LETTERS TO THE EDITOR

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.1

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,2 but the second reference referred to an article about treating urethritis in men in developing countries.3 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.4 Further studies are needed to better understand the transmission dynamics of bacterial vaginosis between women.

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Reply

EDITOR,—I thank Dr Fethers for pointing out the discrepant reference in our paper.1

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.1 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.1 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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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: 18.2
  - Code 2: 27.3

The most frequent specific queries recorded on code 9 related to

(i) The right way to use a condom
(ii) How do condoms prevent HIV/AIDS?
(iii) Masturbation
(iv) Oral sex
(v) Anal sex
(vi) Deep kissing in relation to HIV.

We compared our data with those of the AIDS hotline in the national capital Delhi which is run by an NGO called “Torch.” This hotline has only a “specific query” option and has no provision for a “standard questionnaire.” Since the 4 years of its inception there have been some most frequent “specific queries” on this hotline facility in Delhi which were included in the “standard questionnaire” option of the Chandigarh hotline when it was set up at a later date.

With increasing media exposure, there is an increasing curiosity in the general public in India to know more regarding various health related issues such as HIV/AIDS. The pattern of queries on various helplines keeps changing, in keeping with the changing public awareness. Since the government spends ample funds annually on information, education, and counselling (IEC) activities related to HIV/AIDS, we feel that it would be worthwhile to utilise the most common “specific queries” on these helpline services (which are a direct reflection of the general quest for information related to HIV/AIDS) to update IEC strategies. Also, questions asked often on the “specific query” option can be incorporated from time to time in the “standard questionnaire” to make it more informative.

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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 1999.5

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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 = 2.50) or white collar (OR = 2.25) class and to be smokers (OR = 3.50). Caribbeans were more likely to have daily vaginal intercourse (OR = 3.33), 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 ethnically acceptable clinical services before the appearance of HIV infection.

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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 a recent US study. 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) approach to study cervical biopsies from 44 adolescent Quebec girls (14–17 years old). They 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-I and CIN-II samples. Sixteen HPV types were detected, four of them in more than two samples: HPV6 (n = 8), HPV16 (n = 7), HPV11 (n = 3), and HPV31 (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-II, at the expense of the low risk HPV types, but others insisted that the high risk HPV rates in CIN-I, CIN-II, and CIN-III were similar. 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, II, and 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 grade HPV types, up to a complete lack of detection for HPV6 and HPV11.

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.

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Contributors: LLO, FB, and PS performed the histological evaluation of the samples and signed the pathological reports; ICF-F and SF studied the HPV at DNA level; WVV provided supervision and wrote the manuscript with the help of the others.

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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...
population with oral sex practices and high HIV seroprevalence. Approximately 8500 patients are seen annually at the Hospital La Grave STD centre; this number has remained stable in the last 10 years. Almost 20–25% of patients complain of STD symptoms and 5–6% of the men are defined as homosexual.

Between October 1999 and September 2000, 41 gonorrhoea episodes in 33 patients were diagnosed. Thirty (81%) cases were male; among the male population, 25 (83.3%) patients described homosexual contact. There were three cases of acute anal gonorrhoea, two of asymptomatic gonococcal pharyngitis, and 28 gonococcal typical acute urethritis giving a total of 33 episodes.

Twenty one (84%) of the 25 homosexual men described oral sex with an occasional partner without anal intercourse. Five patients were HIV seropositive, 10 were negative at the entry, 10 refused HIV testing. There was no HIV in the heterosexual population.

Between 1989 and 1996, the total number of patients with gonorrhoea attending in La Grave STD centre fell from 71 to two cases per year; in 1999 and 2000, this number was multiplied by more than 6, to rise to 31 cases in 2000.

The number of cases in the homosexual population fell between 1989 and 1993, to stay stable at three cases a year until 1998; in 2000 the rate was multiplied by 8 (fig 1).

High HIV seroprevalence in homosexual patients with gonorrhoea became a real problem during the last year of the sera survey. 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 sero-negative patients.

The sequence of events indicates that the patient suffered an adverse drug reaction (ADR) to a constituent in the Rifinah tablets not present in the Rifitah, rifampicin, or isoniazid tablets. The manufacturer of Rifinah were consulted and to our knowledge such a reaction has not been described before. The Committee on Safety of Medicines was informed via the grey card system.

Co-infection with HIV and Mycobacterium tuberculosis is a problem increasingly encountered by physicians caring for individuals with HIV. A recent study in London found that 24.8% of patients commencing antituberculous chemotherapy were also HIV antibody positive. HIV positive individuals are known to be at increased risk of adverse drug reactions, particularly those with advanced immunosuppression. One study documented a frequency of adverse drug reactions of 32% in HIV positive patients receiving drug therapies.

