Figure 1 Perianal warty papules.
Lack of evidence for sexual transmission of hepatitis C virus in patients attending STD clinics in Pune, India

The presence of hepatitis C virus (HCV) RNA in semen among two of six (33%) HIV negative and six of 15 (40%) HIV infected males, reported recently suggests that HIV may facilitate genital shedding and subsequent sexual transmission of HCV. We determined HCV prevalence and examined evidence for its sexual transmission in a cohort of STD patients with observed HIV prevalence of 21.2%.

Consecutive serum samples (n=9141) collected between January 1994 and December 1999 were batched, pooled, and tested for anti-HCV antibody (Ortho HCV 3.0, Ortho-clinical Diagnostic, Germany). As previously described, 25 μl aliquots of five samples were pooled and 20 μl of each pool were screened. Samples from positive pools were then tested individually. Positive sera were tested by HCV RNA polymerase chain reaction (PCR) using standard primers. HIV antibody status of each sample was ascertained using the algorithm described previously. Data were analysed using statistical package SPSS version 10.0. This study was a part of a prospective cohort study that was approved by ethics committee/institutional review boards of the collaborating organisations and blood samples were collected after counselling and informed consent.

Overall prevalence of anti-HCV antibodies was 0.68% (62/9141, 95% CI 0.52 to 0.87). The prevalence among HIV infected individuals (1.5%, 95% CI 1.0 to 2.1) was higher (p = 0.01) than that in those not infected (0.44%, 95% CI 0.3 to 0.6). The annual anti-HCV antibody prevalence rate between 1994 and 1999 was 0.57%, 0.46%, 1.0%, 0.81%, 0.37%, and 0.61%, which did not change significantly over time (table 1). Of the 55 anti-HCV antibody positive sera tested, 27 (49%) were HCV RNA PCR positive.

Univariate analysis revealed that history of past or current STD was not associated with HCV, whereas female sex (OR = 2.07, 95% CI 1.17 to 3.66), prevalent HIV infection (OR = 3.38, 95% CI 2.05 to 5.58), history of tattoo (OR = 2.18, 95% CI 1.31 to 3.63), and being a sex worker (OR = 2.35, 95% CI 1.27 to 4.35) were significantly associated with presence of anti-HCV antibody. However, multivariate analysis revealed that prevalent HIV infection and tattooing increased the likelihood of presence of anti-HCV antibodies by 3.08-fold (AOR 3.08, 95% CI 1.86 to 5.11, p < 0.00) and 1.87-fold (AOR 1.87, 95% CI 1.17 to 3.13, p = 0.017), respectively (table 1).

A rapid spread and high HCV prevalence of 80% has been reported recently among a cohort of injecting drug users from Kolkata, India. In contrast, we observed a low and stable prevalence of anti-HCV antibody among STD clinic attendees over the past 6 years in an urban setting where HIV transmission was predominantly sexual. Given that a high HIV prevalence was reported among female sex workers (FSWs) in this population and about 70% of males attending STD clinic had visited FSWs in the past 3 months, stable HCV prevalence over 6 years suggests that HCV is not efficiently transmitted sexually. Additionally, no association was found between past or current STD and HCV prevalence, and a high prevalence and incidence of HBV, a known sexually transmitted infection, have been reported in this population. Our analysis failed to identify any evidence that could support sexual transmission of HCV.

References


Monosymptomatic hypochondriacal psychosis

Dr O'Mahony illustrates in his literary and graphic way the difficulties associated with dealing with this condition (from which his patient was almost certainly suffering). It is good to know that his hospital is taking seriously the issue of actual sterilized violence to staff. Having had several similar cases over the past couple of years, including one who eventually committed suicide, I have been able to make appropriate arrangements with a psychiatrist who was, I felt, right in his advice that he should be in on a subsequent consultation right from the start and be introduced to the patient as a double consultation. The ethics of this include the fact that such delusional patients are, of course, psychotic and unable to bring rational decision making processes to the problem.

