Sexual and reproductive health among female adolescents: preliminary results

The recognition of adolescence as an essential formative stage of life has implications for programmatic content and approaches. Young people have to be treated as people in their own right, and their individual needs considered on a case to case basis. The realisation that this is a time of significant change and risk highlights the urgency to deal directly with sensitive topics such as sex and drugs. The aim of this study was to identify demographic, behavioural and clinical factors for STI and unplanned pregnancy among female adolescents assisted by the family health programme (PSF) of Vitória Municipality in Brazil. A cross-sectional study was performed among female adolescents (15–19 years old) assisted by the PSF. Participants were screened for Chlamydia trachomatis and Neisseria gonorrhoea using ligase chain reaction (LCR) applied to urine and answered a face to face questionnaire. Standard descriptive statistical analysis was performed. Prevalence rates were calculated to reflect the relative frequency of each disease and the results are reported in Table 1. Seventy per cent of adolescents had already had sexual intercourse. Among those the prevalence rate of CT was 11.4% (95% CI 7.6 to 14.4), 4.0% (95% CI 2.1 to 5.2) of GC. Behaviour and clinical data are reported in Table 1. There was statistical significance between chlamydial infection and previous STI (OR = 20.1, 95% CI: 5.9 to 67.9); gonorrhoea and no condom use (OR = 1.2, 95% CI: 1.06 to 1.12); and gonorrhoea and alcohol abuse (OR = 1.3, 95% CI: 1.1 to 2.1). Clinical problems identified were genital ulcer 6.0%, dysuria 15.4%, inguinal lymphadenopathy 12.1%, vaginal bleeding 3.4%, and pelvic pain 5.2%. STIs deserve attention not only because of their high prevalence but also because they frequently go undetected and untreated, and often result in serious sequelae and association with HIV infection. High prevalence rates associated with high frequency of risk were observed in this ongoing study. These two factors identify female adolescents as an important group to target with STI including HIV prevention efforts. These data are descriptive and need to be completed but they are in agreement with the last research about Brazilian sexuality. It was reported that adolescents have their first intercourse earlier than the older generation and the knowledge about STI/AIDS does not modify the exposition. Eighteen per cent of adolescents in Brazil become pregnant at least once and 54.1% among the married ones use some method of contraception. The preliminary results suggest that humane, healthcare providers’ involvement and the health family programme can be an acceptable intervention, as well as one that is highly targeted epidemiologically. Screening, treatment and prevention counselling, and support in communities should be considered.
Factors affecting co-infection with genital chlamydia and genital gonorrhoea in an urban genitourinary medicine clinic

Co-treatment for chlamydia is common practice when gonorrhoea is diagnosed in a UK genitourinary medicine setting. In Glasgow, the incidence of gonorrhoea across the city has tripled from 1995 to 2000. Given this rise, we investigated whether our practice of co-treatment was of continued benefit. We examined all patients presenting to the Glasgow Royal Infirmary Genitourinary Medicine (GUM) Service (including the Steve Retson Project service for gay men) between 1 April 1997 and 30 September 2000 who had genital gonorrhoea diagnosed on routine culture. We diagnosed genital chlamydia co-infection by ligase chain reaction (LCR) on first pass urine (for men) or endocervical swab (for women). We diagnosed gonorrhoea in 351 attenders (287 men, 64 women), of whom 86 (25%; 95% CI 20% to 29%) were co-infected. Co-infection was significantly more common in women than men (29/464 (6%) vs 27/287 (20%; p = 0.02). Homosexual or bisexual men were significantly less likely to be co-infected than heterosexual men (15/134 (11.0%) vs 42/133 (32%; p = 0.001). Co-infection became less common with increasing age (15–19 years 43%; 20–24 years 34%; >24 years 18%; χ² for trend = 15.4; p < 0.0001) (see table w1 on STI website). Logistic regression modelling showed young age and female sex to be independent predictors of co-infection, while homo/bisexuality was protective (see table w2 on STI website).

We recommend continuing co-treatment for chlamydia in all women and heterosexual men presenting with gonorrhoea in our setting. However, in common with other recent findings, co-infection with genital chlamydia is uncommon in male homosexual or bisexual attenders with genital gonorrhoea, and co-treatment may not be necessary in this group.

