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**LETTERS**

Perforating chancre: any cause-effect relation with HIV infection?

Variation in clinical pictures of syphilis, when co-infected with HIV are well known.1 Nor-
mally, a classic Hunterian chancre heals within 1–2 weeks of treatment without scarring.2 Primary chancre, healing with perforation of the site, does not commonly occur. Here we report four patients with primary syphilis, in whom the chancre healed with perforation of the genitalia. Concomitant infection with HIV is presumed to be responsible for this destructive sequela.

**Case 1**
A 21 year old woman presented with a painless, indurated ulcer on the inner aspect of the left labia majora, along with same sided inguinal lymphadenopathy of 1 week’s duration. Dark ground microscopy (DGI) was positive for *Treponema pallidum* and VDRL titre was 1:64. Following treatment with penicillin, the ulcer healed slowly, leaving a perforation on the labia majora.

**Case 2**
A 20 year old unmarried male patient with high risk behaviour presented with a painless indurated ulcer over the lateral aspect of the penis. He gave a history of a painless ulcer on the same site about 1 month earlier. At presentation, his VDRL was 1:32. He was treated with penicillin.

**Comment**
Gram stained smears from the ulcer and culture for aerobic and anaerobic organisms were negative in first three cases. In all the four patients, ELISA for HIV was positive. Immune response to *T pallidum* is primarily cell mediated.7 In an immunocompetent host with primary syphilis, CD4+:CD8+ T lymphocyte ratio is high at the site of the chancre,7 which possibly prevents local multiplication of the organism. Consequent to the loss of local cellular immunity as a result of HIV infection there may be an enhanced ability of the organism to multiply locally, giving rise to larger and deeper ulcers which are slower to heal. This fact has been demonstrated experimentally in animal models.8 Studies exploring the correlation of CD4+ T cell count and stage of HIV infection with this altered manifestation of primary syphilis should be undertaken. This might show the impact of HIV infection on the clinical severity of primary chancre.

**Figure 1** Perforation of prepuce.

Bilateral inguinal lymphadenopathy was present. DGI from the ulcer was negative and VDRL was 1:64. Following penicillin therapy, it healed with perforation of the prepuce.

**Case 4**
A 45 year old married man with high risk behaviour presented with a large perforation on the lateral side of the shaft of the penis. He gave a history of genital ulceration and was treated for suspected lymphogranuloma venereum. Following treatment with penicillin, the ulcer healed at a slower pace leaving a large perforation on the prepuce (fig 1).

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**References**

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**Superior mesenteric artery syndrome in an HIV positive patient**

A 27 year old HIV positive man with a CD4+ lymphocyte count of 26 cells ×10⁹/l presented with a 2 week history of progressive left sided weakness, vomiting, and weight loss. A computed tomograph (CT) brain scan demonstrated ring lesions bilaterally in the basal ganglia. Toxoplasma serology was positive at a titre of 1:256 and treatment for cerebral toxoplasmosis commenced. His weakness responded to therapy but vomiting continued despite antiemetics. An ultrasound scan demonstrated an enlarged, dilated stomach, dilated first and second parts of the duodenum, and an obstruction at the level of the third. Barium studies confirmed these findings but also demonstrated prominent peristalsis in the second part of the duodenum and an abrupt cessation of flow to barium in the middle of the third (fig 1). Some flow of barium into the jejunum was noted when the patient was turned prone. An abdominal CT scan demonstrated a reduction in the angle between the superior mesenteric artery and the aorta (fig 2). A diagnosis of superior mesenteric artery syndrome (SMA) syndrome was confirmed. Two litres of bile were aspirated per nasogastric tube daily and he continued to lose weight. His body mass index (BMI) fell to

**Figure 1** Image from barium meal series. The proximal duodenum is dilated. There is an abrupt calibre change (arrow) in the third part where the superior mesenteric artery crosses. Distinct peristalsis was seen in this region during the study.
12 and total parenteral nutrition was introduced for 6 weeks after which an exploratory laparotomy was performed. An anterior gastrotomy was made and a jejunal feeding tube inserted into the collapsed proximal small bowel. The patient recovered postoperatively but refused to vomit after meals. After 4 weeks his BMI increased to 15, vomiting stopped, and he demanded food. At the time of writing he is well, independent, and on antiretroviral therapy.