Table 1 Characteristics of study participants and association with prevalent anti-HCV antibody

<table>
<thead>
<tr>
<th>Variable</th>
<th>No</th>
<th>Anti-HCV antibody positive (%)</th>
<th>Unadjusted OR (95% CI)</th>
<th>p Value</th>
<th>Adjusted OR (95% CI)</th>
<th>p Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Year screened</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>1901</td>
<td>11 (0.57)</td>
<td>1 (Referent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>1933</td>
<td>9 (0.46)</td>
<td>0.80 (0.33 to 1.94)</td>
<td>0.628</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>1997</td>
<td>22 (1.10)</td>
<td>1.91 (0.93 to 3.96)</td>
<td>0.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>1109</td>
<td>9 (0.81)</td>
<td>1.41 (0.58 to 3.40)</td>
<td>0.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>1064</td>
<td>4 (0.37)</td>
<td>0.62 (0.21 to 2.04)</td>
<td>0.459</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>1135</td>
<td>7 (0.61)</td>
<td>1.07 (0.41 to 2.76)</td>
<td>0.895</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>9139</td>
<td>62 (0.67)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Males who had contact with sex worker</td>
<td>YES</td>
<td>6281</td>
<td>40 (0.69)</td>
<td>1.63 (0.69 to 3.86)</td>
<td>0.259</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>1355</td>
<td>6 (0.39)</td>
<td>1 (Referent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>7616</td>
<td>46 (0.58)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>1323</td>
<td>16 (1.21)</td>
<td>2.07 (1.17 to 3.66)</td>
<td>0.013</td>
<td>0.469</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>7816</td>
<td>46 (0.59)</td>
<td>1 (Referent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>9139</td>
<td>62 (0.67)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Sex worker</td>
<td>YES</td>
<td>933</td>
<td>13 (1.39)</td>
<td>2.35 (1.27 to 4.35)</td>
<td>0.006</td>
<td>0.231</td>
</tr>
<tr>
<td>NO</td>
<td>8206</td>
<td>49 (0.59)</td>
<td>1 (Referent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>9139</td>
<td>62 (0.67)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 HIV serostatus</td>
<td>Pos</td>
<td>2102</td>
<td>31 (1.47)</td>
<td>3.38 (2.05 to 5.58)</td>
<td>&lt;0.001</td>
<td>5.11</td>
</tr>
<tr>
<td>Neg</td>
<td>7037</td>
<td>31 (0.44)</td>
<td>1 (Referent)</td>
<td>1 (Referent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>9139</td>
<td>62 (0.67)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 History of tattoo</td>
<td>YES</td>
<td>3703</td>
<td>37 (0.98)</td>
<td>2.18 (1.31 to 3.63)</td>
<td>0.003</td>
<td>3.13</td>
</tr>
<tr>
<td>NO</td>
<td>5424</td>
<td>25 (0.46)</td>
<td>1 (Referent)</td>
<td>1 (Referent)</td>
<td></td>
<td></td>
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<tr>
<td>TOTAL</td>
<td>9127</td>
<td>62 (0.67)</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

*Multivariate analysis was done using binary logistic regression by forward LR method. OR=odds ratio.
A population based dynamic approach for estimating the cost effectiveness of screening for Chlamydia trachomatis

We read the recent paper in STI on cost effectiveness for Chlamydia trachomatis screening by Honey et al with great interest.1 We concur with their conclusion that more data derived from clinical trials are needed for policy making, particularly when considering the evidence on the subsequent risk of pelvic inflammatory disease (PID) in women who test positive for Chlamydia trachomatis.

Our paper2 was included and discussed in this review. As our approach was rather complex, we note that some parts of our design and results may have been misinterpreted. Honey et al note that our study was focused on screening both men and women in general practice with an age range for evaluation of 15–64 years. Although this information is correct, it does not reflect that screening for women only was considered separately and that women older than 34 years were not included in the screening programme. This misinterpretation by Honey et al formed the basis for exclusion of our study from further systematic review.

