

# Whistlestop tour

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The public impact of human papilloma-virus (HPV) figures prominently this month. Samaranayake (*see p 540*)<sup>1</sup> reports reduced diagnoses of genital warts following introduction of quadrivalent vaccine in Australia. Pirotta's study (*see p 508*)<sup>2</sup> of the psychosocial burden of HPV disease and screening interventions is timely, showing that external genital warts and cervical intraepithelia neoplasia 2/3 had similar negative psychosocial impact. This will re-ignite debate about quadrivalent versus bivalent vaccine.<sup>3</sup> Treatment of warts remains unsatisfactory. A randomised controlled trial of cryotherapy (*see p 514*)<sup>4</sup> with podophyllotoxin versus cryotherapy alone showed clearance of 68.6% and 64.3%, respectively, by 24 weeks. Larger trials are needed.

Prevention strategies for the longer term impacts of HPV on males, are poorly understood. Li *et al* (*see p 503*)<sup>5</sup> report a 27% prevalence of abnormal anal cytology in that MSM, higher among HIV positives and confirming the need for programmatic research. Worryingly, Lucky *et al*<sup>6</sup> report that genitourinary medicine clinics in the UK are a source of potential delay in diagnosis of penile cancer (*see p 527*). There is a need for improved dermatological training and experience for UK genitourinary physicians.

The Melbourne group reports a new source of pressure on services (*see p 499*).<sup>7</sup> 7.7% of consultation time was consumed by "swab only testing" of female sex workers (FSW) who were diagnosed with 4 sexually transmitted infections (STI) per 100 consultation hours, compared with 11 for all clients and 19 for MSM. The authors could have detected 205–417 more cases of STI over 3 years with 3-monthly testing of this low-risk population. In Kenya, by contrast, Mandaliya *et al*<sup>8</sup> report a herpes simplex virus 2 incidence of 23/100 person-years among FSW (*see p 489*). These papers contribute to the evidence-base needed to plan for prevention for sex workers, which must take a realistic account of their place in STI transmission and prevention. As Mandaliya *et al* point out, bar work was associated with higher transmission rates despite lower partner numbers at the individual level—an understanding of networks is essential to understanding risk.

Sexual network structures are given detailed treatment in Fichtenberg's study of American adolescents (*see p 493*).<sup>9</sup> Individual-based information underestimates the association between STI risk and network position, while being at the centre of a network increases odds of infection. There is growing consensus on the inadequacy of partner numbers to a measure risk. Translation of these insights into clinical practice and prevention interventions is overdue.

Decker's study of intimate partner violence in relation to STI/HIV diagnosis and a range of standard and "gendered" risk behaviours (such as condom refusal, of concurrent partnerships) (*see p 555*)<sup>10</sup> demonstrates increased STI/HIV risk among abusive men, with gendered risk behaviours partly responsible for this increased risk. The sexual networks associated with these behaviours create asymmetrical power structures and need further study.

Editorials explore disappointments in HIV testing both among MSM (*see p 487*)<sup>11</sup> and the wider population (*see p 486*).<sup>12</sup> A related paper by Mbonye (*see p 534*),<sup>13</sup> explores the potential of private midwives contributing to HIV testing in a setting where a fifth of HIV transmission is thought to be mother-to-child. Evans *et al* (*see p 543*)<sup>14</sup> further support the case for widening HIV testing by showing that when patients are known to the general practitioner to be HIV positive, their consultation rates approximate the wider population, providing opportunities for wider preventive health care. But only half of patients have their status recorded in the electronic record (*see p 520*).<sup>15</sup>

Finally, good news in the field of gonorrhoea. Gopal Rao *et al*<sup>16</sup> achieved culture confirmation of 87.2% of nucleic acid amplification test (NAAT) positive cases in community sexual health services through improved transportation (*see p 531*), enabling continued surveillance in the face of growing antibiotic resistance. Should we forget why this is important, a few minutes in the archive will provide some nostalgic reflections at Christmas time and remind us how far venereology has come...<sup>17–20</sup>

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