Table 1  Behavioural and clinical data among female adolescents

<table>
<thead>
<tr>
<th>Variables</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco use</td>
<td>45</td>
<td>30.2</td>
</tr>
<tr>
<td>Alcohol regular use</td>
<td>39</td>
<td>26.2</td>
</tr>
<tr>
<td>Cannabis use</td>
<td>22</td>
<td>14.8</td>
</tr>
<tr>
<td>Illicit drug abuse</td>
<td>56</td>
<td>37.6</td>
</tr>
<tr>
<td>Access to information about sexuality</td>
<td>104</td>
<td>69.8</td>
</tr>
<tr>
<td>Access to information about contraception</td>
<td>86</td>
<td>57.7</td>
</tr>
<tr>
<td>Regular medical consultation</td>
<td>92</td>
<td>61.7</td>
</tr>
<tr>
<td>Vaginal intercourse</td>
<td>97</td>
<td>65.1</td>
</tr>
<tr>
<td>Anal intercourse</td>
<td>8</td>
<td>5.4</td>
</tr>
<tr>
<td>Regular condom use</td>
<td>31</td>
<td>31.9</td>
</tr>
<tr>
<td>Previous STI</td>
<td>10</td>
<td>10.3</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>26</td>
<td>26.8</td>
</tr>
<tr>
<td>Rape</td>
<td>13</td>
<td>13.4</td>
</tr>
</tbody>
</table>

*Data related to 97 adolescents that reported sexual intercourse.

Presented in part at the MSSVD Spring Meeting May 2001.

L Hijazi, C Thow, A J Winter
Sandford Initiative, Glasgow G3 7NB, UK
Correspondence to: A J Winter; andy.winter@glascom.scot.nhs.uk

References

Accepted for publication 21 May 2002

Screening for STIs in individuals with HIV infection

In Australia, Victoria has seen an increase in new HIV cases from 1999 to 2000, and this rise has been sustained in 2001. The rise primarily involves men who have sex with men (MSM), where rates of unprotected anal intercourse and bacterial sexually transmitted infections (STIs) have also increased. As bacterial STIs enhance HIV transmission, screening for asymptomatic infections may reduce the incidence of HIV.

A sexual health service in Melbourne reviewed medical records of MSM clients with HIV infection. This was conducted to determine how commonly STI screening of asymptomatic clients is performed and the proportion with bacterial STIs. At the sexual health clinic the records of MSM with HIV care primarily at that clinic between 10 January 2001 and 1 March 2002 were reviewed. Any record of bacterial STI screening in the last year, the anatomical sites screened, and the laboratory results of screening were collected on printed forms. At the Alfred hospital a pilot programme screening asymptomatic clients with HIV (n = 40) was undertaken in the outpatient department between 30 October 2001 and 4 December 2001.

Of the 66 sexual health clinic records fulfilling the criteria, 22 (33%) had screening for bacterial STIs, and eight were tested at all anatomical sites with infection (urethra, rectum, throat). Of the 22 tested, three (14%) tested positive for Neisseria gonorrhoeae (NG) by culture and/or Chlamydia trachomatis (CT) by ligase chain reaction (LCR). Three had rectal infection (NG = 2, CT = 3), two also had pharyngeal infection (NG = 2), and one also had urethral infection (CT = 1). At the Alfred Hospital 40 clients had swabs taken from all sites. Of these 40, eight (20%) HIV infected clients had rectal NG detected by polymerase chain reaction (PCR) with confirmatory assay.

We identified a relatively high proportion of infections in those screened—11 positive of the 62 tested (18%, 95% CI 9% to 30%). These findings do not mean that these individuals have been placing others at risk of HIV transmission because STIs may be acquired from unprotected sexual contact with other HIV infected individuals, or through sexual contact that is low risk for HIV transmission. Nevertheless, it would seem prudent to reduce the prevalence of STIs by making screening a routine part of the management of MSM. In the United States STI screening is recommended, and screening of MSM is also recommended in the draft “STI management guidelines for priority populations” from the Australasian College of Sexual Health Physicians (Chris Bourne, personal communication).

Contributors
The data extraction was carried out by all authors and analysed by NL and CF. The article was drafted by all authors and all have approved the final draft. The authors declare that they have no conflict of interest in connection with this paper.

The completion of medical record reviews, the analysis, and drafting of this letter did not involve funding.