Superior mesenteric artery syndrome is a controversial diagnosis synonymous with vascular compression of the duodenum, arteriomesenteric duodenal compression syndrome, the cast syndrome, chronic duodenal ileus, and Wilkie’s syndrome. First described by Rokitskian in 1842, frequency of reports have recently declined and its existence debated.1 The syndrome has been ascribed to a reduction in the angle between the aorta and the superior mesenteric artery, scissoring the duodenum in its third part causing obstruction. This is often because of sudden, severe weight loss resulting in a reduction of mesenteric and retroperitoneal fat. Precipitating factors include eating disorders, severe wasting conditions, prolonged immobilisation, previous abdominal surgery, or inflammatory conditions. It has also been reported in cases of severe kyphoscoliosis.2 It has not previously been reported in AIDS. Characteristic symptoms, typically intermittent in nature, comprise bloating, nausea, and intractable bilious vomiting relieved by adopting the prone or knee to chest position. A barium meal is the most useful diagnostic investigation. Features of note include dilatation of the first and second parts of the duodenum and an abrupt, linear hold up of flow to barium in the third with abnormal peristalsis and even reverse peristalsis frequently observed. Relief of the obstruction can in some instances be achieved by placing the patient prone during the investigation.2 CT studies can demonstrate reduction in the aortomesenteric mesenteric artery angle and serve as a non-invasive diagnostic tool.3 Reversal of weight loss is key to resolution, by surgical means if necessary. Nutritional support should be attempted first. Endoscopic or nasogastric decompression is often difficult because of severe gastric dilatation. Duodeno-jejunostomy or gastrojejunostomy are the surgical procedures of choice when medical therapy fails.4–6 Our patient did not experience immediate symptomatic relief through surgery but did achieve rapid weight gain via jejunal feeding. We report the first case of SMA syndrome in a patient with AIDS. The spread of HIV worldwide and its association with severe wasting makes this an important differential diagnosis for the clinician.

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References

Accepted for publication 16 December 2002

Was the Papanicolaou smear responsible for the decline of Trichomonas vaginalis?

There has been a dramatic decline in the prevalence of trichomoniasis in Australia over the past 30 years. In 1979, 17.8% of women attending a Sydney STI clinic had Trichomonas vaginalis infection.1 By 1998 less than 1% of non-Indigenous women presenting to family planning and STI clinics in another part of the duodenum. Clin Radiol 1982; 33: 75–81.


1 The spread of HIV worldwide and its association with severe wasting makes this an important differential diagnosis for the clinician.

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The HIV/AIDS epidemic in Ukraine: stable or still exploding?

A recent article published in Sexually Transmitted Infections3 presented evidence suggesting that the HIV/AIDS epidemic in Ukraine had peaked in 1997 and has since declined. The world has only recently awoken to the threat of a widespread HIV/AIDS epidemic in eastern Europe, including projections of an
epidemic in Russia of between 6–11% by 2010, and the potential for economic decline and geopolitical instability: HIV trends in Ukraine, with many of the same socioeconomic characteristics and risk factors found in Russia—namely, large numbers of injecting drug users (IDUs), an expanding sex industry, internal and external migration, poor access to health care, sexual and economic and social upheaval, and a recent explosive syphilis epidemic—must therefore be examined closely. Could Ukraine present a model for Russia in terms of controlling the HIV epidemic, or does Ukraine in fact represent an ongoing epidemic inadequately described by official statistics?

The first indication that perhaps the data presented by Mavrov and Bondarenko1 noted the increase in the ongoing HIV epidemic in Ukraine is the apparent contradiction in table 1, which reports the prevalence of HIV among select groups in 1998 and 1999. While HIV prevalence for “all populations” declined, every subpopulation increased, except for a decline from 0.07% to 0.064% among blood donors. Prevalence among pregnant women, who reflect the likely future of the epidemic, increased by 33%.

Current official statistics in Ukraine simply do not reflect the current status of the epidemic, and, importantly, do not reflect the likely future course of the epidemic. As Mavrov and Bondarenko report, the majority of new HIV cases continue to be among IDUs. This population is wary of the healthcare sector, as the acknowledgement of drug use to a healthcare provider leads to obligatory registration and confinement for treatment, possible job loss, loss of one’s driving licence, and criminal prosecution. Kobyschina2 reported that only 5% of IDUs were covered by the current system of HIV surveillance. Rather than the 8.6% prevalence reported by Mavrov and Bondarenko among IDUs, cross sectional studies have shown prevalence of between 18% and 64% (table 1).

Behavioural factors also argue against the likelihood of a stable epidemic in Ukraine. In a study of female sex workers (FSWs) in Odessa conducted in 1997 and 1999, the percentage of FSWs reporting always using condoms declined (from 49% to 40%).3 A 1999 national reproductive health survey found that 27% of women reported condom use at the time of first sexual experience.4

Recent attempts to model the future course of the HIV/AIDS epidemic in Ukraine, developed an “optimistic” scenario, where HIV prevalence increased to 2% of the adult population by 2010, and a “pessimistic” scenario, where HIV prevalence increased to 5%. While official statistics might indicate a stable epidemic, after more than two decades of global experience, no one should mistake the clear evidence that an explosive epidemic is ongoing in the Ukraine. Failing to acknowledge the true nature of an epidemic has yet to save any nation from its consequences.

