Highlights from this issue

doi:10.1136/sextrans-2012-050621

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By the time you read this, Olympic fever will be upon those of us in the UK—leave is cancelled in the public health agencies, road closure imminent, and a frenzy of emergency planning and resilience exercises is reaching its final stages. Where does sexual health fit in to Olympic preparation? Traditionally, large construction projects and major public events have been seen a magnet for sex work, bringing together large communities of men living apart from partners and families. A before and after analysis exploring Canada's 2010 Winter Olympics suggests that an influx of sex workers is no longer to be expected in a developed setting, but displacement and perceived police harassment need to be addressed.[1] Significantly, the researchers noted no increase in new reports of youth or trafficked sex workers. Some of our editors are involved in work to assess impact in the UK—watch this space!

In this month's Editor's Choice, Lyons *et al*[2] explore the relationship between age at first anal intercourse, and HIV/STI vulnerability in Australian MSM (men who have sex with men). Men with a history of STI or HIV experienced first anal sex earlier, a fact with important implications for prevention interventions for this vulnerable adolescents. In a thought-provoking accompanying editorial, Gebrekristos[3] explores the landscape and assesses the implications of this and other work for policy and practice in schools. Another Australian study explores attitudes to HIV post-exposure prophylaxis, condom use and risk perception in this group,[4] concluding that the match between vulnerability to HIV and willingness to use is good enough to justify post-exposure prophylaxis introduction.

The need for adaptation of epidemic responses to local structural features is a constant theme of our Programme Science series, edited by Aral and Blanchard, which continues with with Sgaier and colleagues' exploration of India's HIV epidemic response.[5] Their theme resonates throughout the journal, with an important article by Benzaken *et al*[6] demonstrating the value of a Situational Analysis of Sexual Health in assessing transmission potential the Brazilian Amazon. They identify conditions for rapid transmission, but relatively low rates of HIV and STI, which suggest there is a window of opportunity for prevention interventions to derail rapid growth of the epidemic. On a smaller scale, a study of male sex workers in Côte d'Ivoire assesses the vulnerability and behaviours of male sex workers, with a view to improved intervention,[7] showing high rates of STI and HIV, despite good rates of condom use. And Pépin's[8] fascinating history of how STI treatment may have contributed to the early HIV epidemic brings a rich account of the life of a migrant worker community into epidemic analysis. David Mabey has reviewed Pépin's recent book[9]—we highly recommend it.

Recent infection algorithm tests for HIV have an important place worldwide in assessing HIV epidemics and potential for testing interventions to reduce transmission in different population groups. However, UK clinicians have led the way in using these tests in clinical practice—this is a controversial use of the tests, which are not designed for use in the management of patients. Carlin and Taha[10] are to be congratulated for their 'How to do it' article, which sets out the practical issues in using these tests with patients to inform customised partner notification strategies. Tell us what you think on the website. Will other countries follow?

Clinicians will be interested in Orellana *et al*'s demonstration of the low sensitivity of Gram stain for urethritis,[11] and a case report of inguinal syndrome secondary to *Prevotella bivia* following a bite during oral sex.[12] Bacterial microbiology is increasingly becoming an Achilles heel for STI control. The threat of untreatable gonorrhoea looms, and we still do not understand the role of *Mycoplasma genitalis*, while bacterial vaginosis continues to present mysteries. As our testing regimes rely increasingly on nucleic acid amplification, we will increasingly be testing only for what we already think could be there. Sobel's editorial[13] on genital malodour provides clinicians and researchers alike a timely reminder that there are still major unsolved problems that will not be eliminated by multiplex point of care NAAT tests. Patients come to us because they itch, they smell, they are sore, they have discharge, they are afraid of infection, they cannot get pregnant. As the age of 'pee in a pot and wait for the text' comes upon us, we need to make sure that sexual health services, our research interests and our advocacy are driven by felt patient needs and not only by available technologies.

Provenance and peer review Commissioned; not peer reviewed.

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