N A Lister, C K Fairley
Department of Public Health, The University of Melbourne, Australia
T Read
Carlton Clinic, 88 Rathdowne Street, Carlton 3053, Australia
A Mijch
HIV Services, Alfred Hospital, Department of Infectious Diseases, Alfred Hospital, Prahran, Vic 3181, Australia
Erythema nodosum induced by chancroid

Erythema nodosum is a panniculitis which is often regarded as a complex reaction pattern to various aetiological factors of infective and non-infective origin. Infective agents outnumber inflammatory causes and drugs in causation of erythema nodosum in the developing countries. Almost all the infective agents including aerobic and anaerobic bacteria, viruses, fungi, parasites and mycobacteria can induce eruption of erythema nodosum. Among sexually transmitted infections lymphogranuloma venereum has been known to be associated with erythema nodosum not infrequently.

A 23 year old woman presented with genital ulcer disease and painful rash over the legs of 1 week's duration. There was no history of trauma, fever, or drug intake. She had a single stable septrum which was apparently unaffected. Examination revealed a single, 1–1.5 cm, irregular tender ulcer on the right labia minora with undermined margins and bleeding on touch. The inguinal lymph nodes were firm, moderately enlarged, and tender. Speculum and vaginal examination was normal. Examination of the perianal region, perineum, and other mucosae was also normal.

Multiple tender, erythematous nodular subcutaneous lesions with dusky erythema were present over both shins, calves, and ankle joints. Investigations revealed a normal complete blood count, serum biochemistry, urinalysis and blood sugar. VDRL, HIV-1 ELISA, and HBsAg were negative. Dark ground illumination, smears, and cultures from the ulcer did not reveal aetiologic diagnosis. Histopathology from the ulcer revealed an ulcerated surface with necrosis and neutrophilic infiltrate deeper to which a zone of new blood vessel formation with marked endothelial proliferation and a lymphoplasma-cell infiltrate was observed. These features were consistent with diagnosis of chancroid while histopathology of leg lesions confirmed it to be septal panniculitis consistent with a diagnosis of erythema nodosum. The ulcer was treated with erythromycin stearate 500 mg hourly for 7 days. The genital ulcer healed completely in 7−10 days but the lesions of erythema nodosum subsided completely in 5−7 days without any other treatment.

Erythema nodosum as a cutaneous reaction pattern was first observed by Willan in 1798. A female preponderance with a ratio of 3:1 is often observed in adults compared to an equal incidence at prepubertal age. Although the exact pathogenesis of erythema nodosum is not known, it has been regarded as an immune complex, deposition disease which prefers the richly supplied vascular adipose tissue of the legs.

In the present patient the erythema nodosum and chancroid had a strong temporal correlation as erythema nodosum immediately followed the appearance of the chancroid and resolved completely with its resolution. Although erythema nodosum is known to be associated with innumerable infective agents, to the best of our knowledge chancroid leading to causation of erythema nodosum has not been observed before.
and Chlamydia trachomatis were ported in the pre-antibiotic era with intravenous ceftriaxone and metronida-zole and surgical drainage.

Swabs from the rectum, throat, and urethra as well as urine were negative for Neisseria gonorrhoeae, whereas Bartholin’s, periurethral abscesses appeared from contemporary descriptions of Bacteroides species probably played a part in the development of an abscess, consistent with animal inoculation experiments. Another possible factor was the moderate immunosuppression (CD4 count of 280) from his HIV infection.

Six months passed from the time of infection to diagnosis, during which the patient was largely free of symptoms which then developed when co-trimoxazole was stopped. The likely explanation is that the co-trimoxazole was suppressing the gonococcal infection without curing it. The failure to detect N gonorrhoeae by PCR from the rectal specimen raises the possibility that co-trimoxazole may have eradicated a rectal infection in this case while only suppressing an extraprostatic manifestation.

It is now standard practice to stop PCP prophylaxis when CD4 counts rise above 200 x 10^3 in patients taking antiretroviral therapy. This may in turn reduce the impact on both the transmission and the manifestations of gonorrhea in these patients, perhaps even contributing to increases in gonorrhea in HIV infected populations.

Gonococcal perianal abscess: re-emergence after cessation of co-trimoxazole

We report a case of perianal abscess due to Neisseria gonorrhoeae, which appears to have been suppressed but not eradicated by chronic low dose co-trimoxazole for a period of almost 6 months between acquisition and diagnosis. The patient was a 34 year old HIV infected homosexual man treated with dianorarine, stavudine, and nevirapine with a HIV viral load of 500 copies per ml and a CD4 lymphocyte count of 280 x 10^3. He was taking co-trimoxazole 400 mg/80 mg on daily to prevent Pneumocystis carinii pneumonia (PCP).

