LETTERS TO THE EDITOR

Is bacterial vaginosis a sexually transmitted infection

Editor,—I have a concern about a reference used in the article “Is bacterial vaginosis a sexually transmitted infection?” in the February issue of STI. I have a particular interest in BV, especially in the potential for BV to be sexually transmitted between women. In the recent article the authors stated that: “...past studies focusing on concordant BV infections within lesbian couples have failed to produce consistent results.”

To this statement there were two references. One supported concordant BV results in lesbian couples, but the second reference referred to an article about treating urethritis in men in developing countries. It is no wonder they didn’t find any evidence of BV transmission between women.

Previous studies have consistently demonstrated higher rates of BV in women who have sex with women. Further studies are needed to better understand the transmission dynamics of bacterial vaginosis between women.

KATH FETHERS
Alice Springs Sexual Health Unit, Alice Springs Australia

Correspondence to: Katherine.Fethers@nt.gov.au


Accepted for publication 10 May 2001

Reply

Editor,—I thank Dr Fethers for pointing out the discrepant reference in our paper.

The discussion paragraph referred to conflicting results from studies focusing on the transmission of bacterial vaginosis (BV) in lesbians. A cross sectional prevalence study by Berger et al of among monogamous sexual partners reported that of 11 index women with BV, eight (72.2%) had partners with BV. This compared with only one (10%) partner with BV of the 10 index women without infection. The high level of concordance was attributed to the probable sexual transmission of BV within lesbian couples.

The evidence against the sexual transmission of BV among lesbians should have referred to a paper by McCaffrey et al, though this was not among concordant partners. This study of sexual practices among women attending a specialist genitourinary medicine clinic in London reported that of 15 exclusively lesbian women, 40% had BV compared with 55% of the 76 women who were not exclusively lesbian. Therefore, the presence of BV did not appear related to sexual practices among lesbians.

I hope that the matter has now been clarified.

MARIANNE MORRIS
PHLS Communicable Disease Surveillance Centre, 61 Colindale Avenue, London NW9 7WF, UK
MMorris@phls.org.uk


Accepted for publication 10 May 2001

Dial 1097 (tolle free)

EDITOR,—Even as psychologists the world over ponder over whether computers can be good psychotherapists, computerised AIDS helplines are operating successfully in 35 Indian cities. The strategy behind these helplines is that as AIDS has no cure and prevention is its only remedy, “greater AIDS awareness” is akin to “greater AIDS prevention.”

Chandigarh AIDS hotline is a computerised telecounselling service which is a joint venture of a non-government organisation (NGO) called “Servants of the People Society” and the State AIDS Control Society, Union Territory, Chandigarh. This helpline was started in January 1999 with the motive of “AIDS prevention” through “AIDS awareness.” It is a 24 hour computerised interactive voice response service which is accessible on a 4 digit number (1097) by telephone. Confidentiality and anonymity of the caller are the hallmarks of this service. HIV/AIDS hotline is a toll free service that provides information and counselling on HIV/AIDS related issues in English, Hindi (national language), and Punjabi (regional language). The service consists of two parts—a prerecorded “standard question” option and a “specific inquiry” option. The prerecorded standard coded questions are:

- Code 1: What is HIV/AIDS?
- Code 2: How does it spread?
- Code 3: How is HIV not transmitted?
- Code 4: Prevention of HIV/AIDS
- Code 5: Symptoms of HIV/AIDS
- Code 6: Where is HIV testing done?
- Code 7: Relation of IV drug use and HIV
- Code 8: About STDs and HIV
- Code 9: Other specific queries on HIV/AIDS

The most frequent specific queries recorded on code 9 related to

(i) The right way to use a condom
(ii) How do condoms prevent HIV/AIDS?
(iii) Masturbation
(iv) Oral sex
(v) Anal sex
(vi) Deep kissing in relation to HIV.

We compared our data with those of the AIDS hotline in the national capital Delhi which is run by an NGO called “Torch.” This hotline has only a “specific query” option and has no provision for a “standard questionnaire.” Since the 4 years of its inception there been some most frequent “specific queries” on this hotline facility in Delhi which were included in the “standard questionnaire” option of the Chandigarh hotline when it was set up at a later date.

