quine treatment (300 mg base twice a day) was started and continued for three weeks with no improvement. Subsequently the patient developed chronic diarrhoea and left acute oitis media and the general conditions worsened progressively. She died two months after admission with generalised sepsis, unresponsive to broad spectrum antibiotics, including a trial with intensive antitubercular treatment.

AIDS and SLE diagnosis can interfere with each other in three different ways: (a) AIDS presenting with SLE clinical and serological features,2 (b) SLE with false-positive HIV screening tests,1,4,5 (c) SLE with concomitant AIDS.4,6 Moreover the difficulty in differential diagnosis is increased by the limited diagnostic facilities of an isolated rural hospital.

Although our patient did not fully meet the 1982 ARA revised criteria for the diagnosis of SLE,4 the clinical and laboratory features were quite suggestive. Furthermore the hypothesis of SLE autoantibodies producing a false-positive HIV agglutination result opened a therapeutic chance. The most probable diagnosis is AIDS with SLE features. Thus, together with other previous reports, our observation suggests that in high HIV prevalence countries the clinical presentation of SLE could be a marker of AIDS and an indication for HIV testing.

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From 1994 to 1995 there was a 73% (278 to 481 cases) increase in laboratory confirmed Hepatitis A Virus (HAV) infections among adults aged 15 years or over reported to the Public Health Laboratory Service (PHLS) Communicable Disease Surveillance Centre (CDSC) from laboratories in the Thames regions. This was against a background of a 42% fall in such reports from laboratories in non-Thames regions. The age and sex distribution of reports showed a disproportionate rise (225%) among men aged 25-34 years (fig.). Data in the first 5 months of 1996 suggested that the trend was continuing although levels have reduced in the second half of 1996. The number reported as homosexual increased by 346% from 13 to 58 between 1994 and 1995 and there were 23 reports in homosexual men in the first 5 months of 1996.

Reports to consultants in Communicable Disease Control rose markedly in South and East London as well as Brighton and were mainly from general practitioners (GPs) rather than genitourinary medicine clinics. In the boroughs of Tower Hamlets and Hackney during October 1995 to March 1996 reports increased more than fourfold compared with the same period in the previous year and about 40% were known to be gay. No common exposures (such as functions, foods, contacts, travel or recreational venues) were apparent in investigations carried out in South or East London.

Increased levels of HAV infection among homosexual men in the Thames area have been reported previously in 19807 just prior to a national increase in 1981-82, and in 19898 during a national increase in 1989-91. This recent increase in the Thames area appears to be in the absence of a national rise.

Transmission of HAV infection is usually faecal-oral. Among homosexuals risk factors include oral-anal contact,3 and digital rectal intercourse.4 The opportunity presented by the staging of the National Gay Pride Festival in London (6 July 1996) was taken to: (a) deliver public health messages about prevention of HAV infection; and (b) carry out an epidemiological study to determine HAV seroprevalence (using a saline antibody test) and risk factors for transmission, results of which are currently being analysed.

The co-operation of consultants in genitourinary medicine and GPs in notifying cases of acute HAV infection and facilitating provision of post exposure prophylaxis with human
normal immunoglobulin (HNIG) to household and sexual contacts is important. Hepatitis A vaccine has recently been recommended in the United Kingdom for homosexual men. Our findings provide some evidence to support its use among this group.

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Services for female prostitutes in genitourinary medicine clinics in the UK

Prostitutes may be at increased risk of sexually transmitted diseases and HIV infection as a result of their numbers of sexual partners, although the risks vary. Genitourinary medicine (GUM) services have a role in helping reduce these risks.

It is impossible to determine the proportion of all GUM clinic workloads made up by prostitutes; in our own experience in London, female prostitutes accounted for 6% of female attendances. Some prostitutes are reluctant to use GUM services, and when they do they may not disclose their work. This reflects fears about confidentiality, and prior experiences of moralistic and prejudiced attitudes from health and other services.

Over the past decade a number of initiatives have been taken within GUM services to reduce HIV and STD risks in the sex industry. We undertook a survey to establish the range of services provided by genitourinary medicine clinics in the UK. Questionnaires were sent to the consultant in charge of all UK GUM clinics; 172 (73%) of the 237 were returned.

The majority of respondents (119, 69%) reported that female prostitutes attended their clinics. These clinics saw very few prostitutes; estimates ranged from zero to 20 (mean of 1-4) per week, with nine clinics seeing more than five. Twenty five clinics provided some form of specialist service. The breakdown of these services is shown in the table.

GUM clinics have a number of responsibilities in relation to prostitution. Firstly, prostitutes should have the same access to services as everyone else. Some obstacles relate to broader problems of the law and local policing, but others can be addressed within the clinic itself. These include increased awareness of prostitution and a conscious attempt to overcome prejudice in all members of staff. This should include soliciting the views of local prostitutes on the services, and staff training to address any problems. Some clinics have established drop-in facilities where prostitutes can meet staff and other prostitutes in a less formal setting to address wider health and social problems. Such centres are often very popular and may be an important way of increasing prostitutes’ access to health care. Secondly, clinics with a large local sex industry should consider setting up specialist clinical services. This survey shows that only a small number of clinics (5%) are doing this, probably reflecting the relatively small proportion of total workload thought to be represented by prostitutes. Advantages of specific clinic sessions within a GUM service include the development of trust between staff and users of the clinic, and the provision of appropriate screening and advice.

Thirdly, clinics have a responsibility, in liaison with other local agencies, to help reduce the risks of STD and HIV associated with the sex industry. It is this aspect which appears to have been most frequently addressed; 10% of clinics reported providing outreach. This outreach generally means detached health promotion work, with health advisers or other specially trained staff making contact with prostitutes outside of the clinic to provide advice, distribute condoms and facilitate visits to the clinic. Outreach work may include visits to saunas, clubs and agencies as well as to areas of street prostitution and to magistrates’ courts. Through this work clinic staff can also learn about the local sex industry and assess the need for the provision of specific clinic or drop in services.

<table>
<thead>
<tr>
<th>Services for female prostitutes in GUM clinics</th>
<th>Number of clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Combination of services</strong></td>
<td><strong>Number of clinics</strong></td>
</tr>
<tr>
<td>Outreach only</td>
<td>10 (6%)</td>
</tr>
<tr>
<td>Drop in only</td>
<td>4 (2%)</td>
</tr>
<tr>
<td>Clinic only</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Outreach and clinic</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Outreach and drop in</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Drop in and clinic</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>All three</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>None</td>
<td>147 (85%)</td>
</tr>
</tbody>
</table>