Physicians should remain alert to the possibility of ADRs and warn HIV positive patients of their increased risk, even when such a reaction would not have been anticipated, as in this case.

No conflict of interest to declare.

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Increasing HIV prevalence in STD clinic attendees in Delhi, India: A 6 year (1995–2000) hospital based study results

EDITO,**—**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 a tertiary care centre in Delhi. The breakdown in the number of STD attendances 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 1998, and 296 out of 513 (51%) in 1999, and 261 out of 513 (51%) in 1998, respectively, among STD attendances for screening, were found to be positive for HIV infection among STD attendees is less than 1% but the discrepancy in total number of patients in both groups is due to the presence of more than one STD.

HIV positivity was observed in 4.5% patients with GU diseases, in contrast with only 1.7% HIV positivity among non-ulcerative STD patients, which is statistically significant (p > 0.002). All but one male HIV positive patients gave a history of sexual contact with at least one commercial sexual worker. Out of two HIV positive women, one possibly was infected by her husband and the other from her regular sexual partner; both were not pregnant at the time of HIV testing. Five (19%) HIV seropositive patients had more than one STD.

HIV sentinel surveillance in India shows the HIV epidemic at different stages of evolution in different states of India. 1 Six out of 32 states have HIV prevalence of more than 1% in antenatal clinics (ANC) and are classified as high prevalence states including Maharashtra and Tamil Nadu. In seven other states the ANC rates are less than 1% but prevalence among STD clinic attendees is more than 5% classified as moderate prevalence. The remaining 19 states including Delhi are low prevalence states because HIV prevalence among STD attendees is less than 5%. 1,2 The HIV sentinel surveillance data of Delhi show 1.6% and 3.2% HIV infection in 1998 and 2000, respectively, among STD attendees from four other major STD clinics in Delhi, where anonymous HIV testing was done from VDRL blood samples. 3 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. 1 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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Genital piercing and sexually transmitted infections

EDITO,—An interesting observation was noted among patients with genital piercing in our clinic. We looked at 12 case notes of patients retrospectively who attended our clinic for sexual health screening in the past 12 months. There were seven males and five females in the age group 22–36. Looking at the results of their screening tests for STIs, none of the males had chlamydia. Interestingly, four out of six female contacts of these males, who also attended for screening, were found to be positive for chlamydia detected by enzyme immunoassay (EIA). None had gonorrhoea. It was also noted that none of these female contacts had their genitals pierced. Of the five females who had their genitals pierced, three had chlamydia, one had genital warts, and one was found to have bacterial vaginosis. Their corresponding male contacts again with no genital piercing also had chlamydia and genital warts. Two other contacts did not attend but were said to be asymptomatic. The method of genital piercing in males was with the so called Prince Albert ring (famously worn by Prince Albert) where the metal ring is inserted through the external urethra and glans penis (Figure 1). For females, however the urethra is not involved and the piercing is mostly through the clitoris or vulva. We wondered whether this involvement of the urethra in males was significant. It appeared that there was a protective effect in males despite having chlamydia positive female sexual partners. Possible mechanisms could be slow release of metal ions having an antibacterial effect, the presence of epithelial metaplasia or a chronic inflammatory process contributing to a local immune response. We do acknowledge that this is a very small cohort and these findings may be by chance or can be explained by the low sensitivity of EIA.

Genital piercing is becoming more fashionable in the Western world and is performed to enhance sexual pleasure and also for cosmetic effect. It was traditionally practised in the tribal population of India and Africa, mostly for ritual and cultural reasons. Metal or ivory studs or rings or bars are commonly used. The metals can be made of steel or various other alloys containing iron, copper, zinc, and...
Sexually transmitted infections (STIs) are a significant health concern, especially in the context of HIV transmission. Recent studies have highlighted the importance of understanding the role of STIs in HIV transmission, particularly in the context of high-risk sexual behavior among homosexual men.

A study conducted in London, UK, surveyed 500 homosexual men, with 494 legible questionnaires returned. The study aimed to determine the reported incidence of sexually transmitted infections (STIs) and to assess the impact of these infections on HIV transmission.

**Table 1: Reported incidence of sexually transmitted infections (STIs) over past year by respondents**

<table>
<thead>
<tr>
<th>STI</th>
<th>Incidence (n=494)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhoea</td>
<td>36 (35.3)</td>
</tr>
<tr>
<td>Chlamydia/NSU</td>
<td>22 (21.6)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>4 (3.9)</td>
</tr>
<tr>
<td>Herpes (first episode)</td>
<td>20 (19.6)</td>
</tr>
<tr>
<td>Warts (first episode)</td>
<td>29 (28.4)</td>
</tr>
<tr>
<td>Others</td>
<td>12 (12.7)</td>
</tr>
<tr>
<td>Combination of STIs</td>
<td>22 (21.6)</td>
</tr>
<tr>
<td>Gonorrhoea + chlamydia/NSU</td>
<td>8 (8.3)</td>
</tr>
</tbody>
</table>

Studied individuals who had unprotected vaginal and anal intercourse were at a higher risk of acquiring new sexually transmitted infections. This emphasizes the need for comprehensive sexual health screening and education among at-risk populations.

