HIV tests in young adolescents attending a GUM clinic

A pretest counselling session is recommended by the General Medical Council before carrying out an HIV test and it is generally accepted that adolescents deemed competent enough to understand the counselling process can have an HIV test without parental consent. A recent survey in the United Kingdom showed that 79% of clinics were prepared to test for HIV infection in children under the age of 16. We reviewed the characteristics of adolescents between the ages of 13 and 16 seen in the Coventry genitourinary medicine (GUM) clinic for an HIV test between 1990 and 2000 (table 1). This was part of a larger review of GUM attendances by children, the results of which have been published. Providing it isn’t libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on “eletters submit a response”. Providing it isn’t libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on “eletters submit a response”. Providing it isn’t libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on “eletters submit a response”.

The editors will decide, as before, whether to also publish it in a future paper issue.

AADLENTON SEXUAL HEALTH LETTERS

If you have a burning desire to respond to a paper published in Sex Transm Infect, why not make use of our “rapid response” option?

Log on to our website (www.sextransinf.com), find the paper that interests you, click on “full text” and send your response by email by clicking on “eletters submit a response”.

Providing it isn’t libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on “eletters submit a response”.

The editors will decide, as before, whether to also publish it in a future paper issue.


Table 1 Demographics

<table>
<thead>
<tr>
<th>Total number</th>
<th>82</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>70 (85.4%)</td>
</tr>
<tr>
<td>Accepting to have HIV test</td>
<td>70 (85.4%)</td>
</tr>
<tr>
<td>Median age</td>
<td>15</td>
</tr>
<tr>
<td>Virgins</td>
<td>8 (9.8%)</td>
</tr>
<tr>
<td>Prostitutes</td>
<td>3 (3.7%)</td>
</tr>
<tr>
<td>Injecting drug users</td>
<td>2 (2.4%)</td>
</tr>
<tr>
<td>Positive for HIV antibodies</td>
<td>0</td>
</tr>
</tbody>
</table>

Sexual and reproductive health among female adolescents: preliminary results

The recognition of adolescence as an essential formative stage of life has implications for programmes, 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 the time of significant opportunity 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 gonorrhoeae 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, calculated with corresponding 95% confidence intervals (CI).

The national school of public health (FIOCruz) ethics committee approved this study. Written, informed consent was obtained by all participants and their parents.

The study included 149 adolescents. Mean age was 17.2 (SD 1.5) years; mean education was 8.3 (SD 2.9) years of schooling, and the mean age of the first sexual intercourse was 15.4 (SD 1.6) years. 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), 4.0% (95% CI 2.1 to 5.2) of GC. Behaviour and clinical data are reported in table 1. There was statistical significance between chlamydia infection and previous STI (OR = 20.1, 95% CI: 5.9 to 67.9); gonorrhoea and no condom use (OR = 1.9, 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 3.4%.

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.

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 based, STI/HIV prevention services in 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.

PostScript
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 Reseton 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 (294/486 (49%) vs 57/278 (20%; p = 0.02). Homosexual or bisexual men were significantly less likely to be co-infected than heterosexual men (15/334 (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 the 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.

Presented in part at the MSSVD Spring Meeting May 2001.

L Hijazi, C Thow, A J Winter
Sandyford Initiative, Glasgow G3 7NB, UK

References

 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 Listner, C K Fairley
Department of Public Health, The University of Melbourne, Australia

T Read
Carlton Clinic, 88 Batholow Street, Carlton 3053, Australia

A Mijch
HIV Services, Alfred Hospital, Department of Infectious Diseases, Alfred Hospital, Prahran, Vic 3181, Australia
cultivation with each fraction were determined for HIV p24 antigen and proviral DNA after co-cultivation. The percentage collection of sperm from Fr 1, centrifuged at 400 g for 30 minutes, was prepared with Pure sperm. Semen washed with Hank's solution was laid on this gradient and centrifuged at 400 g for 30 minutes. The specimen of each fraction was extracted to determine sperm quality and to obtain better quality sperm.

Methods
After ethics committee approval and written informed consent, normozoospermic semen was provided by two asymptomatic HIV carriers. Discontinuous four layer density gradient, whose fractions (Fr) were 1.065 (Fr 4), 1.085 (Fr 3), 1.110 (Fr 2), and 1.135 (Fr 1), was prepared with Pure sperm. Washed semen with Hank's solution was laid on this gradient and centrifuged at 400 g for 30 minutes. The specimen of each fraction was extracted to determine sperm quality and to obtain better quality sperm.

Results
The percentage collection of sperm from Fr 1, Fr 2, Fr 3, and Fr 4 was 3% (SD 2%), 32% (9%), 19% (8%), and 10% (4%), respectively. Motility rate was 55% (19%), 94% (4%), 57% (25%), and 19% (11%), respectively. Proximal HIV DNA and HIV RNA were detected only from Fr 4. HIV p24 antigen was observed in the lymphocytes co-cultivated with Fr 4 and from the positive control, but was not observed in other fractions. HIV proximal DNA was not detected from Fr 2 or Fr 3 (tables 1 and 2).

