No documented treatment failures in Africa

The case report stage. Furthermore, there are raised, possible treatment failures are still at advanced immunosuppression have been discussed. However, penicillin in HIV positive subjects with clinic staff, would also be solved. Although the issues and arguments raised here have been discussed in depth previously, they bear repeating. The risk of the recent increase in syphilis in the United Kingdom.

References

Acceptor for publication 7 March 2002

Vulvovaginitis due to fluconazole resistant Candida albicans following self treatment with non-prescribed triazoles

Resistance of Candida albicans to triazoles is uncommon with short term treatment but has been increasingly reported in immunocompromised patients, including those with HIV infection who are receiving long term systemic or maintenance therapy. Vaginal triazole resistant C albicans isolates are extremely rare in non-immunocompromised HIV seronegative women. 4 To our knowledge, only a single case has been reported to date. 4 As the over counter oral triazole antifungals are now widely available there is potential for drug resistance to increase. We report another case of vulvovaginitis due to triazole resistant C albicans in an otherwise healthy woman.

The patient was a 28 year old woman who presented with symptoms of vulval pruritis and profuse vaginal discharge over six months. She was not taking regular medication but had used clotrimazole and fluconazole several times in the preceding months for vaginitis and thrush. On examination, the vulva looked healthy but the vagina was erythematous and white plaques were noted. The cervix appeared normal and bimanual pelvic examination was unremarkable. The patient declined HIV serology but was fit and well with no stigmata of HIV infection and no risk factors.

Microscopic examination of vaginal secretions did not reveal any yeast blastospores or pseudohyphae, nor any clue cells or tri- chomonaads. However, C albicans was isolated on culture. In view of the documented history of a lack of response to topical imidazoles, the patient was treated with nystatin pessaries daily for two weeks, while antifungal sensitivity tests were being performed. The patient returned to clinic two weeks later and reported only slight improvement in her symptoms despite using vaginal nystatin as prescribed. Unfortunately, the sensitivity test results were not available at this time and the patient subsequently failed to attend the clinic.

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References

www.sextransinf.com
Will the legalisation of street sex work improve health?

The legalisation and regulation of street sex work in Victoria, Australia, is likely to improve the health of street sex workers and their clients.

In Victoria, street sex work is illegal. In comparison, brothel and escort agency sex work is legal, and these individuals are required by law to have monthly certification of STI screening. Any incident infections are treated promptly, and hence make regular STI screening a legal requirement. Rightly, there is no such requirement for street sex workers, who have frequent STI screens and high rates of STIs.

Following an acceptability and feasibility study, funding was secured for the Inner South Community Health Service Youth Health Bus to offer STI screening using self-administered samples to street sex workers. Female workers provided a tampon sample and male and transsexual workers a first passed urine sample. These samples were then tested by polymerase chain reaction (PCR) for Chlamydia trachomatis, Neisseria gonorrhoeae, and Trichomonas vaginalis. The Youth Health Bus provides support and condoms to street sex workers several evenings a week in St Kilda, Melbourne’s street sex worker precinct. They have been offering self-collected samples for testing since mid-1999.

Over a 2 year period 102 samples were collected yielding 15 positive results (14.7%, 95% CI: 7.8% to 21.6%). This group included 81 female, 20 males, and one transsexual individual, with a mean age of 24 years (range 16–43). C trachomatis was identified in seven sex workers, T vaginalis in seven, and N gonorrhoeae in one. These high prevalences of STIs are compared with the low prevalences in brothel sex workers attending Melbourne Sexual Health Centre in the corresponding time (table 1 above). These street sex workers were also not having regular STI screens, with only eight (7.9%) of the 102 individuals reporting an STI screen in the preceding month, and 12 (11.8%) who had never had one.

The legalisation of street sex work would allow it to be regulated and hence make regular STI screening a legal requirement. Recently, a 2 year trial of designated areas for street sex work in Melbourne has been recommended.1 These recommendations were adopted to protect the health of street sex workers and their clients, in addition to the targeted intervention described here. Further research is needed into the best health promotion model for street sex workers.

Contributors
AM and CF, design, analysis, and writing of paper; ST and SG, laboratory analysis and interpretation; PL and PR, design and collection of specimens.

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References
4 Accepted for publication 5 April 2002.

