

Table Incidence of HIV I infection in 734 women by western blot in relation to incidence of *Treponema pallidum*, *Chlamydia trachomatis*, and *Neisseria gonorrhoeae* (figures numbers (and percentages))

Results on western blot	<i>T pallidum</i>		<i>C trachomatis</i> *		<i>N gonorrhoeae</i> †	
	Negative (n = 661)	Positive (n = 72)	Negative (n = 310)	Positive (n = 415)	Negative (n = 506)	Positive (n = 223)
Antibodies to:						
Core proteins	18 (2.7)	8 (11.1)	11 (3.5)	15 (3.6)	16 (3.2)	10 (4.5)
Core and envelope proteins	8 (1.2)	1 (1.4)	6 (1.9)	3 (0.7)	7 (1.4)	2 (0.8)

*Results not available for nine women.

†Results not available for five women.

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TO THE EDITOR, *Genitourinary Medicine*

Persistence of high risk activity in homosexual men

Sir,
 Reports from the United States of America indicate that nearly half the homosexual men living in areas of low prevalence for human immunodeficiency virus (HIV) infection persistently engaged in high risk activity.^{1,2}

During January 1985 to July 1987 196 homosexual men (excluding bisexual men) presented to the department of genitourinary medicine in Sheffield and were counselled before being screened for antibody to HIV. Of those presenting, 19 (10%) were found to be HIV seropositive, 22 (11%) had gonorrhoea, and three (2%) had infectious syphilis.

Of the 177 men who were initially HIV antibody negative, 84 (mean (SD) age 26 (7) years) subsequently reattended (32 at 6-12 months, 29 at 13-18 months, 10 at 19-24

months, and 13 after more than 25 months; mean time from initial testing to reattendance was 12 months). The table shows that no significant difference in the incidence of gonorrhoea was seen at their second visits. Only one man who had presented initially with gonorrhoea subsequently attended with the same condition. Of the 84 men, 79 (94%) were tested again for antibody to HIV, and three of them were found to be HIV seropositive. The numbers with a regular sexual partner, casual partners, or both regular and casual partners had not changed appreciably since their initial attendance. At reattendance significantly more homosexual men were engaged in safe sex practices with casual partners ($\chi^2 = 12.8$, $p < 0.01$), al-

Table Results of tests for 84 homosexual men at initial and subsequent attendances and types of sexual partners and safe sex practices undertaken during three months before each visit (figures are numbers (percentages of those in category) of men)

	Initial attendance (n = 84)	Re-attendance (n = 84)
With gonorrhoea	5 (6.0)	6 (7)
Tested for HIV antibody	84 (100)	79 (94)
Seropositive for HIV	0	3 (4)
Types of sexual partners:		
Regular only	27 (32)	30 (36)
Regular and casual	15 (18)	17 (20)
Casual only	42 (50)	31 (37)
None	0	6 (7)
Activities with regular partners:	(n = 42)	(n = 47)
No penetrative sex	6 (14)	9 (19)
Condoms used	1 (2)	7 (15)
No safe sex practised	35 (83)	31 (66)
Activities with casual partners:	(n = 57)	(n = 48)
No penetrative sex	8 (14)	10 (21)
Condoms used	0	13 (27)
No safe sex practised	49 (86)*	25 (52)*

HIV = human immunodeficiency virus.

* $p < 0.01$.

though there was no significant difference in sexual practices with regular partners.

In this group of men there was a change towards fewer casual partners and safer sexual practices, which reflects the effect of counselling in the clinic. We also confirm results from the United States regarding the persistence of high risk sexual activity in homosexual men, which implies the need to reinforce health education in this group of men.

Yours faithfully,

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TO THE EDITOR, *Genitourinary Medicine*

Markers of sexually transmitted diseases in prostitutes in central Tunisia

Sir,
 Lack of accurate data on sexually transmitted diseases (STD) in the general population or in high risk groups is a major problem, and the spread of STD in north Africa is inevitable with the development of tourism.

Prostitutes are important in the spread of STD. As more attention is again being directed towards this group because of the advent and spread of human immunodeficiency virus (HIV) infection, we undertook a study on markers of STD (including HIV) in 42 female prostitutes. For comparison, a group of 342 male and female university students were used. The study period was the first trimester of 1987. Serological tests performed included: two enzyme linked immunosorbent assays (ELISAs) (Elavia 1 and Wellcome) for HIV; the microimmunofluorescence (MIF) test (Biosys) at a titre of more than 1/16 for *Chlamydia trachomatis*; enzyme immunoassays (EIAs) (Abbott) for hepatitis B surface antigen (HBsAg); and antibodies to HBsAg and hepatitis core antigen (HBcAg); and the Venereal Disease Research Laboratory (VDRL) test and the *Treponema*

Correspondence

Table Incidence of serological STD markers in prostitutes and students in Tunisia

	Prostitutes (n = 42)	Students (n = 342)
HIV	0	0
Hepatitis B:*		
HBsAg	2	8
Any marker	23	41
<i>Chlamydia trachomatis</i>	31	41
Syphilis:*		
VDRL/TPHA	12	Not tested
TPHA	16	Not tested

*Only 33 prostitutes tested.

pallidum haemagglutination assay (TPHA) for syphilis.

The table summarises the incidence of HIV and the other STD markers for both

groups. No HIV antibodies were found in either the prostitute or the student population. In 1986 prostitutes in Tunis were also found negative for HIV infection.¹ The incidence of hepatitis B and infection with *Chlamydia trachomatis* was high in the prostitutes, and serological markers for syphilis were found in nearly half of them. This figure compares with an incidence of 0.8% TPHA positivity in women attending prenatal clinics in the same area.²

Our study confirms that prostitutes represent an important high risk group for the acquisition and transmission of STD. As yet, they are not a reservoir for HIV infection in central Tunisia. The incidence of HIV infection is also low in non-drug addicted prostitutes in Europe. In Paris, 5/134 (3.7%) prostitutes were HIV positive in early 1987, but three of them were intravenous drug addicts (Catalan and Aim, unpublished data).

Yours faithfully,
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