Our approach differs from others in that we investigate cost effectiveness by employing a population based dynamic model (Monte Carlo simulation).3 This approach enables us to simulate the C. trachomatis transmission, the impact of prevention measures on the C. trachomatis incidence and prevalence, and the risk for C. trachomatis infection in a population. As a result, indirect effects (for example, future partners of current partners) over a period of several years can be considered using rates of partner change, mixing patterns, and transmission probabilities. We chose to analyse the screening programme over a period of 10 years. In our baseline analysis we assessed screening of men and women aged 15–24 years. However, in the scenario analysis we evaluated several other screening strategies, including screening of women aged 15–24, 15–29, and 15–34 years.

Despite the restriction of C. trachomatis screening to the age groups labelled as “young” women, an evaluation of the transmission dynamics of C. trachomatis in the population as described by our dynamic model requires the inclusion of men and older women in the model. For example, it may well be that C. trachomatis is transmitted from a young woman to a man, from this man to an older woman, etc. Such transmission chains may occur over a period of years and may involve men and women of all ages. So, to adequately evaluate screening of women aged 15–24, a model is required that considers all active sexual age groups. Therefore, sexual activity was modelled for both men and women aged up to 64 years, using assumptions based on a Dutch Sex Survey.

Application of our model to the Netherlands showed that screening women aged 15–24, 15–29, and 15–34 years over a period of 10 years would result in net cost savings to society. When including (excluding) indirect costs, cost savings were reached after 2.8 (3.8) years, 3.1 (4.3) years and 3.3 (5.0) years, respectively. This evaluation considered the costs of screening (polymerase chain reaction testing, azithromycin treatment, GP fee) and partner referral as well as direct (medical) savings as a result of averted health-care and indirect savings as a result of averted productivity loss.

We think that our dynamic approach leads to more realistic assessments of cost effectiveness in this area as it appropriately considers the highly infectious character of C. trachomatis. At this time, our approach is being used to evaluate the cost effectiveness of C. trachomatis screening programmes in two other European countries.

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References

Contamination of environmental surfaces by genital human papillomaviruses (HPV): a follow up study

In a previous study we investigated the contamination of environmental surfaces with human papillomavirus (HPV) DNA in two genitourinary medicine (GUM) clinics.1 This study was intended to review the GUM clinic in which HPV DNA was found to be present. Cleaning with “general purpose neutral liquid detergent” (detergent) (Youngs Detergents, Lancare Ltd, UK) and water, or 2% Clearsol (disinfecting detergent, 40% VV Tar Acids; Coventry Chemicals Ltd, Coventry, UK) in 70% methylated spirits (Clearsol) was performed following the results of the previous study.

Twenty samples were collected from two treatment rooms and patients’ toilets at each time of sampling. Samples were tested and typed as described previously.2 Surfaces sampled, and accumulation of HPV DNA during a single day, are listed in table 1.
Sampling was performed at 08.30 on two consecutive days and a third set of samples was collected at 16.30, the end of the clinic hours, on day 2.

Following cleaning with detergent and water at the end of the working day (sampling 1), nine of the 20 surfaces tested were contaminated. It was decided to clean surfaces with a more stringent agent. After subsequent cleaning with Closersol solution HPV DNA was present on one surface at the beginning of the day, and on four at the end of the day.

β Globin DNA was detected in all HPV DNA positive samples, indicating HPV was cell associated, and in a further five samples taken at the end of the day from HPV DNA negative surfaces.

Compared to our previous study a 50% reduction in surface contamination with HPV DNA was found after cleaning with detergent and the number of types detected was reduced. Only HPV types 6, 11, 16 and 58 were detected on the nine different surfaces. This is also a 73% reduction in the number of types detected in our previous study. HPV types 6, 11, and 16 were still the most common types found (all types in table 1).

Three of the samples positive for β globin DNA but negative for HPV DNA were from the patients' toilets and/or the male clinic examination couch. On the examination lamp switch and the edge of the examination couch in the patients treatment room, DNA was probably from the doctors' gloves, whereas β globin DNA detected on the surfaces sampled in the patients' toilets was probably the result of cells shed naturally. Cleaning with Closersol was more effective then cleaning with a detergent, which was more effective than no cleaning, but not sufficient.

