Highlights from this issue

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Syphilis, has always been known the "protean" disease, capable of manifesting in many forms and deceiving physicians as to its true nature. It confused Hunter, whose inoculation experiments[1] were the forerunner of the Tuskegee and Guatemala experiments[2]—it is disputed whether he experimented on himself, but not that he inoculated others in support of a unitary theory of gonorrhoea and syphilis. The huge impact of syphilis on pre-penicillin public health together with its place at the centre of moral debate, and the difficulty of diagnosis made it central to paradigm shifts in the philosophy of science as described in Fleck's seminal work "The Genesis and Development of a Scientific Fact",[3] first published in German in 1935. Many developed countries have seen a huge resurgence of syphilis, particularly among men who have sex with men (MSM), though it is now generally a benign condition since we have effective treatment. This month's case report by Muldoon *et al*[4] is a timely reminder that syphilis can be dangerous even in its earliest stages. The authors report a case of secondary syphilis presenting with coronary ostial occlusion and aortitis. It's important too that we regularly reflect on the clinical characteristics of long established conditions, which can evolve with selection pressures on their causative organisms, and depend on the curiosity and drive of clinicians to document what they are seeing. On a related note, Towns *et al*[5] report a high frequency of multiple and painful anogenital syphilis lesions, in the absence of herpes virus infection.

A striking feature of global epidemiology is the resistance of sexual health inequalities in vulnerable ethnic groups to health improvements in the wider societies surrounding them. Though minority ethnic groups experience many dimensions of poor health, the rate ratios for poor sexual health outcomes continue to be staggering in many developed world settings. This has been shown time and time again. Recent years have seen an emphasis on structural determinants of sexual health. This month we publish a call to arms for Indigenous sexual health in Australia, by the redoubtable Kerry Arabena. Her Editorial relates primarily to Australia—where, astonishingly, trachoma remains endemic among Indigenous peoples and generates diagnostic debates about the source genital chlamydia in children.[6] Health inequalities on this scale affecting First Peoples present all of us health professionals and politicians with a radical challenge, that we must all embrace. We all know the special character of this challenge in our own setting, and have a daily duty to put it at the heart of our service planning and advocacy.

How much does oral sex matter in STI transmission? While it's clearly a minor player in HIV transmission, there is growing interest in the role of oral sex in the transmission of bacterial STI,[7] and in the significance of oral human papilloma virus (HPV).[8]

Population based studies of adolescents are difficult to do, so we are pleased to publish sister Norwegian studies by Gravningen *et al*[9] [10] which report self-perceived risk and online partner recruitment in relation to chlamydia infection. Continuing the chlamydial theme, Kampman *et al*[11] report on the effectiveness of recalling young people for re-testing following a chlamydia diagnosis.

Other studies explore the value of integrating HIV and sexual health services in an African setting,[12] bacterial vaginosis in women at risk of HIV in Uganda,[13] mother to child HIV transmission in China,[14] methods of training for STI treatment,[15] the HIV care cascade in Russia[16] and provider offers of HPV vaccine.[17]

Finally, we welcome reader letters, and are pleased this month to publish on treatment for rectal chlamydia[18] and Raltegravir for post-exposure HIV prophylaxis.[19]

Competing interests None.

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