tion sheet. He had taken "apply the solution to each wart in turn using the same applicator" and "On each occasion the maximum number of loops applied should not be in excess of 50" to mean "apply up to 50 loops to each wart!" Gross over application to a small number of prepucial warts resulted in marked sub prepuical burns. This reaction prompted him to seek help at our department. Screening for other sexually transmitted disease was negative. He was given hygiene advice and cotrimoxazole 960 mg bd for one week and on review normal anatomy had been restored and his warts had resolved.

Effective treatment of viral warts with any modality be it surgical, chemical, or thermal will result in some degree of normal tissue damage. Local self treatment with podophyllotoxin 0·5% has been advocated to alleviate pressure on clinic and medical time. Purified podophyllotoxin 0·5% in recommended doses is felt to have minimal toxicity compared with that of unpurified podophyllin resin. Local reaction (mostly mild or moderate) with inflammation, erosion, burning and pain can occur in up to 64% of patients.[1] Our first patient required hospital admission for an erroneous diagnosis. The second developed problems due to misinterpretation of the product information. The moderate severity of his burns, however, confirms the underlying lack of serious side effects even in relative local overdosage.

All patients prescribed home therapy should have the procedure explained clearly and demonstrated before ending the consultation. Left to the patient, errors of application may occur both in amount and duration of treatment. Podophyllotoxin is as safe and effective a method of treatment of male genital warts as other modalities, but it is not without side effects.

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1 Beutner KR, Conant MA, Friedman-Kien AE, *et al.* Patient applied Podofilox treatment of genital warts. *Lancet* 1989;i:831–4.

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MATTERS ARISING

Sexual assault of men: a series

We read with interest the recent paper by Hillman *et al.*[1] This prompted us to review our own experience. Eight men, alleging recent sexual assault, presented to our department within the last three years. The victims ranged in age from 10 to 25 years (mean 16 years). Six of eight patients attended within three months of the assault (range two days to 18 months).

Referrals were arranged by general practitioners (GPs) in two cases, Accident and Emergency departments in two cases and a social worker in one case. Four of the eight assaults were reported to the police.

The assailant was known to two of the victims. One case involved multiple assailants. HIV/AIDS anxiety was a prominent symptom in three patients. Oral and/or anal penetration took place during seven of the eight assaults. Sexual orientation was unknown for six victims and in five of these the assault was their first sexual experience. One patient considered himself to be heterosexual. One man had been exclusively heterosexual prior to the assault, but had had a number of both male and female partners thereafter. Voluntary intercourse had occurred in two patients after the rape and before presentation. Alcohol was reported to be a factor in only one assault.

Three patients had a sexually transmitted infection. These were scabies, rectal chlamydia and rectal gonorrhoea. The patient with rectal gonorrhoea was seen 18 months after the incident and had had a number of partners in the intervening period. All patients were investigated according to standard guidelines.[2] Three patients attended only once. For the other five, average follow-up time was three months. HIV and hepatitis B serological testing were negative in five patients at three months from the time of the assault.

One case is particularly worthy of mention as it involves an infection not heretofore reported in the context of male sexual assault. A 15 year old boy was referred to us by his GP complaining of a four week history of anal soreness. He had run away from home 3 months earlier. He had stayed with a man whom he stated was homosexual, who forced him to have anal intercourse four times against his will, the last occasion being ten days prior to presentation. No condoms were used on any occasion. He had no prior sexual experience. There was no history of intercurrent antibiotic therapy. The boy was mildly withdrawn and very anxious about AIDS. On examination, he was found to have perianal erythema, anal dilatation and two small ulcers at the anal margin. He declined proctoscopy. *Chlamydia trachomatis* was isolated from a blind rectal swab. Rectal cultures for *Neisseria gonorrhoeae* and herpes simplex virus were negative. Gonococcal and chlamydial cultures from the urethra and pharynx were negative. Serological testing for syphilis and hepatitis B were negative at presentation and at three months follow-up. An HIV test was performed at three months following informed consent, the result being negative. The chlamydial infection was treated with oral doxycycline 200 mg daily for one week and subsequent cultures were negative. Counselling and support were provided by health advisors within the department.

We agree with Hillman *et al*[1] that cases of male sexual assault are underreported. More data are required, enabling us to counsel our patients about the risk of acquiring STD, including HIV, following sexual assault.

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1 Hillman RJ, Tomlinson D, McMillan A, French PD, Harris JRW. Sexual assault of men: a series. *Genitourin Med* 1990;**66**:247–50.
2 Schwarz SK, Whittington WL. Sexual assault and sexually transmitted diseases: Detection and management in adults and children. *Rev Inf Dis* 1990;**12:Suppl 6**:S682–90.

Value of performing biopsies in genitourinary clinics

We fully agree with the views expressed by Arumanayagam and

Sumathipala[1] on the value of performing biopsies in genitourinary clinics.

