MATTERS ARISING

Sexually transmitted diseases in rape victims

I was interested to read of the experience of S Estreich *et al*[1] in the screening for STDs in women who have been raped. However, I was very concerned at the suggestion of using the findings of such screening tests as medicolegal evidence.

Jenny *et al*[2] have found that pre-existing STD was common (43%) amongst women alleging rape (although their assumption that infection diagnosed within 72 hours of rape indicated pre-existing infection is contentious). At the St Mary's Sexual Assault Referral Centre in Manchester it was found that sexual activity in the 3 months prior to rape was the highest risk indicator for a STD detected following rape.[3] Only in exceptional circumstances can the acquisition of a STD be attributed to rape with the certainty required to be considered as evidence. At the St Mary's centre, where both forensic and genitourinary screening tests are carried out, I have decided against using the results of STD screening as evidence, as, given the high rate of pre-existing infection in rape victims the presentation of these results in court is more likely to discredit the witness than support her case.

If the inclusion of STD screening in support of a victim's case becomes commonplace then counsel for the defence could routinely request the judge to overrule the 1974 venereal disease regulations act. This can only be to the detriment of all women who seek the reassurance of screening following rape.

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1 Estreich S, Forster GE, Robinson A. Sexually transmitted diseases in rape victims. *Genitourin Med* 1990;**66**: 433–8.
2 Jenny C, Hooton TM, Bowers A, *et al*. Sexually transmitted diseases in victims of rape. *N Engl J Med* 1990; **322**:713–6.
3 Lacey H. STD and rape. The experience of a sexual assualt centre. *Int J STD & AIDS* 1990;1:405–9.

Preventing neonatal herpes?

The recent editorial on preventing neonatal herpes[1] highlights the lack of consensus in the United Kingdom over the management of women with genital herpes during pregnancy. The suggestion of acyclovir suppression for pregnant women at risk of recurrent genital HSV in the last few weeks of pregnancy failed to address the issue of asymptomatic viral shedding whilst on suppressive doses of acyclovir.[2] The infectivity of the virus shed whilst on such doses is not known. Because shedding does occur, albeit in a small proportion of those treated, acyclovir suppression cannot be used as a substitute for screening women at risk by viral culture from multiple genital sites during the last few weeks of pregnancy if we are to minimise the transmission to the neonate.

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1 Mercey DE, Mindel A. Preventing neonatal herpes? *Genitourin Med* 1991;67:1–2.
2 Bowman CA, Woolley PD, Herman S, Clarke J, Kinghorn GR. Asymptomatic herpes simplex virus shedding from the genital tract whilst on suppressive doses of oral acyclovir. *Int J STD & AIDS* 1990;1:174–7.

Mercey and Mindel reply:
Unfortunately, viral culture gives information which is at best one week old and for this reason has largely been abandoned. Acyclovir suppression during the last few weeks of pregnancy should be used only as part of randomized, blinded, carefully monitored trials.

BOOK REVIEWS

Atlas of Sexually Transmitted Diseases. Edited by SA Morse, AA Moreland, SE Thompson (Pp 292; £85). New York, London: Gower Medical Publishing, 1990. ISBN 0-397-44663-2.

This is a first-class atlas providing an easily accessible overview of the sexually transmitted diseases. The photographs are of good size and, although there is the very occasional out of focus shot, by and large the quality is excellent. A few of the pictures are not prime examples of the condition portrayed—I have seen better "pearly penile papules" and rather more representative Gram stains of bacterial vaginosis. However, this really is nit-picking. The layout of the text is "reader friendly"—it is unusual for text to make up more than half a page and there is liberal use of tables, which are relevant and well presented. The sections on epidemiology make sensible use of graphs and bar charts. Disease prevalences are restricted to the USA and the latest figures shown relate to 1987 or 1988. As one would expect from an atlas of this calibre, the chapter on non-venereal dermatoses is well presented and illustrated. A strong emphasis has been placed on pathology and laboratory diagnostic techniques which is particularly useful for the "pure" clinician; however, in some places this proves a little too detailed. For example, the section on bacterial vaginosis contains a lot of detail on *Gardnerella vaginalis* isolation and identification. Recommendations for therapy are not always in keeping with practice in the United Kingdom but then this is not the prime purpose of a book such as this. Bibliographies at the end of each chapter contain a short but well chosen list of references with journals featured up to 1988.

The authors have well succeeded in their attempt to "provide a comprehensive pictorial account of sexually transmitted diseases." The text inevitably lacks in detail and for those more advanced in their genitourinary medicine training there would be a need to consult one of the more