With increasing media exposure, there is an increasing curiosity in the general public in India to know more regarding various health related issues such as HIV/AIDS. The pattern of queries on various helplines keeps changing, in keeping with the changing public awareness. Since the government spends ample funds annually on information, education, and counselling (IEC) activities related to HIV/AIDS, we feel that it would be worthwhile to utilise the most common “specific queries” on these helplines (which are a direct reflection of the layman’s quest for information related to HIV/AIDS) to update IEC strategies. Also, questions asked often on the “specific query” option can be incorporated from time to time in the “standard questionnaire” to make it more informative.

RANJU RAI
Department of Dermatology, Venereology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh, India

AMRITA AHLUWALIA
N M SHARMA
State AIDS Control Society, UT Chandigarh

INDERJEET KAUR
BHUSHAN KUMAR
Department of Dermatology, Venereology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh, India

Correspondence to: Dr Bhushan Kumar, Department of Dermatology, Venereology and Leprology, PGIMER, Chandigarh - 160 012, India

kumarrbhusan@hotmail.com

Accepted for publication 10 May 2001

Rates of gonorrhoea and chlamydial infection in black ethnic groups

Editor,—In their cross sectional study of patients attending 11 clinics in London, Low et al report the incidence of both gonorrhoea and chlamydial infection to be higher in black Caribbeans and black “other” ethnic groups than in black Africans. Neither the authors nor the writers of the accompanying editorial refer to similar findings in black men attending one of the clinics contributing to their study, which we published in 1999.

Code 3: 5.6
Code 4: 4.8
Code 5: 2.2
Code 7: 1.6
Code 8: 5.4
Code 9: 31.1

The most frequent specific queries recorded on code 9 related to

(i) The right way to use a condom
(ii) How do condoms prevent HIV/AIDS?
(iii) Masturbation
(iv) Oral sex
(v) Anal sex
(vi) Deep kissing in relation to HIV.

www.sextransinf.com

Ranjit Rai
PGIMER, Chandigarh - 160 012, India

Accepted for publication 10 May 2001

Sex Transm Infect: first published as 10.1136/sti.77.5.390-a on 1 October 2001. Downloaded from http://sti.bmj.com/ on August 5, 2023 by guest. Protected by copyright.
We compared black African men with black Caribbean men and found that Caribbean men were less likely to be married (odds ratio (OR) = 0.09) and to have non-regular partners (OR = 0.09) but more likely to be from blue collar (OR = 250) or white collar (OR = 25) class and to be smokers (OR = 50). Caribbean men were more likely to have daily vaginal intercourse (OR = 33), begin intercourse before 16 years of age (OR = 3.3), and for chlamydial infection having had multiple partners (OR = 10.5).

Among Caribbean men, the risk factors for gonorrhoea were being teenaged (OR = 9.5) and commencing intercourse before 16 years of age (OR = 3.3) and for chlamydial infection having had multiple partners (OR = 10.5).

Our conclusion was that the problem should be addressed by the setting up of more ethically acceptable clinical services before the appearance of HIV infection.

BRIAN EVANS
Department of GU Medicine, Charing Cross Hospital, London

ROBERT BOND
Imperial College School of Medicine, Charing Cross Hospital, London

KEN MacRae
Postgraduate Medical School, University of Surrey, Guildford

Correspondence to Dr B A Evans

2 Zeinman JM, Shahnameh M, Winter AJ. Ethinicity and STIs: more than black and white. Sex Transm Inf 2001;77:52–5.

Accepted for publication 22 May 2001

Human papillomavirus PCR direct sequencing study of cervical precancerous lesions in Quebec children

Editor.—Similarly to adult pathology, human papillomavirus (HPV) infection is the most common sexually transmitted disease in adolescent girls, whose prevalence is 16% according to one US study.1 However, little or no HPV sequencing data from paediatric specimens are available. We used our two tier polymerase chain reaction (PCR) direct sequencing (PCR-DS) approach2 to study cervical biopsies from 44 adolescent Quebec girls (14–17 years old). They originated from various social and ethnic groups, as well as geographically distinct areas of Quebec. Written informed consent about the use of the specimens was obtained from the ethics committee of this institution. All biopsies were analysed for histological changes and presence of HPV specific DNA. Most of them (n = 36) were diagnosed as cervical intraepithelial neoplasia (CIN), seven as inflammatory changes, and one as “nil.” Among the 36 CIN, 33 (92%) tested HPV positive, including all CIN-II and CIN-III samples.