Adult and paediatric contact immunotherapy with squaric acid dibutyler (SADBE) for recurrent, multiple, resistant, mucocutaneous anogenital warts

Treatment of recurrent anogenital warts is often troublesome, because, among the various treatment modalities currently available, few are uniformly effective or virucidal. Currently, topical immunotherapy with squaric acid dibutyler (SADBE) represents an effective treatment in the management of multiple plantar and common warts (table 1 below). 4,5 In the genital area the use of SADBE has some limitations, as it may be associated with a significant degree of irritation that produces considerable discomfort to the patient. Based on studies showing excellent results (87% of patients with complete resolution) achieved by some authors in treating condylomata acumina of the endocervix with applications of dichlorobenzene (DCNB), a substance similar to SADBE, utilising remote anatomical site applications to the skin of the arm, and our personal observation of spontaneous regression for untreated warts during contact immunotherapy with SADBE for alopecia areata, we decided to compare the results

Table 1 Comparison of STI prevalences

<table>
<thead>
<tr>
<th>STI Type</th>
<th>Street sex workers (n=102)</th>
<th>Brothel sex workers (n=1644)</th>
<th>p Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia trachomatis</td>
<td>7 (6.8%)</td>
<td>44 (2.64%)</td>
<td>0.001</td>
</tr>
<tr>
<td>95% CI</td>
<td>2.8 to 13.6</td>
<td>1.92 to 3.53</td>
<td></td>
</tr>
<tr>
<td>Neisseria gonorrhoeae</td>
<td>1 (0.98%)</td>
<td>12 (0.72%)</td>
<td>0.76</td>
</tr>
<tr>
<td>95% CI</td>
<td>0.031 to 5.34</td>
<td>0.37 to 1.25</td>
<td></td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>7 (6.8%)</td>
<td>4 (0.24%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>95% CI</td>
<td>2.8 to 13.6</td>
<td>0.067 to 0.62</td>
<td></td>
</tr>
</tbody>
</table>

*Prevalence for the difference in the proportion of street sex workers and brothel sex workers with each infection.

Table 1 Treatment of anogenital warts with SADBE: patient data

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Time of onset</th>
<th>Previous treatments</th>
<th>Site of warts</th>
<th>Clinical features</th>
<th>Area of application of SADBE</th>
<th>Number of applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>6</td>
<td>12 years</td>
<td>Multiple DTC</td>
<td>Perianal area</td>
<td>8 keratotic and flat-topped papules</td>
<td>dorsum of left hand</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>15</td>
<td>2 years</td>
<td>Multiple DTC</td>
<td>Perianal area</td>
<td>5 flat-topped papules</td>
<td>dorsum of left hand</td>
<td>38</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>20</td>
<td>10 months</td>
<td>Multiple DTC</td>
<td>Shaft</td>
<td>10 dome-shaped papules</td>
<td>shaft</td>
<td>36</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>24</td>
<td>17 months</td>
<td>Podophyllin resin</td>
<td>Shaft</td>
<td>15 dome-shaped papules</td>
<td>shaft</td>
<td>34</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>25</td>
<td>6 months</td>
<td>Imiquimod 5% cream</td>
<td>Labia majora and minora, up to the coronal sulcus</td>
<td>2 warty plaques</td>
<td>pubic area</td>
<td>17</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>28</td>
<td>3 years</td>
<td>Podophyllin resin</td>
<td>Coronal sulcus</td>
<td>1 warty plaque surrounding the coronal sulcus</td>
<td>pubic area</td>
<td>39</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>28</td>
<td>18 months</td>
<td>Podophyllin resin</td>
<td>Shaft</td>
<td>12 dome-shaped papules</td>
<td>shaft</td>
<td>–</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>29</td>
<td>9 months</td>
<td>Podophyllin resin</td>
<td>Coronal sulcus</td>
<td>1 warty plaque surrounding the coronal sulcus</td>
<td>pubic area</td>
<td>37</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>70</td>
<td>16 months</td>
<td>Multiple DTC</td>
<td>Shaft</td>
<td>20 flat-topped, dome-shaped papules</td>
<td>shaft</td>
<td>32</td>
</tr>
</tbody>
</table>
obtained in the management of multiple and resistant anogenital warts by applying SADBE directly to the lesions with those obtained by applying it to remote unaffected areas. From June to December 1999, nine patients, seven adults (mean age 32 years) and two children (mean age 10.5 years) were treated. Following sensitisation by topical application of 3% SADBE in acetone directly to the skin of the pubic region in adults and to the back of the hands in children, serial dilutions (0.0003% to 3%) were tested 2 weeks later on the same skin area in order to evaluate the minimal concentration capable of eliciting an eczematous reaction. Subsequently, the application of the compound was performed in the clinic by trained staff twice a week. SADBE application varied by age of patients and anatomical site of lesion. In children, SADBE was applied to the dorsal left hand; in adults it was directly applied to lesions located on skin or to the pubic area when lesions were located on mucosae. If an eczematous reaction was not elicited after 1 week, an incrementally higher concentration was applied. If a strong reaction ensued, the treatment was discontinued for 3-6 days and an incrementally lower concentration was used at the following visit.