### Table 1 Sperm characteristics and detection of HIV in each fraction

<table>
<thead>
<tr>
<th>Fraction</th>
<th>Sperm collection rate (%)</th>
<th>Sperm motility rate (%)</th>
<th>HIV RNA</th>
<th>HIV DNA</th>
<th>HIV p24 antigen after co-cultivation</th>
<th>HIV DNA after co-cultivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fr 1</td>
<td>4.6 (1)</td>
<td>55 (19)</td>
<td>negative</td>
<td>negative</td>
<td>negative</td>
<td>positive</td>
</tr>
<tr>
<td>Fr 2</td>
<td>3.2 (9)</td>
<td>94 (4)</td>
<td>negative</td>
<td>negative</td>
<td>negative</td>
<td>positive</td>
</tr>
<tr>
<td>Fr 3</td>
<td>1.9 (8)</td>
<td>57 (25)</td>
<td>negative</td>
<td>negative</td>
<td>negative</td>
<td>negative</td>
</tr>
<tr>
<td>Fr 4</td>
<td>1.4 (11)</td>
<td>19 (11)</td>
<td>positive</td>
<td>positive</td>
<td>positive</td>
<td>positive</td>
</tr>
</tbody>
</table>

### Table 2 Detection of HIV p24 antigen and proviral DNA after 4 weeks’ co-cultivation with each fraction and carrier’s PBL

<table>
<thead>
<tr>
<th>Fraction</th>
<th>HIV p24 antigen</th>
<th>HIV DNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fr 1</td>
<td>pos</td>
<td>pos</td>
</tr>
<tr>
<td>Fr 2</td>
<td>neg</td>
<td>neg</td>
</tr>
<tr>
<td>Fr 3</td>
<td>neg</td>
<td>neg</td>
</tr>
<tr>
<td>Fr 4</td>
<td>pos</td>
<td>pos</td>
</tr>
</tbody>
</table>

PBL = peripheral blood lymphocytes.

Discussion
HIV discordant couples have a risk of transmission generally if they wish to have a baby.\(^1\) Semprini et al\(^2\) reported continuous gradient centrifugation followed by a swim up procedure, and Marina et al\(^3\) carried out a similar method but HIV was detected in 5.6% of 107 samples. However, the condition of the sperm, after these processes, was not always sufficient for intrauterine insemination.

We have developed a novel semen single processing technique to reduce HIV RNA and HIV proviral DNA to undetectable levels in the fraction whose sperm quality was higher than others. Furthermore, this fraction was confirmed to have no HIV infectivity in vitro. This method appears to be an attractive alternative for HIV discordant couples.

Contributors
KK and YA contributed to laboratory work; AY referred HIV positive volunteers.

K Kakimoto, Y Ando, A Yoshika
International Medical Centre of Japan, Tokyo
Japan Correspondence to: K Kakimoto; kakimoto@sannet.ne.jp

References


Erythema nodosum induced by chancroid

Erythema nodosum is a type of 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.\(^4\) Among sexually transmitted infections lymphotoagromal failure has been known to be associated with erythema nodosum not infrequently.\(^5\)

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 exzematous ulcer which was apparently unaffected. Examination revealed a single, 1–1.5 cm, irregular tender ulcer on the right labia minora with undermined maris and bleeding on touch. The axillary lymph nodes were firm, moderately enlarged, and tender. Speculum and vaginal examination was normal. Examination of the perianal region, perineum, and other mucosa 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 aetiological diagnosis. Histopathology from the ulcerated surface with necrosis and neutrophilic infiltrate deep to which a zone of new blood vessel formation with marked endothelial proliferation and a lymphoplasmacytoid infiltrate was observed. These features were consistent with diagnosis of chancroid while histopathology of leg lesions confirmed it to be sepal 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 while 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.\(^6\) 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 a immune complex, deposition disease which prefers the richly vascularized tissues. The disease 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.

C Kaur, G P Thami
Department of Dermatology and Venereology, Government Medical College Hospital, Sector 32 B, Chandigarh 160030, India

Correspondence to: Dr G P Thami; dgurvinde@manthanonline.com
and Chlamydia trachomatis zole and surgical drainage. With intravenous ceftriaxone and metronidazole, he noticed a decrease in swelling, and perianal cellulitis led to his diagnosis (PCR). Swabs from the rectum, throat, and urethra as well as urine were negative for N gonorrhoeae. Bacteroides species were cultured from this discharge.