Sixteen HPV types were detected, four of them in more than two samples: HPV6 (n = 8), HPV16 (n = 7), HPV11 (n = 3), and HPV51 (n = 3). In the group of cervical biopsies from adolescent girls with CIN (n = 36, age 14–17), as well as in the larger control group of adult women (n = 487, age 18–72), the percentage of high risk HPV types increased, and the low risk HPV types decreased with the progression from low grade (CIN-I) to high grade (CIN-II and III) preneoplasic lesions. High risk HPV represented all but one HPV type (33/34) identified in CIN-III lesions from adult women, and all HPV types from 14–17 year old girls with CIN-III (fig 1).

The informative value of HPV testing in CIN, hence its clinical relevance, depends on whether there is an increase of the high risk HPV types in more advanced grades of preneoplasic lesions. The currently available data are conflicting. Some groups reported an increased frequency of high risk HPV from CIN-I to CIN-III, at the expense of the low risk HPV types,3 but others insisted that the high risk HPV rates are significantly increased from less than 50% in CIN-I to almost 100% in CIN-II and III and this is valid for the adolescent and adult patients alike (fig 1). We hypothesise that the reasons for the discrepancies in the detection rate of various HPV types, HPV16, CIN-II, and III may be due to the fact that some groups used the method of PCR with single pair of primers,4 MY09/11, which may be underrepresenting the most frequent low grade HPV types, up to a complete lack of detection for HPV6 and HPV11.5

This study indicates that a mass prophylactic HPV vaccine should be targeted at cohorts younger than 14–17 years, because at that age some girls already develop high grade precancerous cervical lesions with possible long term integration of the viral oncogenes in the host cell genome. We believe that a PCR direct sequencing approach to HPV testing will provide treating physicians and pathologists with precise HPV typing information, and may be used in vaccine design, application, and monitoring in children and adults.

Supported in part by the Canadian Institutes of Health Research (CIHR), grant number MOP-37874, Les Fonds de la recherche en santé du Québec (FRSQ), and La Fondation de l’Hôpital Ste-Justine (to WYV). WYV is a chercheur-boursier (scholar) of the FRSQ.

Contributors: LLO, PB, and PS performed the histological evaluation of the samples and signed the pathological reports; JCF-F and SF studied the HPV at DNA level; WYV provided supervision and wrote the manuscript with the help of the others.

LUC L OLIGNY
JUAN CARLOS FEOLI-FONSECA
PIERRE BROCHU
PIERRE SIMARD
Département de Pathologie, Hôpital Ste-Justine, Montréal, Québec, Canada

SARAH FALCONI
Programme de Biologie Moléculaire, Faculté de Médecine, Université de Montréal, Montréal, Québec, Canada

WAGNER V YOTOV
Département de Pathologie, Hôpital Ste-Justine, Montréal, Québec, Canada; Département de Pédiatrie, Université de Montréal, Département de Biochimie, Université de Montréal, Québec, Canada; wagner.yotov@umontreal.ca

Correspondence to: Dr Wagner Yotov, Hôpital Ste-Justine, Local 4731, 3175 Côte St-Catherine, Montréal, Québec H3T 1C5, Canada
wagner.yotov@eres.umontreal.ca


Accepted for publication 7 June 2001

Substantial increase in gonorrhoea among homosexual men attending an STD centre in Toulouse, France

Editor.—A substantial increase in cases of gonorrhoea in an STD centre in Toulouse, France, was noted between October 1999 and September 2000. It was associated both with predominant transmission in a homosexual

Letters, Books, Notices
Adverse reaction to antimycobacterials administered as a combination tablet with no reaction to the same drugs in isolation

Editor,—A 37 year old Portuguese man presented to the genitourinary (GU) medicine department with constitutional symptoms. He had a history of injecting drug use and had been identified as positive for the human immunodeficiency virus (HIV) antibody in Portugal 5 years previously. He had not been in contact with medical services for a year. Confirmatory HIV antibody testing was positive. The CD4 lymphocyte count was 50 x 10^3 and the viral load below the limit of detection (<40–80 copies/ml). He was admitted for further investigations including a chest x-ray and excision biopsy of an enlarged axillary gland. All tests were initially negative, and he improved on co-trimoxazole 960 mg thrice weekly. However, the night sweats failed to fully abate and 2 months later Mycobacterium tuberculosis, sensitive to all four first line antimycobacterial agents, was cultured from the axillary lymph node biopsy. He was therefore commenced on “Rifinah” (combination tablet of rifampicin, isoniazid, and pyrazinamide) five tablets daily and ethambutol (after visual acuity testing) 800 mg daily. Nevirapine dosage was increased accordingly. On this treatment his condition improved and he became asymptomatic.