Early in the 20th century Ignaz Philipp Semmelweis showed that hand washing with soap/water was not as effective as washing with ethanol. It has also been shown that alcohol based disinfectants have a better effect than antiseptic soaps. Different antiseptics and decontaminants, whether water or alcohol based, may have different viricidal efficiencies. There are few data on environmental decontamination; however, this study suggests cleaning with Closersol-medicated spirit is reasonably effective at decontaminating environmental surfaces, but contamination will recur unless cleaning is performed regularly.

Contributors
The principal author SS, with the co-author HS, collected the samples, and performed the PCR and the reverse hybridisation on the environmental samples; CS supervised the sample collection in GUM clinic and was co-author; JG supervised the project and was senior author.

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Funding was provided by the Public Health Laboratory Service for whom the Cambridge laboratory acts as the National Human Papillomavirus Reference Laboratory.

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2 Wylkicy H, Stepke M, Ignaz Philipp Semmelweis, the prophet of bacteriology. Infect Control 1983;4:267–70


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Issues associated with the introduction of circumcision into a non-circumcising society
A team lead by Kebaabetswe propose the introduction of infant circumcision in Botswana, based on:

- a survey of its acceptability to Batswana (people of Botswana)
- its practice in certain Western nations, and
- its alleged value in preventing HIV infection.

There are several medical, psychological, sexual, social, ethical, and legal problems with this proposal.

Medical effects
Male neonatal circumcision is not an innocuous procedure. There are many complications ranging from trivial to life threatening. Complications generally include bleeding, infection, and surgical accident, including penile necrosis and penile amputations. Bleeding or infection can progress to death. It is difficult to control complications with mass circumcisions. Circumcision excises significant amounts of nerve bearing penile skin and mucosa, especially the ridged band structure near the meatus. The protective effects of circumcision against HIV remain controversial. UNAIDS has not accepted circumcision as a useful public health measure.

In neighbouring South Africa, many children are infected with HIV. This is attributed to unsafe health care.

Circumcision creates an open wound through which infection may proceed. It is not clear that antiseptic circumcisions can be delivered in Botswana. It is possible that mass circumcision may worsen the epidemic.

Psychological effects
Psychological manifestations of circumcision have been an area of study at Bond University. Neonatal circumcision is an intensely painful, traumatic, and stressful operation. General anaesthesia is unsafe in the newborn. Available methods of anaesthesia are only partially effective. Circumcised infants show hypersensitivity to pain suggestive of post-traumatic stress disorder (PTSD). Our study of the incidence of PTSD in the Philippines found extensive PTSD in circumcised boys. PTSD secondary to neonatal circumcision has been found in adult males. Victims of trauma tend to re-enact their trauma either on themselves or others in a cycle of violence. Circumcised males may rely on psychological defence mechanisms such as rationalisation and denial, and strongly avoid thoughts, feelings, or conversations about circumcision.

There are additional concerns. The state of the phallus is closely related to a man's sense of wellbeing. Men who were circumcised neonatally may feel unhappy about being circumcised, experience significant anger, sadness, feeling incomplete, cheated, hurt, concerned, frustrated, abnormal, and violated. In addition, circumcised men may suffer from resultant low self esteem, which frequently can result in a host of disorders and behaviours.

Circumcision may be difficult to eradicate from a society once it is introduced. In addition, to the re-enactment described above, Goldman reports that circumcised men tend to defend the practice. Circumcised doctors tend to develop intellectual arguments to support genital cutting. Fathers who are circumcised may adamantly insist on a son's circumcision in an emotional defence against their own painful feelings of grief for a lost body part and reduced sexual function. Kebaabetswe et al (p 217) reported that, “Being circumcised was the only significant predictor for a man who would definitely or probably circumcise a male child.”

Sexual effects
As noted above, circumcision excises large amounts of skin and mucosa from the penis. The removal of the prepuce tightens the remaining skin and makes it relatively immobile. Since stimulation of the sex nerves normally occurs by movement of the mobile skin, this further desensitises the penis. Perhaps even more than the removal of the ridged band of erogenous nerves noted by Freud, circumcision excises significant amounts of nerve bearing penile skin and mucosa, especially the ridged band structure near the meatus. It is not clear that antiseptic circumcisions can be delivered in Botswana. It is possible that mass circumcision may worsen the epidemic.

