



Figure 1 Ulceration around the introitus. A urinary catheter was in place.

stop using imiquimod and asked to return in 1 week for review. The patient failed to attend her follow up appointment and continued to use imiquimod as originally prescribed. The warts had begun to resolve and this led her to persevere with treatment despite growing discomfort. Approximately 3 weeks after her final GUM clinic appointment, she developed peri-introital ulceration, superficial dysuria, and urinary retention as described above.

When we reviewed the patient at the time of her admission, we confirmed the finding of painful ulceration around the introitus. A urinary catheter was in place (fig 1). A swab was taken from the ulcerated area and sent for viral culture. A course of valaciclovir was prescribed. Viral culture proved negative and a diagnosis of severe ulceration secondary to application of imiquimod cream was made. The catheter was removed after 48 hours.

Application of imiquimod cream is known to produce local erythema, oedema, and ulceration and the risk of these unwanted effects may increase at higher than recommended doses.¹ A case of phimosis requiring circumcision has been reported in an HIV positive man who received imiquimod cream.² We believe this is the first reported case of genital ulceration requiring urinary catheterisation in a female using imiquimod. Although our patient adhered to the normal treatment schedule, she continued to use the cream against medical advice. Patients are understandably anxious to be rid of their genital warts, but physicians should advise them of the potentially harmful effects of continuing to apply imiquimod cream when severe skin discomfort occurs.

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doi: 10.1136/sti.2004.009811

Accepted for publication 10 March 2004

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Knowledge of post exposure prophylaxis (PEP) for HIV among general practitioners in northern Sydney

Post exposure prophylaxis (PEP) for HIV infection has been shown to significantly reduce the transmission of HIV in both occupational exposures and vertical transmission; however, its role in non-occupational sexual exposures has been harder to define.^{1,2} In 1988 the New South Wales (NSW) health department released guidelines for PEP use in non-occupational exposures, including sexual exposures, based on recommendations from the Centre for Disease Control and Prevention.^{3,4} Eligibility depends upon risk, time since exposure and negotiated risk versus benefit.^{3,4}

In Sydney, campaigns raising awareness of PEP have focused on the gay community, impacting upon inner city GPs with higher numbers of HIV positive clients. Little is known about the experience or knowledge of HIV PEP among GPs who do not practise in areas of higher HIV prevalence and have lower or no HIV case loads. GP studies have shown that limited HIV experience and training may affect the ability to effectively assess, advise, and treat patients.^{5,6}

We focused on GPs in northern Sydney, an area that comprises approximately 12% of the NSW population. From March to July 2002 a questionnaire was submitted to GPs from the northern suburbs of Sydney via mailout and also distributed at regular GP education meetings. We collected demographic information and GPs were asked what they knew about the availability of HIV PEP, its uses, prescribing time restrictions, and access.

We received 202 GP responses in total: 162 from education sessions, a 68.6% response rate, and 40 responses from the mailout questionnaire, a 6.2% response rate. Most respondents were female (114/202, 56.2%). Women were generally younger (median age: 46 years, range: 28-71 years) and were more likely to work part time (67/114, 58.7%) compared to their male counterparts (median age 54 years, range 27-86 years. Full time work: 65/85, 81.3%).

While 68.5% (139/202) of those surveyed were aware of the availability of HIV PEP for high risk occupational exposures, only half of those (69/139), or 35.1% of all doctors (71/202; $p < 0.0001$) were aware of the availability of HIV PEP for sexual exposures. Of all surveyed, 24.6% (50/202) were aware of the 72 hour time restrictions with 28.1% (56/202) offering explanations of how to access HIV PEP. Of doctors aware of the availability of HIV PEP for sexual exposures, 42.3% (30/71; $p < 0.0001$) were aware of time restrictions with 46.5% (33/71; $p < 0.0001$) offering explanations of access.

Low levels of awareness and knowledge of HIV PEP may translate to missed opportunities for access to PEP, and potential HIV infection. Limited knowledge may reflect the recent introduction of PEP into Australia and/or unfamiliarity with HIV infection and patients. Limitations of this study include the small sample of self selected doctors who, it may be argued, were more motivated learners, or more interested in HIV PEP. Education aimed at increasing GP awareness of basic HIV PEP principles may be beneficial for those in low HIV caseload areas for patients missed by campaigns targeted at high risk communities.

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doi: 10.1136/sti.2004.009977

Accepted for publication 11 March 2004

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A notice of "redundant publication"

A notice of "redundant publication" appeared in the August issue of *Sexually Transmitted Infections* (2004;80:254). In their reply Dr Underhill and her co-authors suggested that they submitted the duplicate paper to the *Journal of Family Planning and Reproductive Health Care* after discussion with me. While I clearly cannot recall the exact content of our conversation, I would like to stress that it would have been most improper, and therefore highly unlikely, for me, as editor of *Sexually Transmitted Infections*, to suggest that they submit a duplicate publication to another journal. I would, therefore, like to correct any erroneous impression that might have been suggested to the reader.

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doi: 10.1136/sti.2004.013060

Accepted for publication 21 August 2004

HIV in black Caribbeans

We read with interest the paper by Dougan *et al*¹ regarding the epidemiology of HIV infection in black Caribbean adults in England, Wales, and Northern Ireland.

In our clinic setting, a district general hospital in north west London with a large black population (fig 1), diagnosis of HIV in