coordinated to promote these initiatives.

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WILLIAM RICHARDS
SIMON E BARTON
Department of HIV/GUM Medicine, Chelsea and Westminster Hospital, London


Accepted for publication 17 August 2001

BOOK REVIEWS


It has become increasingly clear that STIs cannot be controlled simply by diagnosis and treatment of the relevant pathogens alone. This volume on STI prevention is especially relevant as we struggle to provide access for those already infected with sexually transmitted organisms. My first thought when I looked at this book was influenced by the cover illustration of a herpes simplex virion. It looked like another wormy tome


Accepted for publication 20 July 2001

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It is a fact of life that people make mistakes. In the NHS the cost of human error runs into billions of pounds a year through lost bed days and the consequences of serious litigation. More recently, distress and harm patients, undermining their confidence in the organisation and their doctors.

The natural approach to discovering any error is to apportion blame, with its associations of moral weakness. But error management that focuses on any one individual’s lapses and mistakes will not reduce the incidence of error. In the short term a scapegoat may be convenient, but measures to reduce mistakes need to aim at redesigning systems so that they are acknowledged, detected, intercepted, and mitigated.

Highly reliable organisations, such as nuclear power plants and airlines, have a less than the expected number of accidents because they recognise human frailty. Errors are seen as consequences rather than causes. These organisations concentrate on the conditions under which individuals work and try to build defences averting errors before they happen or reducing their effects. Their motto has to be “Safety is everyone’s responsibility.”

The focus of any organisation exposed to risk, including the NHS, therefore, needs to be on the constant possibility of failure and how to prevent it. The second edition of Clinical Risk Management, edited by Charles Vincent, addresses in detail this problem. It covers the evolution of risk management, its expansion beyond health care litigation, and the benefits reaped from the study of safety in high risk organisations. His aim is to highlight the need for clinical risk management to focus on patient safety and quality of care, and not on simplistic prevention of litigation. It is a practical book full of illustrations of how errors arise, risk, and the good and bad management of their consequences.

The book is divided into four parts. The first, on the principles of risk management, contains a particularly revealing chapter by James Reason, “Understanding adverse events: the human factor.” It opens the theme around which the book is constructed, the interrelation between the individual and the organisation. In the second part, “Reducing risks in clinical practice,” the authors discuss and illustrate the circumstances which lead to errors and accidents that are inherent in specific “high risk” specialties, such as obstetrics and anaesthetics. Part III, “Conditions of safe practice,” discusses the relationship between patient and staff, organisation and environment—for example, in work overload, fatigue, and training. Part IV, “The implementation of risk management” describes the importance of “no blame” culture of reporting incidents, investigating and analysing errors, and of the manner in which adverse events are handled. Included in the chapter are aspects of error management often overlooked—continuing patient care and support of the staff involved.

This is an important, well written, readable book which all involved in clinical care should keep on their desks, not on the bookshelf.
MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 2, Viral Infections other than HIV, 26–27 November 2001
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 3, HIV Infections, 28–30 November 2001
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

41st St Andrew’s Day Festival Symposium on Therapeutics, 6–7 December 2001, Royal College of Physicians of Edinburgh
Further details: Ms Eileen Strawn, Symposium Co-ordinator (tel: 0131 225 7324; fax: 0131 220 4393; email: e.strawn@rcpe.ac.uk; website: www.rcpe.ac.uk).

International Conference on HIV/AIDS 16–19 December 2001, Mumbai, India
Further details: Dr Chander P Puri, President, Indian Society for Study of Reproduction and Fertility, Institute for Research in Reproduction, Jehangir Merwanji Street, Parel, Mumbai 400012, India (Tel: 4137730 (Direct), 4132111-2-6-7; fax: 091-022-4964853 or 091-022-4139412; email: vichin@bom4.vsnl.net.in OR dirirr@vsnl.com).

Second International Conference on Sexual Health, to be held in Bangkok, Thailand on 23–28 February 2002
Further details: European Secretariat, Dr Richard Burack (tel: +44 (0) 20 8599 8029; email: siamcare@aol.com).

7th Congress of the European Society of Contraception, “Changing attitudes to contraception and reproductive health,” Genoa, Italy, 10–13 April 2002
Further details: ESC Central Office, Ora-Med, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.uunet.be).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 1, Epidemiology of STIs and Bacterial Infections, 22–25 April 2002
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 2, Sexual Health and Sexuality, 26 April 2002
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 3, Viral Infections other than HIV, 20–21 May 2002
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 4, HIV Infections, 22–24 May 2002
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

10th International Symposium on Human Chlamydial Infection, 16–21 June 2002, in Antalya, Turkey
The scientific programme will encompass the breadth of chlamydial research from clinical and epidemiological studies to molecular and cell biology of all species of Chlamydia.
Further details: Professor A Demir Serter, Department of Clinical Microbiology and Infectious Diseases, Ege University, Faculty of Medicine, 35100 Bornova, Izmir, Turkey (Fax: 90 232 343 71 30; e-mail: ISHCIX@itsa.ucsf.edu).

10th International Congress on Behçet's Disease, Berlin 27–29 June 2002
Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de).

20th World Congress of Dermatology, Paris, 1–5 July 2002
Further details: P Fournier, Colloquium, 12 rue de la Croix St Faubin, 75011 Paris, France (tel: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fournier@colloquium.fr; website: www.derm-wcd-2002.com).
Reply

Marianne Morris

*Sex Transm Infect* 2001 77: 390
doi: 10.1136/sti.77.5.390-a

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