A total of eight patients completed the therapy, showing complete resolution after a mean of 16 weeks of treatment, with variable concentrations of SADBE ranging from 0.0003% to 0.3% (table 1). Local side effects (erythema, desquamation, cutaneous oedema, pruritus, burning, and pain) were generally mild and well tolerated. No relapses occurred during an 18 month follow up.

Clinical resolution and length of treatment in patients treated by applications to remote areas was comparable with those in which SADBE was applied directly to lesions. These results not only substantiate the efficacy and safety of topical SADBE in the treatment of multiple recurrent/recalcitrant anogenital warts, but also indicate a possible systemic effect of contact immunotherapy, suggesting that the mechanism of action of SADBE could be not only a non-specific inflammatory reaction or a local cell mediated process triggered by a non-antigenic immune stimulus.

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References

Recreational drug use by GUM clinic attendees
Recreational drug use (RDU) is widespread in the United Kingdom.1 Studies have suggested that RDU is associated with an increased risk of STI or blood borne virus (BBV) acquisition.2-4 A search of Medline 1966–2000 found no studies looking at the prevalence of RDU in UK genitourinary medicine (GUM) clinics. Therefore this study aimed to estimate the prevalence of RDU by attendees of the Plymouth GUM clinic and to see if the diagnosis of an STI is more common in illicit drug users.

The local research ethics committee approved the study. New patients attending the clinic between August and November 2000 completed a questionnaire which listed a number of drugs and asked about frequency of consumption and injecting drug use. Respondents were asked for their clinic number so that test results could be compared to drug use.

The completion rate was 76% (259/339). The mean age of respondents was 26 years (range 15–54) and 58% were women.

Lifetime illicit RDU was reported by 64% (166/259, confidence interval (CI) 5.8) with 28% (72/259, CI 5.5) reporting use within the last 1 month. Of 16–24 year olds, 66% (87/132, CI 8.1) reported lifetime use while 34% (166/476) reported recent use. There was no significant difference in use between men and women (66% v 62%). Figure 1 shows the proportion of clinic attendees who reported taking each drug.

Two people, 0.77% (2/259, CI 0 to 1.87) of respondents, reported injecting drug use. Most people, 64% (165/259), supplied their clinic number, and 52% (125/241) were diagnosed as having an STI. Men were more likely to be diagnosed with an STI (OR 2.72, CI 1.40 to 5.28). The diagnosis of an STI was independent of units of alcohol to 3% in the preceding month (OR 1.07, CI 0.78 to 1.46), and the use of illicit drugs whether in lifetime (OR 0.82, CI 0.43 to 1.60) or in the past month (OR 1.51, CI 0.71 to 3.20). Subjects who gave their number were less likely to take illicit drugs (OR 0.44, CI 0.25 to 0.77).

This survey has revealed a high prevalence of recreational drug use by attendees at a GUM clinic. Comparing the data with the 2000 British Crime Survey (BCS) shows that the proportion of clinic 16–24 year olds who admitted to illicit drug use within the past month is greater than the same age group surveyed in the BCS (OR 2.32 CI 1.59 to 3.37). Likewise, lifetime use was more common (OR 1.86, CI 1.29 to 2.69). There is a low prevalence of injecting drug use; this might be due to under-reporting. An alternative explanation is that this high risk group is not accessing the clinic. If this is the case it would support moves to set up an outreach clinic.

This study found that the diagnosis of an STI is independent of RDU. This might be because RDU is so common that it is no longer a useful discriminator; alternatively, a larger sample size might have found evidence of an association.

In conclusion, although RDU is common, injecting drug use appears to be rare in this group. The findings of this survey have implications for service provision.

Acknowledgements
I thank Steven Skow for his criticism of the manuscript. Conflict of interest: none.

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References

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Figure 1 Proportion of respondents reporting use of each drug. Error bars show 95% confidence interval.
HIV negative certification and sexual health issues facing performers in the adult entertainment industry in the UK

The production of adult entertainment videos in the United Kingdom has increased in the past 2 years. In July 2000 the British Board of Film Classification introduced changes to the “Restricted 18” (“R18”) classification of videos, legalising the sale of videos featuring explicit images of real sex to people over the age of 18 in registered sex shops licensed by local councils. Changes to the “R18” classification were introduced in response to the incorporation of the Human Rights Act into the British legal system, making freedom of expression part of British law. There are currently around 90 licensed sex shops in Britain, and in the first half of this year the British Board of Film Classification has already classified 485 “R18” videos, compared to a total of 651 videos in 2001.