After 2 months antimycobacterial therapy was simplified to “Rifinah 300” a combination tablet of rifampicin and isoniazid. Other medications were continued unchanged. Four days later he developed widespread macular, erythematous, and intensely pruritic rash. This resolved within 4 days of stopping Rifinah. Rifampicin 600 mg once daily and isoniazid 300 mg once daily were subsequently reintroduced uneventfully.

The sequence of events indicates that the patient suffered an adverse drug reaction (ADR) to a constituent in the Rifinah tablets not present in the Rifinah, rifampicin, or isoniazid tablets. The manufacturer of Rifinah was consulted and to our knowledge such a reaction has not been described before. The Committee on Safety of Medicines was informed via the grey card system.

Infection with HIV and Mycobacterium tuberculosis is a problem increasingly encountered by physicians caring for individuals with HIV. A recent study in London found that 24.8% of patients commencing antituberculous chemotherapy were also HIV antibody positive. 1 HIV positive individuals are known to be at increased risk of adverse drug reactions, particularly those with advanced immunosuppression. One study documented a frequency of adverse drug reactions of 32% in HIV positive patients receiving drug therapies. 2

Physicians should remain alert to the possibility of ADRs and warn HIV positive patients of their increased risk, even when such a reaction would not have been anticipated, as in this case.

No conflict of interest to declare.

MARGARET KINGSTON
LUCIE CHILDSS
ELIZABETH CARLIN
Department of Genitourinary Medicine, Nottingham City Hospital, Hucknall Road, Nottingham NG5 1PB, UK
Correspondence to: Dr Kingston


Accepted for publication 26 June 2001
Increasing HIV prevalence in STD clinic attendees in Delhi, India: 6 year (1995–2000) hospital based study results

EDITOR,—The association between the occurrence of HIV infection and the presence of other STDs has been strongly established. STDs act as important co-factors that promote HIV transmission. The trend of HIV infection in STD clinic attendees, one of the high risk groups, may reflect the trends of HIV epidemic in the community. To estimate the frequency of HIV infection among various STD patients over a period of 6 years from January 1995 to December 2000 and to observe the interrelation between HIV infection and different other STDs, we analysed the HIV status of 1504 STD clinic attendees in Dr RML Hospital, a centrally located major tertiary care centre in Delhi. The breakdown in the number of STD attendees tested for HIV voluntarily or total of STD attendees was as follows: 180 out of 407 (44%) in 1995, 261 out of 513 (51%) in 1996, 245 out of 414 (59%) in 1997, 280 out of 363 (77%) in 1998, 235 out of 368 (63%) in 1999, and 296 out of 442 (67%) in 2000. This variation of percentage from year to year is due to the voluntary nature of testing. HIV testing was done for one of the ELISA rapid sample tests. Any reactive serum sample was retested using a different assay. A sample that was positive in both the tests was considered HIV positive. The other STDs were diagnosed clinically and using appropriate laboratory tests.

Out of 1504 STD patients screened for HIV infection, 42 (2.8%) were found to be seropositive (40 males out of 1354 and two females out of 150). Annual breakdown revealed a slow but gradual increase in HIV prevalence (1.7% in 1995, 2.2% in 1996, 2.1% in 1997, 2.5% in 1998, 2.7% in 1999, and 3.4% in 2000). The cumulative prevalence of HIV seropositivity in different STDs is shown in table 1.

HIV positivity was observed in 4.5% patients with GU diseases, in contrast with only 1.7% HIV positivity among non-ulcerative STD patients, which is statistically significant (p >0.002). All but one male HIV positive patients gave a history of sexual contact with at least one commercial sexual worker. Out of two HIV positive women, one was possibly infected by her husband and the other from her regular sexual partner; both were not pregnant at the time of HIV testing. Five (19%) HIV seropositive patients had no other STD.