He reported last having receptive anal sex in June 2000. This was unprotected, with a casual partner at a “gay” sauna. Three weeks later he reported a perianal abscess which discharged spontaneously, requiring dressings for a few days. A sinus was observed and he was booked for elective surgery. He remained well for 5 months.

Co-trimoxazole CPC prophylaxis was stopped in November 2000 as his CD4 T lymphocyte count had remained above 200. Two weeks later (and almost 6 months after the last reported anal sex) he presented with purulent discharge emerging from a sinus approximately 3 cm from the anus.

N gonorrhoeae (sensitive to penicillin, ceftri-azone, and ciprofloxacin) and Bacteroides species were cultured from this discharge. Swabs from the rectum, throat, and urethra as well as urine were negative for N gonorrhoeae and Chlamydia trachomatis by polymerase chain reaction (PCR).

Ciprofloxacin was started but pain, swelling, and perianal cellulitis led to his admission to hospital where he was treated with intravenous ceftriaxone and metronida-zole and surgical drainage.

Gonococcal perianal abscesses were reported in the pre-antibiotic era but have disappeared from contemporary descriptions of gonorrhea, whereas Bartholin’s, periurethral, and tubo-ovarian gonococcal abscesses are described. The isolation of Bacteroides species and the worsening of the infection despite ciprofloxacin suggest that anaerobic organisms probably played a part in the development of an abscess, consistent with animal inoculation experiments. Another possible factor was the moderate immunosuppression (CD4 count of 280) from his HIV infection.

Six months passed from the time of infection to diagnosis, during which the patient was largely free of symptoms which then developed when co-trimoxazole was stopped. The likely explanation is that the co-trimoxazole was suppressing the gonococcal infection without curing it. The failure to detect N gonorrhoeae by PCR from the rectal specimen raises the possibility that co-trimoxazole may have eradicated a rectal infection in this case while only suppressing an extraprostatic manifestation.

It is now standard practice to stop PCP prophylaxis when CD4 counts rise above 200 x 10^3 in patients taking antiretroviral therapy. This may in turn reduce the impact on both the transmission and the manifestations of gonorrhea in these patients, perhaps even contributing to increases in gonorrhea in HIV infected populations.

References


Accepted for publication 5 June 2002

Gonococcal perianal abscess: re-emergence after cessation of co-trimoxazole

We report a case of perianal abscess due to Neisseria gonorrhoeae, which appears to have been suppressed but not eradicated by chronic low dose co-trimoxazole for a period of almost 6 months between acquisition and diagnosis. The patient was a 34 year old HIV infected homosexual man treated with dianorarine, stavudine, and nevirapine with a HIV viral load of 500 copies per ml and a CD4 lymphocyte count of 280 x 10^3. He was taking co-trimoxazole 400 mg/80 mg on daily to prevent Pneumocystis carinii pneumonia (PCP).

He reported last having receptive anal sex in June 2000. This was unprotected, with a casual partner at a “gay” sauna. Three weeks later he reported a perianal abscess which discharged spontaneously, requiring dressings for a few days. A sinus was observed and he was booked for elective surgery. He remained well for 5 months.

Co-trimoxazole CPC prophylaxis was stopped in November 2000 as his CD4 T lymphocyte count had remained above 200. Two weeks later (and almost 6 months after the last reported anal sex) he presented with purulent discharge emerging from a sinus approximately 3 cm from the anus.

N gonorrhoeae (sensitive to penicillin, ceftri-azone, and ciprofloxacin) and Bacteroides species were cultured from this discharge. Swabs from the rectum, throat, and urethra as well as urine were negative for N gonorrhoeae and Chlamydia trachomatis by polymerase chain reaction (PCR).

Ciprofloxacin was started but pain, swelling, and perianal cellulitis led to his admission to hospital where he was treated with intravenous ceftriaxone and metronida-zole and surgical drainage.

Gonococcal perianal abscesses were reported in the pre-antibiotic era but have disappeared from contemporary descriptions of gonorrhea, whereas Bartholin’s, periurethral, and tubo-ovarian gonococcal abscesses are described. The isolation of Bacteroides species and the worsening of the infection despite ciprofloxacin suggest that anaerobic organisms probably played a part in the development of an abscess, consistent with animal inoculation experiments. Another possible factor was the moderate immunosuppression (CD4 count of 280) from his HIV infection.