The majority of adult entertainment videos are produced showing images of real unprotected sex without condoms, and concerns that these videos give some viewers an impression that sex without condoms is safe has prompted a recent initiative by the British Board of Film Classification to introduce safer sex handling. It is a standard on all “R18” videos. This initiative is supported by the Department of Health, the Public Laboratory Service, and the Terrence Higgins Trust. The British Board of Film Classification has indicated a willingness to collaborate with the major distributors of “R18” videos in Britain in the production of a safer sex message. It is notable that such safer sex messages already exist in some adult videos in the United States.

Central to the health and safety issues for performers of adult entertainment videos is the regulation of HIV negative certification. In the United States, where the estimated yearly income from pornography in 1997 was $2.3 billion, the adult entertainment industry responded to the HIV outbreak in the 1980s by introducing regular compulsory HIV antibody testing. Performers involved in the production of images showing real unprotected sex. In 1998 former performers set up a clinical service, AIM Health Care Foundation, in collaboration with medical experts providing sexual health care and information specifically aimed at performers in the adult entertainment industry. AIM Health Care Foundation provides HIV testing and certification, STI testing and treatment, and provides free condoms, lubrication, and offers information and counselling. AIM Health Care Foundation serves 400 clients per month and runs an effective monitoring and partner notification system using a PCR/DNA test showing negative HIV status within the past 28 days. AIM Health Care Foundation also holds a HIV database that allows producers to confirm that the performers comply with this testing programme, which has succeeded in controlling the spread of HIV in the adult entertainment industry. AIM Health Care Foundation recommends regular STI screening to all their clients. It estimates that in Los Angeles, where the majority of the adult entertainment industry in the United States is based, the prevalence of Chlamydia trachomatis genital infection is 10% higher than the national average. By providing health care and information, AIM Health Care Foundation has contributed towards the development of a more coherent and accountable infrastructure in the adult entertainment industry in the United States.

Although the recent legal changes to the “R18” category have contributed to the growth of the adult entertainment industry in the United Kingdom, the industry still lacks a coherent infrastructure. Production budgets are low and there are no working contracts for performers. For example, performers’ earnings and average employment periods for performers in the United Kingdom are lower compared with the United States. The lack of infrastructure in the adult entertainment industry in the United Kingdom is reflected in the poorly developed health and safety measures for performers. Previous research by one of us has found that, in contrast with the United States, where the industry standard requires performers to have a new HIV test every 30 days and to present their certificate on every job they are hired to do, the majority of performers in the United Kingdom have an HIV test every 3 months, and very few performers have regular STI screenings. This work has also highlighted the discrepancies between the NHS sexual health clinics in their practices of issuing HIV certificates, and shows that most performers in the United Kingdom prefer to use private clinics for this service. This also raises the governance issue of the need to ensure accuracy of identification in issuing these certificates in order to avoid any fraudulent HIV certification.

We have now developed a collaborative project, based on the original research by LG into the health issues in the adult entertainment industry. The HIV/GUM Directorate of the Chelsea and Westminster Hospital are conducting a pilot survey of the detailed sexual health of adult performers in order to define their risk of sexually transmitted infections in the work and private lives. In the United Kingdom we are assessing their awareness of sexual health issues. Clearly the availability of condoms and HIV negative certification is an important issue for the strategic planning of sexual health services which data from our survey should inform.

Contributors

LG conducted the original research and wrote this letter and SEB is primary investigator.

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References

1 British Board of Film Classification, www.bbfc.co.uk/website/statistics.nsf. 20 June 2002.

BOOK REVIEWS

ABC of AIDS. 5th ed.


Writing a good textbook on HIV infection is very difficult. Large textbooks that attempt to be comprehensive face the problem that, in what is now such a rapidly moving field, they are out of date by the time they are published. Smaller textbooks on the other hand have to decide what to leave out. This book is clearly aimed as an introduction to the subject for people with much less experience of HIV. Although not attempting in any way to be comprehensive, it is often remarkably detailed despite its brevity. I think that it is much the best of the small short textbooks for a general readership. It is (relatively) cheap and unlike other books, as it is so concise is likely to be read by those who buy it.

The best chapter is also the longest, on “Treatment of infections and antiviral therapy” (what else is there left?), which forms the core of the book. There are also two very readable chapters written by patients. If read together these three chapters may make the profound changes that combination antiretroviral therapy has produced since 1996, in a way that some other chapters curiously do not. The chapter on gastrointestinal manifestations, for example, has not been revised significantly in this edition to reflect the impact of HAART.