HIV sentinel surveillance in India shows the HIV epidemic at different stages of evolution in different states of India. Six out of 32 states have HIV prevalence of more than 1% in antenatal clinics (ANC) and are classified as high prevalence states including Maharashatra and Tamil Nadu. In seven other states the ANC rates are less than 1% but prevalence among STD clinic attendees is more than 5% classified as moderate prevalence. The remaining 19 states including Delhi are low prevalence states because HIV prevalence among STD attendees is less than 5%. The HIV sentinel surveillance data of Delhi show 1.6% and 3.2% HIV infection in 1998 and 2000 respectively, among STD attendees from four other major STD clinics in Delhi, where anonymous HIV testing was done from VDRL blood samples. These data as well as ours are comparable and support the belief that Delhi is still in a low level epidemic category.

From the experience of the Mwanza trial in Tanzania and the Rakai trial in Uganda, it is speculated that the effect of STD control on HIV transmission may decrease with the maturation of the HIV epidemic. Therefore, it is high time to extend vigorous intervention programmes in all high risk groups as well as the general population of this city which is still in the early epidemic phase to ensure this cost effective opportunity is not missed.

Table 1 Frequency of HIV seropositivity in different sexually transmitted diseases

<table>
<thead>
<tr>
<th>Type of STDs</th>
<th>No of patients having same STD</th>
<th>No of patients found HIV seropositive</th>
<th>Seropositivity rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group I, ulcerated STDs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td>222</td>
<td>10</td>
<td>4.5</td>
</tr>
<tr>
<td>Chancroid</td>
<td>200</td>
<td>10</td>
<td>5.0</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>162</td>
<td>7</td>
<td>4.3</td>
</tr>
<tr>
<td>Donovanosis</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lymphogranuloma venereum</td>
<td>17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All ulcerative STDs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All ulcerative STDs</td>
<td></td>
<td>605*</td>
<td>27</td>
</tr>
<tr>
<td>Group II, non-ulcerative STDs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-gonococcal urethritis</td>
<td>102</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td>Condylomata acuminate</td>
<td>291</td>
<td>7</td>
<td>2.4</td>
</tr>
<tr>
<td>Genital warts</td>
<td>191</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>Vaginosis</td>
<td>77</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Balanoposthitis</td>
<td>226</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>All non-ulcerative STDs</td>
<td>899*</td>
<td>15</td>
<td>1.7</td>
</tr>
<tr>
<td>All STDs</td>
<td></td>
<td>1254*</td>
<td>42</td>
</tr>
</tbody>
</table>

The discrepancy in total number of patients in both groups is due to the presence of more than one STD in some patients.


Accepted for publication 26 June 2001

Genital piercing and sexually transmitted infections

EDITOR,—An interesting observation was noted about patients with genital piercing in our clinic. We looked at 12 case notes of patients retrospectively who attended our clinic for sex health screening in the past 12 months. There were seven males and five females in the age group 22–36. Looking at the results of their screening tests for STIs, none of the males had chlamydia. Interestingly, four out of six female contacts of these males, who also attended for screening, were found to be positive for chlamydia detected by enzyme immunoassay (EIA). None had gonorrhoea. It was also noted that none of these female contacts had their genititals pierced. Of the five females who had their genititals pierced, three had chlamydia, one had genital warts, and one was found to have bacterial vaginosis. Their corresponding male contacts again with no genital piercing also had chlamydia and genital warts. Two other contacts did not attend but were said to be asymptomatic. The method of genital piercing in males was with the so called Prince Albert ring (famously worn by Prince Albert) where the metal ring is inserted through the external urethra and glans penis (fig 1). In the females, however the urethra is not involved and the piercing is mostly through the clitoris or vulva. We wondered whether this involvement of the urethra in males was significant. It appeared that there was a protective effect in males despite having chlamydia positive female sexual partners. Possible mechanisms could be slow release of metal ions having an antibacterial effect, the presence of epithelial metaplasia or a chronic inflammatory process contributing to a local immune response. We do acknowledge that this is a very small cohort and these findings may be by chance or can be explained by the low sensitivity of EIA.