Social effects
There has been little study of social problems that may occur when entire cohorts of males are circumcised and consequently most of the men in a society bear physical and psychological wounds associated with circumcision. We might expect more dependence on alcohol to relieve the symptoms of PTSD. Low self esteem may generate feelings of shame. Shame may generate problems with
relationship dissatisfaction, poorer health, depression, drug use, and loneliness. Increased sexual incompatibility and marital problems in uncircumcised societies might be expected as a result of reduced penile sensibility input, increased sexual dysfunction, PTSD, and low self-esteem among circumcised men. Increased antisocial behaviour may also be expected. Thus, we might expect to see higher levels of domestic violence, rape, child sexual abuse, suicide, and theft.

Human rights

The fight against HIV-AIDS requires the careful protection of human rights. Among these human rights one finds the rights to security of the person and protection from degradation treatment. The unnecessary excision of normal human tissue from unconsenting children is an obvious violation of the security of the person. Through amputation of erogenous tissue, circumcision necessarily diminishes sexual sensation and function as described above and may constitute degradation treatment.

Ethics

Doctors have a duty of care to behave in an ethical fashion. Among other requirements, they are expected to respect the human rights of their child patients. Circumcision has been shown to be a violation of the child’s human rights and, clearly, many ethical doctors are unwilling to carry out destructive circuncisions on normal, healthy boys. The British Medical Association recognises the right of the doctor to conscientious objection to the performance of circumcision.

Law

Male circumcision is not unlawful, but valid consent must be obtained. This may be a problem in the case of circumcision performed on unconsenting minors, in the absence of any medical indication. Cases involving the right of parents to consent to the non-therapeutic surgical sterilisation of a child have been heard in several nations. The cases agree that, in the absence of any medical indication, parents are not empowered to consent to the non-therapeutic, irreversible, surgical alteration of their child’s genitalia.

The absence of a valid consent, a circumcision may constitute an assault.

Conclusion

The value of male circumcision in preventing HIV infection remains unclear. Non-sterile circumcisions may increase the risk.

Reliance on circumcision to prevent HIV transmission is wishful fantasy, and can only result in a calamitous worsening of the HIV-AIDS epidemic.

Once started, circumcision tends to persist even when the need is over. Circumcision was introduced more than 100 years ago in Western nations on the grounds that it would prevent masturbation, which would prevent mental and emotional illness. That, of course, is no longer believed, but the practice of circumcision persists and has proved difficult to eradicate although progress is being made. The incidence of circumcision is declining in Western nations. The Department of Health of the Philippines is trying to discourage circumcision (called “tule”) in that nation where it has persisted. The practice of neonatal circumcision in certain Western countries, such as the United States does not constitute a valid reason for introducing neonatal circumcision in Botswana.

Extreme care must be taken in a decision to introduce circumcision into a society.

References

mind. These are missing. But a direct comparison of the treatment of a common condition, such as vaginal discharge, between the two books points up considerable differences. Whereas *Sexually Transmitted Diseases* tackles in admirable detail the microbiology, epidemiology, diagnosis, management, and complications of various infections, I looked in vain in the atlas to find out whether sexual partners of women with bacterial vaginosis should be treated. There are however novel aspects of the atlas that should be applauded. I especially liked the opening chapter on genital and dermatological examination that brings together the normal and the abnormal in a particularly useful way, especially for physicians with a limited knowledge of dermatology.

Clearly, the general attractiveness of this atlas will ensure its place on the bookshelves of most specialist departments. As an introduction to the specialty, it fills an important niche and might be an ideal purchase for training. It is to be hoped that *Sexually Transmitted Diseases* as a resource for serious investigators and may eventually become redundant with the advance of electronic media. In the meantime, clinicians with an idle moment might flick through the pictures reminding themselves of rarely seen conditions. My daughter, glancing over my shoulder, shuddered and insisted that the book should not end up on the coffee table. Perhaps a tribute to the quality of the photographs!