Approximately 3 cm from the anus, a purulent discharge emerging from a sinus was noted. The patient was a 34 year old HIV infected man treated with didanosine, stavudine, and nevirapine with a HIV viral suppression (CD4 count of 280) from his HIV infection to diagnosis, during which the “diagnosis interval” of patients testing HIV positive thereby conferring a better outcome, with respect to HAART; identify patients with recent concurrent acquisition of HIV and a STI, entering a high infective seroconversion phase; identify individuals with undiagnosed, established HIV infection and a newly acquired STI which promotes higher infectivity due to increased HIV viral shedding into genital secretions.1

Our study analysed the uptake of HIV testing among attendees who had a genitourinary screen at St Thomas’s Hospital genitourinary medicine department between 1 and 31 December 1999. It compared the uptake of HIV testing, either at the index visit in December or deferred to within the ensuing 3 months, between patients diagnosed with an STI (gonorrhoea, chlamydia, herpes simplex virus, and trichomoniasis (study group)) and patients receiving a negative STI screen (control group). Of 318 attendees, 242 and 76 patients comprised the study and control groups respectively. Only 18% (59/318) of patients tested for HIV on the initial visit. Significantly fewer of the study group tested for HIV (14%) compared to the control group (33%) (p<0.01).

Of those who did not test for HIV, 11 and one patients deferred testing in the study and control groups respectively (table 1) However, none of the deferred or initial non-testers re-attended for HIV testing in the following 3 months.

In view of this unacceptably low rate of HIV testing, both overall and in those patients with a confirmed STI, the following interventions are now being introduced, aiming to improve these figures and comply with the sexual health strategy 2001 targets.

- An “opt out” policy of HIV testing
- Additional waiting room posters and a new patient information leaflet about HIV is given to all patients at registration to read while they wait to be seen explaining the natural history, treatments available, benefits of early diagnosis, and mechanics of reducing transmission. This enhances patient education and may expedite consultation length and waiting times for patients with restricted “time off” and/or other more pertinent issues to discuss

Pretest counselling is reserved for high risk groups instead of being required routinely

Patients are able to obtain their HIV results indirectly, without the inconvenience of a previously required second visit

Educating all GUM staff to encourage a high offer rate of HIV testing to all patients, especially targeting high risk patients, which incorporates those with a confirmed STI.

Table 1

<table>
<thead>
<tr>
<th>Study</th>
<th>Deferred at time of attendance</th>
<th>Attended within 3 months and tested for HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>25/76 (33%)</td>
<td>1/76 (1%)</td>
</tr>
<tr>
<td>Study</td>
<td>34/242 (14%)</td>
<td>11/242 (5%)</td>
</tr>
</tbody>
</table>

Accepted for publication 14 June 2002

Uptake of HIV testing in patients with a confirmed sexually transmitted infection

UK seroprevalence rates indicate that up to 50% of HIV positive patients in genitourinary medicine (GUM) clinics remain undiagnosed.1 HIV is primarily identified at high risk patient groups. Sexually transmitted infections other than HIV (STIs) have been shown to facilitate and be associated indirectly, without the inconvenience of a previously required second visit

Educating all GUM staff to encourage a high offer rate of HIV testing to all patients, especially targeting high risk patients, which incorporates those with a confirmed STI.

Accepted for publication 14 June 2002

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

We report a case of perianal abscess due to N 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 didanosine, stavudine, and nevirapine with a HIV viral load of 500 copies per ml and a CD4 lymphocyte count of 280 × 10^3. He was taking co-trimoxazole 400 mg/80 mg once daily to prevent Pneumocystis carinii pneumonia (PCP).

He reported last having receptive anal sex (and almost 6 months after the last reported anal sex) he presented with pain, swelling, and perianal cellulitis led to his diagnosis (PCR). Swabs from the rectum, throat, and urethra as well as urine were negative for N gonorrhoeae and Bacteroides species were cultured from this discharge. N gonorrhoeae (sensitive to penicillin, ceftriaxone, and ciprofloxacin) and Bacteroides species were cultured from this discharge. N gonorrhoeae (sensitive to penicillin, ceftriaxone, and ciprofloxacin) and Bacteroides species were cultured from this discharge.

N gonorrhoeae (sensitive to penicillin, ceftriaxone, and ciprofloxacin) and Bacteroides species were cultured from this discharge. N. gonorrhoeae and Chlamydia trachomatis by polymerase chain reaction (PCR).

Oral ciprofloxacin was started but pain, swelling, and perianal cellulitis led to his admission to hospital where he was treated with intravenous ceftriaxone and metronidazole and surgical drainage.

Gonococcal perianal abscesses were reported in the pre-antibiotic era but have disappeared from contemporary descriptions of gonorrhoea, whereas Bartholin’s, perirectal, and tubo-ovarian gonococcal abscesses are described.1

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 extragenital manifestation.

It is now standard practice to stop PCP prophylaxis when CD4 counts rise above 200 × 10^3 in patients taking antiretroviral therapy. This may in turn have an impact on both the transmission and the manifestations of gonorrhoea in these patients, perhaps even contributing to increases in gonorrhoea in HIV infected populations.2

References

Accepted for publication 5 June 2002

PostScript
Contributors
SD, CAR, and BL 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 Lakhanli, 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.nhshhs.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 spark 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 EC1A 7BE, UK

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 (website: 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, 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: pubsvc@tsp.sheridan.com).

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: iassid2002@syfy.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, Orgamed, Essenerstraat 77, B-1740 Ternat, Belgium (tel: +32 2582 0852; fax: +32 2582 1515; email: orgamed@village.uunet.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 OAE, 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@rsm.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: bcnxix2003@iu.deuses.uab.es).