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References

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Raising awareness of UK GUM clinic activities

In their recent letter on the sexual health issues which face performers in the adult entertainment industry, Gabrielsen and Bar- ton highlight the current lack of coherent sexual health infrastructure for this population in the United Kingdom.1 The work of the AIM Health Care Foundation in the United States, is a valuable model which identifies the unique sexual health requirements of adult industry workers. By providing specialist care for the performers, AIM Health Care gives advice and information to a group whose specific needs have been globally poorly addressed. Evidence of this is provided by the large number of performers who choose to access AIM Health Care for their HIV tests in the United States.2

In the United Kingdom this would also seem to be the case, as the few adult performers who have any form of STI screening also prefer to use the facilities of private clinics.3 The role of GUM clinics stretches beyond an authenticating agency for HIV certification, which should not be allowed to become the primary reason for contact between performers and GUM staff. Stronger emphasis needs to be placed on re-education within the UK industry to highlight the need for regular STI screening, health education and promotion. Especially since performers have any form of regular STI screening either in their public or private lives.4 We believe that it may be helpful to raise awareness of services offered by modern GUM clinics in the United Kingdom, by training and targeted information for adult performers.

By taking control of sexual health the industry will not only have healthy performers but will also provide the viewing public with a safer sex message that is portrayed in an entertaining, safe and non-threatening manner. Therefore, bearing in mind the complexities facing performers, the adult entertainment industry should be commended for working with core HIV/GUM services and piloting a study into the sexual health of adult performers. It will be of particular interest to see whether sexual health care can be provided for this group within the bounds of the NHS or whether they, like their American counterparts, will choose to rely on private clinics to provide them with care and information.

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1 Gabrielsen L, Barton SE. HIV negative certification and sexual health issues facing performers in the adult entertainment industry in the UK. Sex Transm Infect 2002;78:311.
4 Barton SE, Gabrielsen L. Defining the need to develop sexual health services for performers in the adult entertainment industry. Paper presented at IUSTI Europe 2002. Accepted for publication 16 December 2002

Partner notification in primary care

In the past decade, chlamydia tests have become more widely available in primary care, and many female patients are now diagnosed and treated in this setting.5 The lack of skills and resources for partner notification in primary care is now a matter of public health concern.6 We undertook a survey of GPs in three districts in order to explore their current practice and attitudes in relation to partner notification and treatment.

AIM Health Care, a GUM partnership in the Nottingham Health District (n=367), and GPs recruited for the Chlamydia Partnership Project in north London (n=65) (a randomised trial of health adviser led partner notification for primary care patients) were invited to complete a short questionnaire. The response rate was 56%.

Of the 242 respondents, 86% considered testing for genital Chlamydia trachomatis infection in women to be a GP role, while 60.7% considered that partner notification was not a role of the GP. 90.5% of respondents thought that one or more patients had had a positive test at the practice in the preceding year.

Among GPs who had recently been involved in managing chlamydia, 82.5% always or sometimes managed the patient wholly within primary care; 70.1% said they “always” or “sometimes” managed partners. However, responsibility for ensuring this happened was generally devolved to the patient, since 73.8% “always,” and 22.5% “sometimes” dealt with partner notification by telling the patient to get the partner treated.

GPs appeared to be well aware of the importance of contact tracing. Respondents were asked to state difficulties in managing chlamydia in free text form. Of 200 GPs stating one or more difficulties, 76.5% mentioned contact tracing. Other problems commonly cited were follow up or compliance (21.5%), explanation, supporting relationships and counselling (17.3% of respondents), perceived inadequacies of tests, mainly poor sensitivity and invasiveness (12.5%), and the diagnosis of coexisting infections (10.5%).

The majority of GPs (69.9%) would treat with an appropriate antibiotic of equal or greater dose and duration than that currently recommended by the Central Audit Group for

Table 1 Prevalence of HIV among injecting drug users, 2000

<table>
<thead>
<tr>
<th>Site</th>
<th>HIV prevalence (%)</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poltava</td>
<td>41.7</td>
<td>259</td>
</tr>
<tr>
<td>Donetsk</td>
<td>39.7</td>
<td>252</td>
</tr>
<tr>
<td>Kryvyi Rig</td>
<td>28.1</td>
<td>249</td>
</tr>
<tr>
<td>Odessa</td>
<td>64.0</td>
<td>293</td>
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<tr>
<td>Simferopol</td>
<td>27.2</td>
<td>261</td>
</tr>
<tr>
<td>Kharkiv</td>
<td>17.8</td>
<td>250</td>
</tr>
</tbody>
</table>

Circumcision in genital warts—let us not forget!

