

Sexual health: what's in a name?

Sonnex *et al* presented the results of a survey of 150 of their British patients' preference for signposting for their clinic: 65% chose "clinic 1A", 23% opted for another euphemistic name—for example, "Lydia clinic", 25% chose "department of genitourinary medicine" or "GU clinic", 25% chose "department of sexual health" or "sexual health clinic" and only 8% chose "genito-medical clinic" (more than one choice was allowed). At that time their clinic apparently operated under the name "clinic 1A—genito-medical clinic".¹

Beginning with the then new Parramatta sexual health clinic in 1979, Australian "STD clinics" have, one by one, adopted the title "sexual health clinic/centre". Our own clinic changed its name in 1990. The new name was intended to reflect the broader clinical base: which includes family planning/reproductive medicine, sexuality and relationship counselling, and other general aspects of sexual health medicine. The name also implies a proactive population health approach rather than just providing a clinical service.²

As there has been little consumer consultation about our name change, we included a question on patients' preference for a clinic name as part of a satisfaction survey.

In all, 563 consecutive general clinic patients completed a satisfaction survey questionnaire in 1996. Exclusion criteria were inability to read English and attendance at a special clinic—for example, HIV eye clinic, colposcopy/gynaecology, Thai, or Chinese clinic. The M:F ratio (1:0.6), mean age (30 years), ratio of new to return patients (1:1.6), and proportion born in Australia (61%) were all consistent with the clinic's general patient profile. The patients' (mutually exclusive) responses appear in the table.

The majority of our patients responded favourably or indifferently to the centre's new name. About one in five preferred "Nightingale clinic" (a name that had been promoted in the 1980s) but it was unclear whether this was an expression of preference for a euphemistic name or a desire to commemorate the fact that the building in which the centre is located is the cradle of nursing in Australia. We were surprised at the unpopularity of the names "STD clinic" and "genitourinary medicine clinic" given that the former was the name of the centre 6 years previously and, relevant to the latter name, 15% of the sample were from the United Kingdom or the Republic of Ireland.

Interpreting Sonnex *et al*'s and our studies together, it appears that patients are relatively accepting of a variety of names for STD/HIV medicine services, particularly the name in current usage. However, "STD clinic" and "genitourinary medicine clinic" have not achieved wide acceptance. The British patients' apparent preoccupation with euphemism seems to contrast with the Australian patients' open minded attitude. It is possible that the broader service profile of Australian sexual health services has helped

to partially destigmatise them. Alternatively there may be a true cultural difference. Notably, one quarter of the British patients liked "sexual health" despite their lack of previous exposure to the term.

Australia's choice of "sexual health clinic/centre" was driven by a new service philosophy rather than euphemism. We note that most New Zealand clinics and a number of new services in the United Kingdom have also adopted the term. Dissatisfaction with the name "genitourinary medicine" is becoming increasingly explicit.³

In accordance with this new name and philosophy for our health services we have developed professional titles: sexual health counsellor (previously health adviser, contact tracer, etc), sexual health nurse, and sexual health physician (previously venereologist, family planning consultant, etc). A vote for a name change from The Australasian College of Venereologists to The Australasian College of Sexual Health Physicians achieved an 84% approval by those who voted in 1996.⁴ There has also been a well reasoned call for a new specialty of sexual health promotion.⁵

Only time will tell us whether we have found the right name.

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Accepted for publication 9 May 1997

Photosensitivity due to saquinavir

Photosensitivity induced by the HIV protease inhibitor saquinavir (Invirase, Roche) is listed as a rare adverse effect in the *US Physician's Desk Reference*¹ but is not recorded in the patient information sheet nor in the Summary of Product Characteristics (SmPC) available in the UK. We wish to highlight this discrepancy. A 38 year old man with AIDS (CD4+ count < 10 cells × 10⁶/l) and no prior history of photosensitivity underwent 11 sessions of biweekly UVB therapy for a lichenified papular eruption. The UVB dose was chosen according to the patient's skin type and then increased by 40% every other treatment. Meanwhile, because of intolerance of both zidovudine and lamivudine he commenced saquinavir (1800 mg daily) and stavudine (60 mg daily), continuing on didanosine (250 mg daily) and monthly inhaled pentamidine. Three days after starting the new drugs he attended for his twelfth UVB treatment (80 seconds, 40% UVB) and sustained a severe painful sunburn reaction which settled with topical steroids.

