Table 1 Comparison of STI prevalences

	Street sex workers (n=102)	Brothel sex workers (n=1664)	p Value*
Chlamydia trachomatis	7 (6.86%)	44 (2.64%)	0.001
95% CI	2.8 to 13.6	1.92 to 3.53	
Neisseria gonorrhoeae	1 (0.98%)	12 (0.72%)	0.76
95% CI	0.031 to 5.34	0.37 to 1.25	
Trichomonas vaginalis	7 (6.86%)	4 (0.24%)	<0.001
95% CI	2.8 to 13.6	0.067 to 0.62	

*Prevalence for the difference in the proportion of street sex workers and brothel sex workers with each infection.

Will the legalisation of street sex work improve health?

The legalisation and regulation of street sex work in Victoria, Australia, is likely to improve the health of street sex workers and their clients.

In Victoria, street sex work is illegal. In comparison, brothel and escort agency sex work is legal, and these individuals are required by law to have monthly certification of STI screening. Any incident infections are detected early and treated so that the prevalence of STIs is low.[1] There is no such requirement for street sex workers, who have infrequent STI screens and high rates of STIs.[1]

Following an acceptability and feasibility study,[1] funding was secured for the Inner South Community Health Service Youth Health Bus to offer STI screening using self administered samples to street sex workers. Female workers provided a tampon sample and male and transsexual workers a first passed urine sample. These samples were then tested by polymerase chain reaction (PCR) for *Chlamydia trachomatis, Neisseria gonorrhoeae*, and *Trichomonas vaginalis*.[2] The Youth Health Bus provides support and condoms to street sex workers several evenings a week in St Kilda, Melbourne's street sex worker precinct. They have been offering self collected samples for testing since mid-1999.

Over a 2 year period 102 samples were collected yielding 15 positive results (14.7%, 95% CI: 7.8% to 21.6%). This group included 81 females, 20 males, and one transsexual individual, with a mean age of 24 years (range 16–43). *C trachomatis* was identified in seven sex workers, *T vaginalis* in seven, and *N gonorrhoeae* in one. These high prevalences of STIs are compared with the low prevalences in brothel sex workers attending Melbourne Sexual Health Centre in the corresponding time (table 1 above). These street sex workers were also not having regular STI screens, with only eight (7.9%) of the 102 individuals reporting an STI screen in the preceding month, and 12 (11.8%) who had never had one.

The legalisation of street sex work would allow it to be regulated and hence make regular STI screening a legal requirement. Recently, a 2 year trial of designated areas for street sex work in Melbourne has been recommended.[3] These recommendations would protect the health of street sex workers and their clients, in addition to the targeted intervention described here. Further research is needed into the best health promotion model for street sex workers.

Contributors

AM and CF, design, analysis, and writing of paper; ST and SG, laboratory analysis and interpretation; PL and PR, design and collection of specimens.

A N Morton
Melbourne Sexual Health Centre, 580 Swanston Street, Carlton, Victoria, 3053, Australia

S N Tabrizi
Molecular Microbiology Laboratory, Royal Women's Hospital, 132 Grattan Street, Carlton, Victoria, 3053, Australia

S M Garland
Royal Women's and Royal Children's Hospitals, 132 Grattan Street, Carlton, Victoria, 3053, Australia

P J Lee
Inner South Community Health Service, 18 Mitford Street, St Kilda, Victoria, 3184, Australia

P E Reid
Inner South Community Health Service, 18 Mitford Street, St Kilda, Victoria, 3184, Australia

C K Fairley
University of Melbourne and Director of Melbourne Sexual Health Centre, 580 Swanston Street, Carlton, Victoria, 3053, Australia

Correspondence to: Anna Morton, Melbourne Sexual Health Centre, 580 Swanston Street, Carlton, Victoria, 3053, Australia; amorton@mshc.org.au

References

1 **Morton AN**, Wakefield T, Tabrizi SN, *et al*. An outreach programme for sexually transmitted infection screening in street sex workers using self-administered samples. *Int J STD AIDS* 1999;**10**:741–3.
2 **Tabrizi SN**, Paterson B, Fairley CK, *et al*. A self-administered technique for the detection of sexually transmitted diseases in remote communities. *J Infect Dis* 1997;**176**:289–92.
3 **Attorney-General's Street Prostitution Advisory Group Interim Report**. September 2001.

Accepted for publication 5 April 2002

Adult and paediatric contact immunotherapy with squaric acid dibutylester (SADBE) for recurrent, multiple, resistant, mucocutaneous anogenital warts

Treatment of recurrent anogenital warts is often troublesome, because, among the various treatment modalities currently available, few are uniformly effective or virucidal.[1] Currently, topical immunotherapy with squaric acid dibutylester (SADBE) represents an effective treatment in the management of multiple plantar and common warts (table 1 below).[2–5] In the genital area the use of SADBE has some limitations, as it may be associated with a significant degree of irritation that produces considerable discomfort to the patient. Based on studies showing excellent results (87% of patients with complete resolution) achieved by some authors in treating condylomata acuminata of the endocervix with applications of dinitrochlorobenzene (DNCB), a substance similar to SADBE, utilising remote anatomical site applications to the skin of the arm,[6] and our personal observation of spontaneous regression for untreated warts during contact immunotherapy with SADBE for alopecia areata,[5] we decided to compare the results

Table 1 Treatment of anogenital warts with SADBE: patient data

Patient No	Sex	Age (years)	Time of onset	Previous treatments	Site of warts	Clinical features	Area of application of SADBE	Number of applications
1	F	6	12 years	Multiple DTC	Perianal area	8 keratotic and flat-topped papules	dorsum of left hand	32
2	F	15	2 years	Multiple DTC	Perianal area	5 flat-topped papules	dorsum of left hand	38
3	M	20	10 months	Multiple DTC	Shaft	10 dome-shaped papules	shaft	36
4	M	24	17 months	Podophyllin resin Multiple DTC	Shaft	15 dome-shaped papules	shaft	34
5	F	25	6 months	Imiquimod 5% cream	Labia majora and minora, up to the vaginal introitus	2 warty plaques	pubic area	17
6	M	28	3 years	Podophyllin resin Multiple DTC	Coronal sulcus	1 warty plaque surrounding the coronal sulcus	pubic area	39
7	M	28	18 months	Podophyllin resin Multiple DTC	Shaft	12 dome-shaped papuls	shaft	–
8	M	29	9 months	Podophyllin resin Multiple DTC Surgical excision	Coronal sulcus	1 warty plaque surrounding the coronal sulcus	pubic area	37
9	M	70	16 months	Multiple DTC	Shaft	20 flat-topped, dome-shaped papules	shaft	32