Patients with genital warts present to the healthcare professional with two major problems of persistence and recurrence. These problems are attributable to the persistence of human papillomavirus in the keratinocytes, defective immune response in individuals with persistence and recurrence of warts, and the lack of specific antiviral therapy. Various treatments tried in the management of genital warts are topical podophyllin, podophyllotoxin, cryotherapy, electrocoagulation, chemical cautery, carbon dioxide laser, 5-fluorouracil cream, topical imiquimod cream, and intralesional interferon. ¹,² We wish to highlight the role of circumcision in extensive genital warts involving prepuce, which were refractory to the conventional treatment. A 50 year old patient presented to us with genital warts for duration of 4 years. On examination, lesions were in the form of sessile, filliform, and papular keratotic verrucous lesions present involving both outer and undersurface of almost whole of the prepuce (fig 1). These lesions were treated by us and in the past by various doctors with topical podophyllin, trichloroacetic acid cautery, electrocoagulation, etc, for periods ranging from weeks to months with only minimal response, with the lesions coming back. The patient had some difficulty in retraction of the prepuce and was psychologically disturbed. The patient otherwise was healthy with no evidence of any other disease. Considering the extensive involucrum of prepuce and refractory nature to various treatments, circumcision was performed. Histopathological examination of the excised tissue showed changes consistent with warts without any cellular atypia. Surgical healing occurred well in a week with no complications.

Extensive genital warts with evidence of keratinisation are often refractory to podophyllin, podophyllotoxin, cryotherapy, etc, and are best dealt with surgically or by topical 5-fluorouracil cream. Scissor excision has been mentioned in the treatment of sessile lesions over the shaft of penis, labia majora, and perianal warts.³ However, circumcision for extensive preputial warts finds no place in the list of treatments for genital warts in men. In addition to the psychological morbidities, larger and more numerous warts can cause discomfort, and particularly involving prepuce can cause phimosis, secondary infection, and marital disharmony and considerable anxiety in the sexual partner. Globally, approximately 25% of the women are circumcised for religious, cultural, medical, or parental choice reasons. However, controversies surround its benefits and protective effects against STDs.⁴ For genital warts, one study has reported a significant association with the lack of circumcision.⁵

Substantive evidence supports the premise that circumcision protects males from HIV infection, penile carcinoma, the majority of treponemal infections, and ulcerative STDs.⁶ Although it may be debatable to recommend circumcision to reduce the risk of acquiring any one of the other STDs/HIV infection in isolation, taken together however the psychological and sexual discomforts for the patients and their sexual partners with recurrent/persistent extensive preputial warts, circumcision should be tried.

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Treatment of Candida glabrata using topical amphothericin B and fluycytosine

We read with interest the article by White and colleagues on the treatment of Candida glabrata using topical amphothericin B and fluycytosine because this infection can prove difficult to treat.¹ We have since used this treatment on a 28 year old woman with a 10 year history of recurrent candida.

The woman first attended our department complaining of a recurrent itchy white discharge. She had received numerous courses of antifungals including topical clotrimazole, oral itraconazole, and fluconazole with no relief. Vaginal swabs were positive for C. glabrata and she was treated with nystatin pessaries 200 000 units at night for 14 nights. Culture was still positive for C. glabrata at follow up 4 weeks later so she was advised to continue with nystatin pessaries for a further 4 weeks. On review she felt her symptoms were slightly better but she found the pessaries were not dissolving so she was switched to nystatin cream 200 000 units by
vagina for 28 nights. After this course of
treatment she remained symptomatic and
positive on culture for C. glabrata. Following
the success with topical fluconazole and
amphotericin B in the above article our phar-
macist obtained this preparation. The patient
was given amphotericin 100 mg plus flucozy-
sine 1 g in Aquagel in a total 8 g dose, which
was given by vaginal applicator nightly for 14
nights. She was reviewed 2 and 6 weeks after
finishing treatment, her symptoms had
experienced greaty improved and cultures for yeast were
negative on both occasions.

White’s paper described the successful
treatment of three patients with candidiasis
using topical amphotericin B and fluconazole.
Our patient makes up the fourth case of suc-
cessful eradication of refractory vaginal C. gla-
brata using this combination which, like the
other cases, was very well tolerated.