Genital piercing is becoming more fashionable in the Western world and is performed to enhance sexual pleasure and also for cosmetic effect. It was traditionally practised in the tribal population of India and Africa, mostly for ritual and cultural reasons. Metal or ivory studs or rings or bars are commonly used. The metals can be made of steel or various other alloys containing iron, copper, zinc, and...
even gold or silver. Currently, there are very few data in the literature about STIs and genital piercing but it has been postulated that there can be an increase in the risk of transmission of blood borne viruses as well as other STIs because of damage to condoms caused by the objects. A recent study also did not find any association between body piercing and genital infections in general; however, we wondered whether genital pierc- ing should be included in the KC 60 data collection. We would welcome observations from the readers of STI on this subject.

RAVINDRA GOKHALE
MARY HERNON
AJIT GHOSHI
Department of Genitourinary Medicine, Arrowe Park Hospital, Wirral CH49 5NE, UK

Correspondence to: Dr Gokhale
ravindragokhale@yahoo.com


Accepted for publication 20 July 2001

Safer sex in HIV infected patients in London: practices and risks

EDITOR—Recent figures from the Public Health Laboratory Service (PHLS) report1 have shown the largest number ever of new cases of HIV infection (2968 cases) during 2000 in the United Kingdom. The majority of HIV infected individuals attending clinics for their treatment and care will have been counselled and strongly advised to practise safer sex. Specific risks of unsafe sex will be summarised, including the risk of transmis- sion of HIV to their partners, as well as their own risk of acquiring new sexually transmitted infections and the spectre of multidrug resistant HIV variants.

The overall effect of such safer sex messages were called into question by Dodds et al who recently reported evidence of an increasing incidence of high risk sexual behaviour among homosexual men in Lon- don. The accompanying editorial by Grulich called for improved data on risk behaviours, specifically in HIV infected individuals. We can present data on this from a questionnaire survey of patients attending the largest HIV outpatient centre in London.

The questionnaire was distributed to 300 consecutive individuals attending the Kobler HIV outpatient clinic at the Chelsea and Westminster Hospital during spring 2000. The confidential questionnaire could be completed anonymously if the patient wished. Data were gathered concerning the individuals’ sexual behaviour over the past year in terms of number of sexual partners and episodes of unprotected sex. Further data were collected on whether individuals had sexually transmitted infections (STIs) diagnosed in the past year and/or attended for sexual health screening (table 1). We also asked them how they had acquired HIV infection.

A total of 494 legible questionnaires were suitable for analysis. Anonymous question- naires were received from 240 respondents, whereas 254 (50.8%) disclosed their identity, and 35 (7%) were female. Although 317 patients (64%) reported engaging in only protected sex in the past year in terms of number of sexual partners. Further analysis of this group, it was found that 15 out of the 317 patients had never engaged in anal sex and the remaining two always used protection.

Following this observation we have further identified six patients who have probably acquired HIV through unprotected oral sex, and we can summarise data from all 11 patients. They were all homosexual men. Eight out of 11 never practised anal sex and the remaining three always used protection. Five of these patients had never engaged in oro-anal sex and the remaining two always used protection.

Table 1 Reported incidence of sexually transmitted infections (STI) over past year by respondents

<table>
<thead>
<tr>
<th>STI</th>
<th>Diagnosed with an STI in the past 12 months (n = 102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhoea</td>
<td>36 (35.3)</td>
</tr>
<tr>
<td>Chlamydia/NSU</td>
<td>22 (21.6)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>4 (3.9)</td>
</tr>
<tr>
<td>Herpes (first episode)</td>
<td>20 (19.6)</td>
</tr>
<tr>
<td>Warts (first episode)</td>
<td>29 (28.4)</td>
</tr>
<tr>
<td>Others</td>
<td>22 (21.6)</td>
</tr>
<tr>
<td>Combination of STIs</td>
<td>8 (7.8)</td>
</tr>
</tbody>
</table>


It has become increasingly clear that STIs cannot be controlled simply by diagnosis and treatment of the relevant pathogens alone. This volume on STI prevention is espe- cially relevant as we struggle to provide access for those already infected with sexually transmitted organisms. My first thought when I looked at this book was influenced by the cover illustration of a herpes simplex virion. It looked like another worthy tome

WAEID A KHAN
WAHID RICHARDS
SUNDHYA MANDALIA
SIMON E BARTON
Department of HIV/GUM Medicine, Chelsea and Westminster Hospital, London

www.sextransinf.com

Letters, Books, Notices

BOOK REVIEWS

Letters, Books, Notices

Letters, Books, Notices

Letters, Books, Notices

Letters, Books, Notices

Letters, Books, Notices

Letters, Books, Notices
Clinical Risk Management. 2nd ed. Ed

It is a fact of life that people make mistakes. In the NHS the cost of human error runs into billions of pounds a year through lost bed days and the consequences of serious litigation. More importantly, errors distress and harm patients, undermining their confidence in the organisation and their doctors.