We would like to share our experience at the Melbourne STD Centre. During the period August 1988 to October 1990, 53 biopsies were performed. The main indication for biopsy was atypical wart-like lesions. Of 27 such lesions biopsied 15 were confirmed as human papilloma virus infection, five were reported as seborrhoeic keratosis, four were bowenoid papulosis, one scar tissue, one skin tag and one compound naevus. Although five of these patients were regular sexual partners of women with cervical intraepithelial neoplasia no cases of penile intraepithelial neoplasia were identified. More recently we have started doing HPV typing on these samples. Of three cases tested one was positive for HPV type 16/18, the other two were negative. Many patients with atypical lesions are very keen to know whether or not they have a virus which may put their sexual partners at the risk of developing cervical neoplasia. We were very happy to be able to reassure at least eight patients that they had no evidence of human papilloma virus infection and in four others with bowenoid papulosis we were able to plan more definitive therapy and ensure careful follow up.

We had nine cases of Lichen sclerosus et atrophicus. Of these five had significant phimosis and were referred for circumcision. Two had severe ulceration which healed with conservative treatment.

There were three cases each of dermatitis and psoriasis, and two cases each of lichen planus and circinate balanitis. Both the pigmented lesions biopsied were reported as benign lentigo. The diagnosis was erythroplasia of Queyrat in one case and non specific changes were seen in four cases.

We have found biopsy to be a very useful and safe diagnostic tool in the venereologist's armoury.

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1 Arumanayagam JT, Sumathipala AHT. Value of performing biopsies in genitourinary clinics. *Genitourin Med* 1990;**66**:407.

BOOK REVIEWS

The Medical Management of AIDS. Edited by MA Sande and PA Volberding. Philadelphia, Saunders (Pp 436; Price £30) 1990.

This book provides a great deal more than the title suggests. The contents are neither confined to AIDS nor to its medical management, with chapters on topics such as strategies for preventing HIV transmission, host immunological responses to HIV, and risks of occupational transmission comprising some of the best written reviews. Even the chapters on specific AIDS conditions include considerable background details of epidemiology, microbiology and the natural history of these diseases.

Although 41 authors contributed to this work, the style remains clear and well organised throughout. There is some inevitable repetition of some basic points, such as the discovery of HIV and the role of cells bearing CD4 receptors in the pathogenesis of infection. However, these are minor irritants in a generally well-written and eminently readable text on which the editors are to be congratulated.

Several features do serve as drawbacks to this book. Firstly, the overwhelming use of North American references with the exclusion of much (sometimes conflicting) work from elsewhere. Furthermore, transatlantic differences in the use of certain therapies (eg Foscarnet in CMV disease) are not acknowledged or discussed. Secondly, despite the preface note that the book had been published within only 6 months, the pace of change has resulted in a few obvious deficiencies, such as the role of steroids in the treatment of PCP. The solitary page of unremarkable colour illustrations at the front of the book could have been dispensed with to reduce the cost of the book without any effect on its quality.

Overall, this book provides a clear overview of the entire subject of HIV infection and AIDS which should appeal to a wide readership of all those wishing to update and close gaps in their knowledge of these conditions. The numerous algorithms proposed for the investigation and therapy of early HIV disease, various clinical presentations and individual opportunistic infections are of particular interest and should stimulate thought and debate amongst all physicians involved in the care of patients with HIV infection and AIDS.

SIMON BARTON

Promoting Safer Sex. Edited by Maria Paalman (Pp 252; Price Dgl52.50). Amsterdam: Swets and Zeitlinger, 1990. ISBN 90-265-1012-0.

This is a book which should, at least in parts, interest all doctors and other health professionals in the field of sexually transmitted diseases. We all have the responsibility of trying to prevent the sexual transmission of HIV and other STDs. As such, we require some grounding in the arts of health promotion. This book, subtitled *Prevention of Sexual Transmission of AIDS and Other STD*, helps to provide this grounding. Anyone who is sufficiently interested to pick up the book will almost certainly find much that is already familiar, but also find other sections illuminating.

Maria Paalman has drawn together twelve formal presentations and summaries of twelve workshops from the First International Workshop on the prevention of STD and AIDS, held in The Netherlands in May 1989. (The Second International Workshop is being held in Cambridge in March 1991). Among the presenters were Jonathan Mann, Andre Meheus and Peter Piot. Topics covered in the presentations include "Screening and Case Finding in the Prevention and Control of STD's and HIV Infection", "The Role of Contact Tracing in Prevention", and "The Role of Community-based Organisations in AIDS and STD Prevention".

I was particularly interested in the presentation "Fear and Humour in Prevention Campaigns". The use of fear as a motivator for changing behaviour has apparently been seriously studied for the last 40 years.