**P E Munday**

**Clinical Practice in Sexually Transmissible Infections**


This book, aimed at doctors in training in genitourinary medicine, is highly readable and manages to pack in a lot more material than one would guess from its size. It is largely successful in this goal, combining clarity of language and excellent clinical photographs where these are used.

In a book this compact the authors clearly did not intend to address comprehensively all the subjects raised, as indicated by the widespread referral to reviews and specialist books and use of up to date references for those inclined to seek further information. The length I think is more a strength than a weakness although it must have been difficult to decide what aspects of these disparate infections to include and what to leave out. However, perhaps because of the wider audience, when discussing certain pathologival states some information on, or illustrations of, normal state or function would have been helpful. For the same reason legends explaining some of the abbreviations used (for example, for recently defined cytokines and cellular molecules) would not have been remiss.

It is a brave person who sets upon the task of writing a medical textbook, not least because it is such hard work, but also because the accelerating pace of change in the biomedical sciences can make an author seem more like a historian. Even in this up to date book there is information that needs revision already, in view of recent changes (for example, p 158 Management of Pneumocystis jiroveci. Arch Intern Med 2001;161:1529–33). The authors have acknowledged this to some extent, by the use of “evolving” references in many instances (p 151 UNAIDS website; www.aidsmap.com for HIV treatment).

Long term utility of this kind of book depends, among other things on how well it is researched and written, but also crucially on the pace of further progress in the field and thus how often it needs revision. Progress is bound to continue in many areas of STI epidemiology and clinical practice. It would seem that web based books in a state of perpetual revision (for example, www.hopkins-aids.edu/publications/book/book_toc.html) may go some way to addressing the question of whether a book survives as a useful text.

This book may not be the last word on the subject of STIs but it is certainly a good place to start.

**Sylvia Ojoo**

**CORRECTIONS**

In the STI supplement 1 this year, 80th MSSVD Spring Meeting held jointly with the 19th STI Congress of IUSTI Europe, the following abstract was omitted from the printed abstract book, with apologies to the authors.

**Methods:** Patients attending an inner city HIV clinic with peripheral eosinophilia (≥0.5 x 10^9/l) on two or more occasions were identified as cases from a retrospective review of haematological records from October 1999 to August 2001. Controls (Africans without eosinophilia) were obtained from an ongoing prospective study. Demographic and clinical data were ascertained by case notes review and patient questionnaire. Investigations for parasitic infections were undertaken (schistosomal, filarial, and strongyloidises serology).

**Results:** 295 patients had haematological tests during the observation period, of which 67 (23%) had peripheral eosinophilia. 60/67 (90%) of the cases were of African origin, the mean nadir CD4 count was 195 and 25% were stage 3/4. Controls (n = 45) were broadly similar. To date, 26/45 (58%) African cases had positive serological screens for parasites (23 schistosomal, 4 strongyloidises, and 2 filarial infections), compared with 4/45 (9%) of controls (4 schistosomal infections) p<0.001, $\chi^2$ test. There was no positive serology in 3/7 non-African cases screened.

**Conclusions:** Although previous studies have demonstrated a low incidence of parasitic infection in HIV-1 positive patients with eosinophilia, we have identified a high number of treatable parasitic causes. No cause has been identified in 42%, suggesting that for a proportion of these HIV may be the cause. Despite this, routine screening for parasitic infection, guided by geographical exposure, is recommended in HIV-1 infected Africans with eosinophilia.

The following acknowledgement was omitted from the original article entitled Chlamydial infection: an accurate model for opportunistic screening in general practice, by A Cheever, H Cavols (1995) www.stijournal.com. We would like to thank Eddy Van Dyck and Hilde Smet from the Prince Leopold Institute of Tropical Medicine, Antwerp, for their help with setting up the diagnostic protocol and for performing confirmation tests, Jost Weyler of Antwerp University for his statistical advice, and all participating GPs in the field. This work was partly supported by Eurogenetics, the Scientific Organisation of Flemish GPs (WVVH), and the Local Health Promotion Organization (LOGO) of Antwerp. The sponsors of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report.
Issues associated with the introduction of circumcision into a non-circumcising society

G J Boyle

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