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1 White DJ, Habib AR, Yantnouve A, et al.
Combined topical fluconazole and
amphotericin B for refractory Candida
glabrata infections. Sex Transm Infect

Accepted for publication 27 February 2003

BOOK REVIEW

Immunotherapy for Infectious Diseases. 
0896036693.

I judge this is a jewel of a book, although you
would not think so from my comments in the
next paragraph.

My initial reaction was one of intense
irritation. The preface stated that the inten-
tion was to “review the state of the art . . . of
this rapidly emerging . . . field.”

A bold promise for which tight editorial
time lines and up to date references would
be essential. Yet, even though the book was
published in 2002, there were very few references
from 2001 or even from 2000 in some
chapters. To take as one particularly bad
example, the chapter dealing with the immu-
notherapy of HIV had only one reference as
recent as 2000, and all the rest were from the
last millennium.

It is a credit to the book’s other talents that
my bad humour was rapidly dissipated. The
introductory chapters were, quite simply, a
pleasure. The basis of humoral immunity was
a clear rendition of the area, and the chapter
on the principles of cellular immunology was
as good, and as enjoyable an introduction to
the field as you could get. The final introduc-
tory chapter, on mucosal defences, maintains
the high standards set by the first two.

The remainder of the book is divided into
three sections covering the molecular basis for
immunotherapy, immunotherapy for HIV
infection, and immunotherapy for other infec-
tious diseases. Each of these three sections
provides a good review of the major issues.
The molecular basis for immunotherapy
contains an excellent chapter on the role of
dendritic cells, and usefully explains how
their crucial role in immune defences might
be utilised for immune therapy. The chapter
on cytokines sheds light on an area which is
too complex or obtuse for many.

The section on immunotherapy for HIV
infection covers in turn the basis for immuno-
therapeutic HIV vaccines, passive immuno-
therapy, and gene therapy. There are some
notable omissions dictated by the presumed
delay between the research for each chapter,
and publication of the book. For instance,
RNA interference, sometimes known as post-
transcriptional gene silencing, is currently
being investigated as a possible major thera-
peutic strategy for the future. True, the
problem of delivery to the target cells still has
to be solved, but for RNA interference to be
left out dates the book already. Similarly many
of the viral and bacterial vectors for vaccine
delivery worked on the past few years, such as
adenovirus, and salmonella, to name just two,
are not included. Even those that are, such as
canarypox, are not included in the index.

Which leads to my final criticism before sum-
ming up—the index is entirely inadequate and
militates strongly against using this as a

So in conclusion, this book represents a
flawed gem. Viewed from a certain light it is
illuminating, a joy to behold. From other
angles, the imperfections are all too obvious.
None the less, for a physician or scientist
working in the field of infectious diseases or
related areas such as STDs or HIV, it provides
an introduction to the field of immuno-
therapy which is both accessible and enjoy-
able. Read it within the next couple of years
before it begins to date further and it will be
time well invested. For a specialist in the field
it has limited value, except to recommend it
to trainees or newcomers.

If the editor decides to bring out another
edition, he should somehow do the near
impossible for multiauthored texts, and en-
sure they are all up to date. Oh, and also invest
in a professional indexing service. Then, there
really will be a precious jewel.

Barry S Peters

INTERNATIONAL HERPES ALLIANCE AND INTERNATIONAL HERPES MANAGEMENT FORUM

The International Herpes Alliance has intro-
duced a web site (www.herpesalliance.org) where
patient information leaflets can be
downloaded. Its sister organisation the Inter-
national Herpes Management Forum (web
site: www.IHMF.org) has launched new
guidelines on the management of herpesvirus
infections in pregnancy at the 9th Inter-
national 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).

AUSTRALASIAN SEXUAL HEALTH CONFERENCE: TANGO DOWN SOUTH—2003!

4 – 7 June 2003, Christchurch Convention
Centre, New Zealand

Further details: Dart Associates (tel: +02
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7TH EUROPEAN SOCIETY OF CONTRACEPTION SEMINAR


The 7th ESC Seminar on contraceptive prac-
tice in Europe: differences in availability and
accessibility, will be held in Budapest Hun-
gary. The main themes are availability and
accessibility of: (1) contraceptive methods, (2)
emergency contraception, (3) testing and
treatment of sexually transmitted infections,
and (4) abortions.

Further details: ESC Central Office, Ess-
enerstraat 77, B-1740 Ternat, Belgium (tel: +32
2 582 0852; fax: +32 2 582 5515; email:
escentraloffice@contreception-esc.com;
website: www.contraception-esc.com).
Perforating chancre: any cause-effect relation with HIV infection?

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