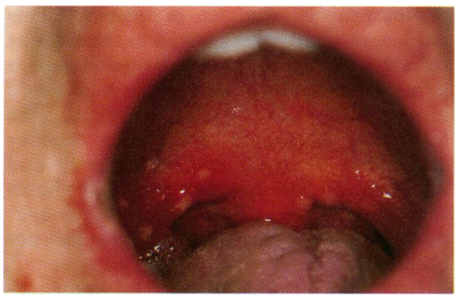

Photograph illustrating multiple herpetic ulcers on oropharynx.

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 × 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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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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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