This is the first officially reported case of

photosensitivity due to saquinavir.² This adverse reaction is recognised in the USA as reflected by the product labelling and patient information leaflets.³ According to Roche's international drug safety expert, the European Medicines Evaluation Agency considered a causal relation unlikely and therefore did not include the risk of photosensitivity in the SmPC for saquinavir. Stavudine induced photosensitivity has not been reported.

Because UVB therapy is useful in managing skin eruptions associated with HIV infection, photosensitivity is an important adverse drug reaction even if it is rare. A San Francisco AIDS Foundation patient information leaflet warns those taking saquinavir to avoid ultraviolet light and use sunblock.³ In spite of the current lack of warning in the UK SmPC, we believe patients taking saquinavir should follow the same advice and UVB therapy should be administered warily if at all.

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Accepted for publication 13 May 1997

Sexually acquired herpes simplex virus infection of oropharyngeal cavity

Unprotected orogenital sexual activity has increased in recent years and the reported prevalence varies between 40% and 70%.^{1,2} This altered sexual behaviour could in part be the result of media coverage of the HIV epidemic, which seems to have promoted the belief that orogenital sex is a low risk activity in relation to transmission of HIV and other STDs. Investigations on the effect of such sexual activity on pharyngeal bacterial flora have shown a twofold increase in pharyngeal carriage of *Neisseria meningitidis* in homosexual men¹ but no increase in asymptomatic carriage or infection with *N gonorrhoeae*.² However, transmission of HSV infection from the anogenital region to the oropharyngeal cavity in healthy adults resulting from sexual activity (fellatio and cunnilingus) has not been reported. We report a case of oropharyngeal ulcers due to herpes simplex virus type 1 (HSV-1) infection without associated anogenital herpes, which occurred following orogenital sexual activity (fellatio) in a homosexual male.

A 33 year old homosexual man presented to the genitourinary clinic with a 4 day history of "sore throat", dysphagia and flu-like symptoms and a 2 day history of dysuria and urethral discharge. He reported to have had unprotected, active, and passive orogenital sex (fellatio) with a casual male partner 1 week previously. An examination revealed multiple shallow ulcers with irregular margins, and marked surrounding inflammation on the pharynx, palate, and fauces (fig). There were no lesions on the anogenital region but a copious amount of purulent

Response of patients to a question about their preference for a clinic name (n = 563)

Sydney sexual health centre	40.5%
No preference	32.5%
Nightingale clinic	20.2%
STD clinic	4.6%
Genitourinary medicine clinic	1.4%
Other	0.7%



Photograph illustrating multiple herpetic ulcers on oropharynx.

urethral discharge was noted. Microscopy of a Gram stained urethral specimen revealed Gram negative, intracellular diplococci for which he was treated immediately with a dose of 400 mg of ofloxacin. A provisional diagnosis of first episode of herpes simplex virus infection of the oropharyngeal cavity was made, and he was advised to take aciclovir 200 mg \times 5 for 5 days.

The patient reported to have always practised homosexual orogenital sex and had never practised anal sex. The sexual history of the recent casual partner was not known. He admitted to having had a similar sexual contact with another male partner 10 weeks earlier. This was his previous regular partner for 5 years who had no known history of genital herpes.

He returned after 10 days when he was reported to be well and asymptomatic. On examination the oropharyngeal ulcers were noted to be almost healed. A test of cure for *N gonorrhoeae* from a urethral specimen was reported negative on microscopy. A blood sample was sent for a repeat estimation of HSV antibody.

Herpes simplex virus type 1 (HSV-1) was isolated from the specimen from oropharyngeal ulcers in cell culture. The serum HSV-1 antibody level showed a significant rise from less than 1 in 10 during the first visit to more than 1 in 40 on the tenth day during the follow up visit. This rise in HSV-1 antibody level was consistent with seroconversion for HSV-1.

Microscopy result of *N gonorrhoeae* from the urethra on his first visit was confirmed on culture. A pharyngeal specimen did not grow *N gonorrhoeae*.