The book has some shortcomings. There is little mention of the issue of late presentation of disease, which is a particular problem in the United Kingdom especially among those with heterosexually acquired infection; the sections on counselling and epidemiology fail to reflect this. The massive problem of co-infection with hepatitis C is touched on only briefly in two chapters. There is no separate section on women with HIV infection (although mother to child transmission is well covered in the paediatric section). While the colour illustrations are generally excellent, the reproductions of chest x rays are not so good, and the same mangled slide of a patient with pulmonary lymphoma found in earlier editions of the book is reproduced unchanged in this one. Finally, post-exposure prophylaxis is poorly dealt with, which is a shame as this is a topic like HAART of major interest to the general reader who has just pricked his or her finger with a bloodstained needle.

However, despite these qualifications, this really is a very good book. I hope the sixth edition is even better.

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Human papillomaviruses. Clinical and Scientific Advances.


Most of us have had an encounter with warts at some time in our lives. We try to freeze, poison, or corrode them, occasionally resorting to surgery, laser vapourisation and, latterly, immunotherapy. Our modest success at treatment only underscores the general public’s perception that warts are a common but incurable nuisance. All this trouble from a family of viruses with a host range that spans the animal kingdom and an astonishing spectrum of disease manifestations. The development and subsequent exploitation of increasingly sophisticated molecular techniques over the past 30 years have led to a rapid increase in the understanding of the biology of papillomaviruses, especially human papillomaviruses (HPVs). Much of this effort has focused on the propensity of certain HPV types to contribute to malignant transformation and, increasingly, on the potential for developing more effective therapies, including vaccines to prevent HPV associated cancers.

Jane Sterling and Stephen Tyring have managed to assemble a panel of clinical and scientific experts working on HPV and have produced a highly readable and concise account of the recent advances in our understanding of this fascinating infection. The chapters are laid out logically in three main parts—Molecular and Cellular Aspects, Diseases and Infections, and Future Prospects: treatment and basic research. The book is beautifully illustrated throughout, providing greater clarity in explaining complex molecular mechanisms as well as good clinical examples of the different types of HPV related diseases. Some overlap in coverage is inevitable in a multiauthor textbook but this does not detract from the consistently high quality of the finished product.

This book is ideal for both junior and senior staff who need to acquire some knowledge of the mechanisms and spectrum of HPV disease. The scientific reviews should prove useful to those sitting for postgraduate examinations and other (miscellaneous) purposes. Those of you who may have grown temporarily. [p 3] should be sufficient to keep their overblown egos in check, albeit temporarily.

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Understanding thrush, cystitis and women’s genital symptoms.


This book certainly compares favourably with some of the offerings available in our local pharmacies and health food shops. Overall, it gives a concise summary of female genital infective problems and physiology in clear and accessible language. This is supplemented by a series of clear illustrations, case discussions, and summary boxes. As well as the general public, medical students and nurses might find this a useful and informative book.

While there were no major reservations about the book the title did seem a little misleading. Although “thrush” is covered well and sensibly it is only a relatively minor part of this book. Maybe it should have been called “women’s genital symptoms—including thrush, cystitis, and other infections.” Also it is not really relevant to perimenopausal and postmenopausal women and this isn’t made clear in the introduction. The only real shortcoming was that painful sex was given too little space and although vulvodynia is mentioned and indexed there is no mention of the vulval vestibulitis syndrome despite this being commonly misdiagnosed as “problem thrush.”

A good little book for the pharmacy bookshelf and to recommend to patients.

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NOTICES

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, official office of the World Health Organization

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tpsp.sheridan.com).

18th Congress on Sexually Transmitted Infections

IUSTI-Europe 2002


Chair of the Congress, Director of the European Branch of IUSTI: Angelika Stary, MD (Austria)

Further details: Angelika Stary, c/o Administration and Scientific Secretariat, Vienna Academy of Postgraduate Medical Education and Research, Alser Strasse 4, A-1090 Vienna, Austria (tel: (+43 1) 405 13 83 13; fax: (+43 1) 407 82 74; email: iusti2002@medacad.org; website: www.iusti-europe-2002.org)

26th National Conference of the Indian Association for the Study of Sexually Transmitted Diseases & AIDS

18–20 October 2002, All India Institute of Medical Sciences, New Delhi, India

The last date for submission of abstracts for free papers is 1 September 2002. The registration fees for foreign delegates is $50 (SAARC countries) and $100 (other countries).

Further details: Indian Association for the Study of Sexually Transmitted Diseases & AIDS (fax: (0)91 011 686 2663; email: iastisd2002@sify.com)