Six months passed from the time of infection to diagnosis, during which the patient was largely free of symptoms which then developed when co-trimoxazole was stopped. The likely explanation is that the co-trimoxazole was suppressing the gonococcal infection without curing it. The failure to detect N gonorrhoeae by PCR from the rectal specimen raises the possibility that co-trimoxazole may have eradicated a rectal infection in this case while only suppressing an extraprostatic manifestation.

It is now standard practice to stop PCP prophylaxis when CD4 counts rise above 200 x 10^3 in patients taking antiretroviral therapy. This may in turn reduce the impact on both the transmission and the manifestations of gonorrhea in these patients, perhaps even contributing to increases in gonorrhea in HIV infected populations.

Gonococcal perianal abscess: re-emergence after cessation of co-trimoxazole

We report a case of perianal abscess due to Neisseria gonorrhoeae, which appears to have been suppressed but not eradicated by chronic low dose co-trimoxazole for a period of almost 6 months between acquisition and diagnosis. The patient was a 34 year old HIV infected homosexual man treated with dianorarine, stavudine, and nevirapine with a HIV viral load of 500 copies per ml and a CD4 lymphocyte count of 280 x 10^3. He was taking co-trimoxazole 400 mg/80 mg on daily to prevent Pneumocystis carinii pneumonia (PCP).

He reported last having receptive anal sex in June 2000. This was unprotected, with a casual partner at a “gay” sauna. Three weeks later he reported a perianal abscess which discharged spontaneously, requiring dressings for a few days. A sinus was observed and he was booked for elective surgery. He remained well for 5 months.

Co-trimoxazole CPC prophylaxis was stopped in November 2000 as his CD4 T lymphocyte count had remained above 200. Two weeks later (and almost 6 months after the last reported anal sex) he presented with purulent discharge emerging from a sinus approximately 3 cm from the anus. N gonorrhoeae (sensitive to penicillin, ceftri-azone, and ciprofloxacin) and Bacteroides species were cultured from this discharge. Swabs from the rectum, throat, and urethra as well as urine were negative for N gonorrhoeae and Chlamydia trachomatis by polymerase chain reaction (PCR).

Ciprofloxacin was started but pain, swelling, and perianal cellulitis led to his admission to hospital where he was treated with intravenous ceftriaxone and metronida-zole and surgical drainage.

Gonococcal perianal abscesses were reported in the pre-antibiotic era but have disappeared from contemporary descriptions of gonorrhea, whereas Bartholin’s, periurethral, and tubo-ovarian gonococcal abscesses are described. The isolation of Bacteroides species and the worsening of the infection despite ciprofloxacin suggest that anaerobic organisms probably played a part in the development of an abscess, consistent with animal inoculation experiments. Another possible factor was the moderate immunosuppression (CD4 count of 280) from his HIV infection.

Six months passed from the time of infection to diagnosis, during which the patient was largely free of symptoms which then developed when co-trimoxazole was stopped. The likely explanation is that the co-trimoxazole was suppressing the gonococcal infection without curing it. The failure to detect N gonorrhoeae by PCR from the rectal specimen raises the possibility that co-trimoxazole may have eradicated a rectal infection in this case while only suppressing an extraprostatic manifestation.

It is now standard practice to stop PCP prophylaxis when CD4 counts rise above 200 x 10^3 in patients taking antiretroviral therapy. This may in turn reduce the impact on both the transmission and the manifestations of gonorrhea in these patients, perhaps even contributing to increases in gonorrhea in HIV infected populations.
Contributors
SD, CAR, and DL designed the study; SD and DL gathered and statistically analysed the data; SD, DL, and CAR contributed to writing the paper.

Conflicting interests: There were no conflicting interests and no costs incurred.

S Day, D Lakhani, C Rodgers
Department of Genitourinary Medicine, Guy’s and St Thomas’s Hospital, London, UK

Correspondence to: Sara Day, Lydia Department, Department of Genitourinary Medicine, St Thomas’s Hospital, London SE1 7EH, UK; Sarah.Day@gstt.nhs.uk

References

Accepted for publication 4 July 2002

BOOK REVIEW


Not many books nowadays try to summarise the broad field of HIV and AIDS. This British Medical Bulletin does attempt to do that, in line with its usual approach to providing substantial coverage of health subjects, but with suitable depth as well as breadth. The last (and first) British Medical Bulletin on this subject was published in 1988. It covered quite similar topics, but the main change is the depth of knowledge.