Isolation of a high proportion of HSV-1 among women with first episode of genital HSV infection was first reported from Sheffield.³ Since then an annually increasing prevalence of HSV-1 in female anogenital herpes has been reported by others.^{4,5} The practice of cunnilingus has been proposed as one of the possible causes of such a trend.⁵ It seems reasonable to assume that such sexual activity could similarly lead to a transmission of HSV from the genital area to the oropharyngeal cavity. In the present case, the occurrence of herpetic lesions in the oropharyngeal cavity within 1 week of unprotected orogenital contact suggests possible transmission of HSV-1 from the genital area to the oropharynx. A first episode of genital HSV-1 infection almost always indicates a true primary infection with HSV.⁶ Thus, seroconversion for HSV-1 in the present case suggests primary infection with this virus and also substantiates the possibility of transmission of HSV from recent orogenital contact.

The incidence of sexually acquired oropharyngeal herpes due to HSV may increase as a result of increased prevalence of

orogenital sexual activity. Because of the risk of transmission of HSV from asymptomatic viral shedding, the prevalence of HSV carriage and shedding from the oropharynx of sexually active adults needs to be investigated. During counselling, the possibility of acquisition of HSV infection of the oropharyngeal cavity from the anogenital region, and vice versa, should be discussed.

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Accepted for publication 13 May 1997

Syndromic management of sexually transmitted diseases

The WHO has recently recommended the syndromic approach for management of various sexually transmitted diseases.^{1,2} This is being adapted in an increasing number of countries as it is easy, adaptable, safe, and efficacious. However it has also received some criticisms.³

In the Sultanate of Oman, STD prevalence is estimated to be around 121/100 000 and the predominant STDs are gonococcal urethritis, non-specific urethritis, and syphilis (particularly latent syphilis). Infections like granuloma inguinale and lymphogranuloma venereum are uncommon.

In Oman, the syndromic approach for management has recently been adapted as part of the national STD control programme. A national STD manual has also been released and has been made available to all healthcare providers. However, we have made certain modifications to adapt it to the prevailing local conditions, after consideration of the various comments made about the approach.^{2,4} We would like to highlight these modifications to show how the approach can be successfully adapted to local conditions.

One well meaning criticism is that the WHO recommendation does not include mandatory testing for VDRL and HIV infection.² This is particularly relevant in view of the well established link between HIV infection and other STDs. Since facilities for the transport of blood samples do exist in Oman, we have made it a mandatory requirement for all cases of STD to be investigated with VDRL and ELISA for HIV infection. This will help in detecting latent syphilis/HIV infection.

Another valid criticism is that, with the

syndromic approach, data collection and statistical analysis of individual STDs, becomes impossible and would affect future planning.³ To overcome this, we have introduced a monthly STD form (in addition to tally sheets for syndromic approach), to be completed by institutions wherein venereologist services are available. The form lists all the sexually transmitted diseases, and would help in collection of data on individual diseases.

A third criticism is that syndromic management results in over treatment and several non-STDs will be treated as STD.² This is perhaps unavoidable in the syndromic approach. We have sought to counter this by giving a list of non-STDs as a differential diagnosis in our STD manual and by sensitising healthcare providers to the pitfalls in diagnosis, through a series of workshops held throughout the country.

A well supported argument has been made against the flowchart for vaginal discharge, that without proper vaginal examination, lesions located intravaginally will be missed.² In our prevailing social conditions, vaginal examination by a male doctor is not possible and hence the flow chart is highly relevant. We have further emphasised in our manual that any patient not responding to treatment, or with complications should be referred to the nearest hospital where facilities are available.

Finally, our data analysis showed that latent syphilis was the most common form of syphilis prevalent in the country. Also, a well established system exists in Oman for antenatal screening and screening of blood donors. In addition, all expatriate workers in the country are screened yearly at the time of visa renewal for VDRL and hence management of reported VDRL titres is extremely important. We have included a special section on interpretation of VDRL in our STD manual, for this purpose.

As can be seen, our syndromic approach provides a simple model which can be adopted quite easily to the regional situation. We hope our letter will stimulate similar modifications elsewhere.

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Accepted for publication 13 May 1997

Decline in the incidence of HIV test requests in general practices in Amsterdam after 1992

I wish to report an interesting trend in HIV test seeking behaviour in Amsterdam, where half of all AIDS cases in the Netherlands have occurred.¹ To assess trends in HIV test seeking behaviour and HIV prevalence in the

Genitourin Med: first published as 10.1136/sti.73.4.323-b on 1 August 1997. Downloaded from http://sti.bmj.com/ on September 22, 2023 by guest. Protected by copyright.