There appears to be no conclusive evidence to avoid hormonal contraception in HIV seropositive women. On balance, based on immune responses, it may be preferable to consider a progestogen-only pill or an injectable progestogen. An IUCD should be avoided in HIV seropositive women if possible, although we were unable to do so in one patient as all other methods were unacceptable.

We advocate that all HIV seropositive women should have easily accessible contraceptive advice. It is important to realise that although fear of pregnancy may be the prime reason for requesting a second contraceptive method other influences may be present.

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4 Selwyn PA, Carter RJ, Schoenbaum BE, Robertson VJ, Klein RD, Rogers MF. Knowledge of HIV antibody status and decisions to continue or terminate pregnancy among intravenous drug users. JAMA 1989;261:3567–71.

The use of barrier contraceptives in Denmark during the AIDS epidemic

In the absence of a cure or vaccine for AIDS, changing sexual behaviour remains the only strategy available to those, who are concerned with this aspect in public health campaigns. Since 1985 the Danish health authorities have given high priority to educational campaigns for prevention of HIV infection in the general population. As a way of controlling the spread of the infection this public information has focused on the use of barrier contraceptives especially condoms for casual sexual intercourse. Less emphasis has been put on reducing the risk of HIV infection by having fewer sexual partners.

Data from Denmark indicate a substantial reduction in the prevalence of major STDs, syphilis, gonorrhoea and hepatitis B since the mid-1980s. In a major STD clinic in Copenhagen a decrease was also noted in the prevalence of chlamydia infections, whereas no consistent changes were detectable in genital warts and genital herpes.

As a result one should expect a general increase in the use of condoms in Denmark since 1984. A figure of the total national use of condoms per year is for obvious reasons not available. In Denmark, the Medicines Department, National Board of Health approves all batches of sold condoms. Each batch contains 72,000 condoms or less. From 1984 to 1993 we have for each year collected the numbers of approved condoms in Denmark (table). The total number of accepted condoms presumably reflects the number of sold or handed out condoms. In addition the number of sanctioned diarrhaphs each year from 1984 to 1993 are shown in the table.

The table shows that a slight increase in the number of approved condoms occurred from 10–11 millions in 1984–85 to 13–14 millions in 1990–93. In one single year (1988) more than 19 million condoms were accepted for sale. A steady but substantial decrease was noticed in approved diarrhaphs.

Recently published data have indicated an increased use of condoms during the AIDS epidemic among Danish adolescents and among females attending an STD clinic. The same trend was noted among US college women. This combined with the fact that sexual behaviour among heterosexuals has not changed in recent years should as a consequence result in a marked increase in the number of sold condoms. Although increased use of condoms has taken place, consistent use of condoms is rarely seen.

An explanation for the observed decrease in STDs in Denmark is probably complex. Several factors may contribute, such as reduced promiscuity among homosexual males, increased use of condoms in high-risk individuals (homosexual males and8 heterosexuals) reduced sexual activity in some groups of heterosexuals and to a certain degree an increased use of condoms in the general population.

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The total number of approved condoms and diarrhaphs in Denmark from 1984 to 1993

<table>
<thead>
<tr>
<th>Year</th>
<th>Condoms</th>
<th>Diarrhaphs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>11.4 x 10^6</td>
<td>15012</td>
</tr>
<tr>
<td>1985</td>
<td>10.8 x 10^6</td>
<td>11829</td>
</tr>
<tr>
<td>1986</td>
<td>13.5 x 10^6</td>
<td>18916</td>
</tr>
<tr>
<td>1987</td>
<td>13.6 x 10^6</td>
<td>12289</td>
</tr>
<tr>
<td>1988</td>
<td>19.3 x 10^6</td>
<td>9157</td>
</tr>
<tr>
<td>1989</td>
<td>12.7 x 10^6</td>
<td>10364</td>
</tr>
<tr>
<td>1990</td>
<td>13.1 x 10^6</td>
<td>12252</td>
</tr>
<tr>
<td>1991</td>
<td>13.0 x 10^6</td>
<td>7867</td>
</tr>
<tr>
<td>1992</td>
<td>13.0 x 10^6</td>
<td>6254</td>
</tr>
<tr>
<td>1993</td>
<td>14.7 x 10^6</td>
<td>1712</td>
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</tbody>
</table>

Letters to the Editor
Polypoidal and giant molluscum contagiosum in an AIDS patient

Between 10% to 20% of patients with symptomatic HIV disease or AIDS have molluscum contagiosum (MC). Individual lesions of MC may be quite large with a diameter of 10 mm or more and designated as "giant molluscum contagiosum". The appearance of multiple (up to 100) typical papules are more common than solitary papules or plaques of MC. Usually MC lesions are seen over the face (including eyelids), neck and in the intertriginous areas (such as axillae, groins or buttocks) in AIDS patients. In a recent study from Denmark none of the 16 cases (with MC) out of 122 HIV infected patients had a MC lesion in the anogenital region.

Recently we saw an AIDS patient with multiple (more than 20) asymptomatic MC lesions limited to the penile skin of 3 months duration (fig). The size of the individual lesions varied from 1 to 15 mm in diameter with no history of spontaneous regression. Two lesions had narrow bases (8 mm diameter) and broad tops (12 mm diameter) like polyps, two were giant molluscum contagiosum and the rest were typical discrete, translucent, umbilicated papules. Even on careful cutaneous examination no other part of the body was found to be affected. Curettage and cauterisation with trichloroacetic acid were performed on a few lesions at a time, with the aim of reducing the number and bulk of the lesions.

Giant MC is well known in AIDS patients. The reason for their absence in non-HIV immunosuppressed patients has yet to be explained. Giant MC attaining polypoidal character and limited to the penile skin as seen in our patient is an uncommon presentation.

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Dipyridamole, as an interferon inducer, versus placebo in the prevention of recurrences of condylomata acuminata after diathermocoagulation

Galabov et al have demonstrated that dipyridamole, a drug which has been used for several years for its anti-aggregant activity, is an endogenous interferon inducer in guinea pigs and in man. A single administration of dipyridamole (100 mg) in man induced an increase in the plasma concentration of alpha interferon equal to 195 times the basal values in 36 out of 40 healthy volunteers, detectable up to 48 hours after administration. A reduction in the plasma concentration of interferon was found, with subsequent administrations of dipyridamole, around 4–6 days after the start of administration of the drug, similar to what was observed for other interferon inducers. This period of hyporeactivity has a mean duration of 5–7 days for the interferon inducers studied.

On the basis of these findings, it was decided to verify whether the activity of dipyridamole as an endogenous interferon inducer could modify the course of condylomata acuminata, a disorder which is difficult to treat owing to the frequent recurrences. Exogenous interferon has been used in the past few years to treat this disorder, with

Figure Giant molluscum contagiosum of penis.