Although the title of this volume reflects the general sense that the face of the pandemic has indeed changed in many ways—not least the global spread, and the impact of antiretroviral therapies where they are available—the overwhelming impression I had was how similar are the issues and perspectives it covers. This is partly a reflection of the extraordinary hothouse atmosphere of the early pioneering years, when we climbed the steep part of the learning curve with unparalleled speed. The subsequent years have been ones of consolidation, during which the detail has been explored and the basic ideas refined. This book reflects that, where the change in the face is in part a shift from an impressionistic image to a more fully representational portrait, evidently from the same original.

The chapters provide a balanced and compact, yet thorough, assessment of the main issues. The authors are active in the field; they have an appropriately British background for this series, yet their perspective is unequivocally global. The accounts are worthy, reliable, and authoritative. If this conveys the impression that they are rather dull to read, that was indeed my feeling. There was generally and disappointingly little sparkle or originality in the concepts or the writing. Where there was, it derived from a narrow focus on a small part of the canvas rather than any broader insight.

Who will use this volume? I would recommend it as a reliable and thorough review for a new entrant to the field. Those who work adjacent to it and who would like a compact, up to date summary would also be well served. Some of the chapters are an excellent springboard for detailed exploration of their topic. But those who already work on HIV/AIDS will find little to engage or excite them. They would probably feel, as I did, that the fascinating wider changes in the actual face of HIV/AIDS, which are palpable in their work, have scarcely been touched upon.

Anthony J Pinching
Department of Immunology, Barts and The London, Queen Mary’s School of Medicine and Dentistry, St Bartholomew’s Hospital, West Smithfield, London ECI A 7BE, UK

NOTICES

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpessaience.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new free papers is 1 September 2002. The recent change in the face is in part a shift from an impressionistic image to a more fully representational portrait, evidently from the same original.

The chapters provide a balanced and compact, yet thorough, assessment of the main issues. The authors are active in the field; they have an appropriately British background for this series, yet their perspective is unequivocally global. The accounts are worthy, reliable, and authoritative. If this conveys the impression that they are rather dull to read, that was indeed my feeling. There was generally and disappointingly little sparkle or originality in the concepts or the writing. Where there was, it derived from a narrow focus on a small part of the canvas rather than any broader insight.

Who will use this volume? I would recommend it as a reliable and thorough review for a new entrant to the field. Those who work adjacent to it and who would like a compact, up to date summary would also be well served. Some of the chapters are an excellent springboard for detailed exploration of their topic. But those who already work on HIV/AIDS will find little to engage or excite them. They would probably feel, as I did, that the fascinating wider changes in the actual face of HIV/AIDS, which are palpable in their work, have scarcely been touched upon.

Anthony J Pinching
Department of Immunology, Barts and The London, Queen Mary’s School of Medicine and Dentistry, St Bartholomew’s Hospital, West Smithfield, London EC1 A 7BE, UK

Pan-American Health Organization, regional 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: pahjv@pahjv.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 fee 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) 11 011 686 2663; email: iasstd2002@sfy.com).

European Society for Gynaecological Endoscopy

Expert Meeting on Pelvic Floor Disorders

28–30 November 2002, Centro Médico Teknon, Barcelona, Spain

Further details: ESGE central office, Organizzazione Medico, Essennestraat 77, B-1740 Ternat, Belgium (fax: +32 2582 0852; fax: +32 2582 1513; email: organismo@village.unet.be; web site: www.ESGE.org).

Royal Society of Medicine Conference on Men’s Sexual Health

13 December 2002, The Royal Society of Medicine, 1 Wimpole Street, London, W1G GA, UK

Is Viagra really the answer to impotence, or are men and their doctors relying on prescription pills and avoiding tackling the psychological causes behind the problem? Besides impotence and other sexual dysfunction, this meeting also looks a range of male sexual problems from STDs to prostate cancer, the effect of sex on the heart to the male menopause. Registration costs: Fellow: £105; Non-Fellow: £175; Student: £20. CPD: 5 credits; PGEA Applied For.

Further details: Ms Georgina Brodie, RSM Administration (tel: +44 (0)20 7290 3856; fax: +44 (0)20 7290 2977; email: georgina.brodie@rsms.ac.uk).

XIX International Congress of the Society of The Fetus as a Patient

1–4 May 2003, Gran Hotel Sitges, Barcelona-Sitges, Spain

Further details: (fax: +34 93 418 7832; email: bcn2003@iudecesu.uab.es).