The natural approach to discovering any error is to apportion blame, with its association of moral weakness. But error management that focuses on any one individual’s lapses and mistakes will not reduce the incidence of error. In the short term a scapegoat may be convenient, but measures to reduce mistakes need to aim at redesigning systems so that they are acknowledged, detected, intercepted, and mitigated.

Highly reliable organisations, such as nuclear power plants and airlines, have a less than the expected number of accidents because they recognise human frailty. Errors are seen as consequences rather than causes. These organisations concentrate on the conditions under which individuals work and try to build defences averting errors before they happen or reducing their effects. Their motto has to be “Safety is everyone’s responsibility.”

The focus of any organisation exposed to risk, including the NHS, therefore, needs to be on the constant possibility of failure and how to prevent it. The second edition of Clinical Risk Management, edited by Charles Vincent, addresses in detail this problem. It covers the evolution of risk management, its expansion beyond its roots in litigation, and the benefits reaped from the study of safety in high risk organisations. His aim is to highlight the need for clinical risk management to focus on patient safety and quality of care, and not on simplistic prevention of litigation.

It is a practical book full of illustrations of how errors arise, risk, and the good and bad management of their consequences.

The book is divided into four parts. The first, on the philosophy of risk management, contains a particularly revealing chapter by James Reason, “Understanding adverse events: the human factor.” It opens the theme around which the book is constructed, the interrelation between the individual and the organisation. In the second part, “Reducing risks in clinical practice,” the authors discuss and illustrate the circumstances which lead to errors and accidents that are inherent in specific “high risk” specialties, such as obstetrics and anaesthetics. Part III, “Conditions of safe practice,” discusses the relationship between patient and staff, organisation and environment—for example, in work overload, fatigue, and transport. Part IV, “The implementation of risk management” describes the importance of “no blame” culture of reporting incidents, investigating and analysing errors, and of the manner in which adverse events are handled. Included in the chapter are two aspects of error management often overlooked—continuing patient care and support of the staff involved.

This is an important, well written, readable book which all involved in clinical care should keep on their desks, not on the bookshelf.

RAK NANDWANI
Clinical Director, Genitourinary Medicine Services, The Sandfords Initiative, 6 Sandford Place, Glasgow G3 7NB

FIONA DAVIDSON
Department of Genitourinary Medicine, St George’s Hospital, London SW17 0QT
MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 2, Viral Infections other than HIV, 26–27 November 2001
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 3, HIV Infections, 28–30 November 2001
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

41st St Andrew’s Day Festival Symposium on Therapeutics, 6–7 December 2001, Royal College of Physicians of Edinburgh
Further details: Ms Eileen Strawn, Symposium Co-ordinator (tel: 0131 225 7324; fax: 0131 220 4393; email: e.strawn@rcpe.ac.uk; website: www.rcpe.ac.uk).

International Conference on HIV/AIDS 16–19 December 2001, Mumbai, India
Further details: Dr Chander P Puri, President, Indian Society for Study of Reproduction and Fertility, Institute for Research in Reproduction, Jehangir Merwanji Street, Parel, Mumbai 400012, India (Tel: 4137730 (Direct), 4132111-2-6-7; fax: 091-022-4964853 or 091-022-4139412; email: vichin@bom4.vsnl.net.in OR dirirr@vsnl.com).

Second International Conference on Sexual Health, to be held in Bangkok, Thailand on 23–28 February 2002
Further details: European Secretariat, Dr Richard Burack (tel: +44 (0) 20 8599 8029; email: siamcare@aol.com).

7th Congress of the European Society of Contraception, “Changing attitudes to contraception and reproductive health,” Genoa, Italy, 10–13 April 2002
Further details: ESC Central Office, oramed, Eissenstraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.uunet.be).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 1, Epidemiology of STIs and Bacterial Infections, 22–25 April 2002
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 2, Sexual Health and Sexuality, 26 April 2002
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 3, Viral Infections other than HIV, 20–21 May 2002
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).