However, the report also notes that genital piercing and its association with sexual health issues are not well understood. A recent study found that genital piercing is associated with an increased risk of HIV transmission, highlighting the importance of further research in this area.

**Conclusion**

The study underscores the importance of sexual health screening and education, particularly among individuals at high risk for HIV and STIs. Improved data on risk behaviors and infection rates are crucial for developing effective prevention strategies. Further research is needed to better understand the role of piercing in HIV transmission and to inform public health policies accordingly.
about vaccine laboratory development spiced up with some phase I and II trial data. However, I am willing to admit that I have been pleasantly surprised by the clinical relevance of much of the book's contents, and that my initial prejudice was unjustified.

The book consists of 18 chapters written by experts from around the world, such as Lawrence Stanberry, Jonathan Zemelman, and Adrian Mindel who will be well known to readers of this journal. The chapters are divided into three sections dealing with epidemiology, physiology and immunology; non-specific strategies for control (such as behavioural interventions and barrier methods); and pathogens and vaccines. This final section makes up the meat of the book and comprises 11 chapters, which each provide an expert review on vaccine development for specific pathogens including herpes, HPV, hepatitis B, and chlamydia, as well as gonorrhoea, syphilis and, of course, HIV. While it is inevitable that any book on this rapidly evolving subject will run the risk of becoming out of date, each author has attempted to ensure that relevant previous vaccine strategies and lessons learnt have been included. I felt this was particularly helpful as I believe that the book will be a valuable single reference source, even when the reviews of current vaccine development pass their "sell-by" date. For me, this is the justification in buying this book rather than saving a collection of journal articles. Highlights from the first two sections of the book included the chapter on vaginal microorganisms which incorporated the International Working Group recommendations on development as part of an appendix. The first chapter on global epidemiology of STIs was particularly well written and referenced and includes a concise section on the HIV epidemic. I did however wonder why HHV-8/KSHV was omitted from such a comprehensive review. In a later chapter, I found the 13 or so pages on genital anatomy poorly illustrated and dispensable. I feel that the chapter on the Russian experience and the factors which led to the massive outbreak of syphilis should be compulsory reading for every sexual health clinician and public health specialist. It is too easy to ignore lessons from the past and from other settings.

Stanberry and Bernstein's multiauthor volume provides a timely antidote to those important, but often dry, editions which are divorced from the realities of routine clinical practice. I feel able to recommend this book to key authors from who have endured dullous presentations and never quite got round to actually reading those articles on STI prevention and control which are gathering dust on desks, or worse still put away into filing cabinets "for later reference." And one final plea to publishers—could they find something a little more human to replace the cover electron micrograph? The whole point of this book is to review ways of ensuring that sexually transmitted pathogens do not gain the upper hand over their human hosts.


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 error-prone culture than other 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 and construction, and the benefits reaped from the study of safety in high risk organisations. Its 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, includes 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 two 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.

**NOTICES**

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, regional office of the World Health Organization

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).

6th Seminar of the European Society of Contraception, “Why are teenagers still getting pregnant?” University of Coimbra, Coimbra, Portugal, 8–9 October 2001

Further details: ESC Central Office, Orga-Med, Eissennestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@ville.uunet.be).

The Theory of Obstetric Medicine for obstetricians, physicians, and GPs, the Royal College of Physicians, Regents Park, London, 9–11 October 2001

Further details: The Symposium Office, Division of Paediatrics, Obstetrics and Gynaecology, IRDB, Imperial College School of Medicine, Hammersmith Campus, Du Cane Road, London W12 ONN (tel: +44 (0)20 7594 2150; fax: +44 (0)20 7594 2155; email: sympreg@ic.ac.uk).

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 October 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 4, Sexual Health and Sexuality, 26 October 2001

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

10th Congress of the European Society for Gynaecological Endoscopy, Lisbon, Portugal, 22–24 November 2001

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: siacare@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, Ormeg, Esseneestraat 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 (rel: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fournier@colloquium.fr; website: www.derm-wcd-2002.com).
Adverse reaction to antimycobacterials administered as a combination tablet with no reaction to the same drugs in isolation
Margaret Kingston, Kate Childs and Elizabeth Carlin

Sex Transm Infect 2001 77: 392-393
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