

in 73 provinces. For instance, at the central sexually transmitted diseases centre at Bangrak Hospital, Bangkok, there were separate clinics for female and male sex workers, with adequate laboratory facilities for all the diagnostic modalities for HIV and sexually transmitted diseases.

The number of people attending sexually transmitted diseases clinics fell from 1103813 in 1987 to 877146 in 1991, and the number with venereal diseases (defined as syphilis, gonorrhoea, chancroid, and lymphogranuloma venereum) fell from 410406 to 182024. The table shows the incidence of various diseases in 1987 and 1991.

Incidence of sexually transmitted diseases per 1000 population in Thailand, 1987 and 1991

	1987	1991
Syphilis	0.41	0.22
Gonorrhoea	4.36	1.64
Chancroid	0.85	0.22
Lymphogranuloma venereum	0.37	0.12
Non-gonococcal genital infection	1.7	1.01
Total	7.69	3.21

Genital ulcer disease is an important factor in the spread of HIV. In Thailand in 1991 the falling incidence of chancroid approached that of herpes genitalis for the first time, reaching 0.22/1000 compared with an incidence of herpes genitalis of 0.18/1000. In December 1991 the prevalence of HIV infection in different groups remained high: intravenous drug users 34%, brothel sex workers (local users) 22%, higher class (tourist) sex workers 5.5%, male patients of sexually transmitted diseases clinics 5.6%, pregnant women 0.67%, blood donors 0.8%.

Thailand is, as Fred Lenihan points out, making an enormous effort to combat these infections.² Recommendations have been made (Chavalit Mangkalaviraj, personal communication) that information given to travellers and epidemiological data should be exchanged internationally and that study tours for health staff in interested countries should be set up.

I thank Dr Anupong Chitwarakorn, Office for Communicable Disease Control, Bangkok, for supplying me with epidemiological information.

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- 1 Noone A, Macdonald N, Evans B, Heptonstall J. HIV transmission, travel, and Thailand. *BMJ* 1992;305:1431. (5 December.)
- 2 Lenihan F. Thailand tries again to tackle AIDS. *BMJ* 1992;305:1385. (5 December.)

EDITOR,—Ahilya Noone and colleagues point out the need for travellers to receive appropriate information on safer sexual behaviour.¹ A four week campaign, jointly organised by Greater Glasgow and Argyll and Clyde Health Boards, was run in the international departure lounge of Glasgow airport in July and August last year. During peak periods of departures of chartered aircraft to Mediterranean destinations a small team of sessional workers was in the lounge. Departing travellers were encouraged to complete a prize crossword on beermats, whose clues related to transmission of HIV and safer sex. On completion the crosswords were placed in a "treasure chest," part of a large and colourful photomontage prominently displayed in the lounge. A prize draw was held regularly, and winners were awarded specially designed T shirts. Participants were also offered free condoms and information about HIV and about health while abroad.

During the four weeks an estimated 66000 people passed through the lounge when the team was present. About 10500 crosswords were completed, almost all correctly. About 30% of

respondents were under 21, 36% were 21-30, and 34% over 30; 52% were female. Around 2500 T shirts were given out, and nearly 6000 people took condoms and information leaflets. The campaign provoked great interest and virtually no adverse comment. In a separate survey most respondents correctly understood the aim of the campaign and thought that it was appropriate in such a venue.

The positive reaction to the campaign suggests that airport departure lounges are ideal locations for conveying information about safer sex. There is a captive audience, most of whom can understand the relevance of the message, and many are prepared to participate as they await their flight.

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- 1 Noone A, Macdonald N, Evans B, Heptonstall J. HIV transmission, travel, and Thailand. *BMJ* 1992;305:1431. (5 December.)

National standard for entry into general practice

EDITOR,—The working party set up to make recommendations on a national standard of entry into general practice¹ seems to have been unaware of European Community directive 86/457/EEC. This is mostly concerned with current standards of training in general practice in the health services of member states. Article 11, however, states that suitable proposals should be brought forward by 1997 for appropriate training for every general medical practitioner in order to satisfy the specific requirements of general medical practice. Informal contact with officials in Brussels through diplomatic sources has indicated that this is intended to apply to all practitioners, in public or private practice, in any form of primary health care. In other words, vocational training in general practice will become the minimum standard for practice of any form of medicine other than specialist practice, or training for such. Therefore proposals to fail people in general practice training will, if the directive is implemented, be tantamount to striking people off the medical register, and the idea of a subprincipal grade may actually be illegal after 1997.

I am also concerned about the working party's proposals for other reasons. Firstly, it seems unreasonable, against nature, and misogynistic to suggest to a young woman that she will have to wait until her late 20s to complete her minimum training and then be able to start a family. Secondly, I find it impossible to accept that general practice is a specialty. Something that is general by definition cannot be a specialty. The alternative term of family practitioner is not acceptable either. I practise as a ship's doctor. I am certainly a general practitioner, but I am not a family practitioner. One problem with the Royal College of General Practitioners is that it seems to equate general practice exclusively with being an NHS general practitioner. There are other forms of general practice.

History indicates that general practice is not so demanding that unqualified people cannot pass themselves off as principals for many years and get away with it. I wonder how many years unqualified people could pass themselves off as consultant thoracic surgeons, for example, without detection. Pretending that general practice is something that it is not runs the risk of people remarking on the emperor's new suit of clothes. I would therefore ask for a sense of proportion over the future of general practice, along with some breadth of vision

and tolerance for alternative types of general practice. I do not want to have to found a Royal College of Ships' Surgeons to carry on practising my brand of general practice.

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- 1 Carney T. A national standard for entry into general practice. *BMJ* 1992;305:1449-50. (12 December.)

Risk stratification for open heart surgery

EDITOR,—If operative mortality is to be of any use as an indicator of quality in cardiac surgery a system of risk stratification must be in place. The purpose of our paper was simply to show that the Parsonnet system can be applied easily and effectively to cardiac surgical practice in Britain.¹ That we found a lower mortality than expected is not relevant to the paper's message. I wish to reassure Andrew Allan and Andrew T Forsyth² that our trial was indeed prospective.

David J Spiegelhalter suggests that the Parsonnet system overstates risk.³ Whether or not that is the case, the system remains an excellent method of stratifying patients into well defined risk groups. Kenneth M Taylor and Peter K H Walton mention other methods of risk stratification such as PANECAN (the pan-European cardiovascular network) and bayesian analysis.⁴ For such methods to gain widespread acceptability they must be comparable to the Parsonnet system in ease of implementation. I look forward to the day when a statistically perfect model is available for assessing the quality of cardiac surgical care. In the meantime, however, widespread implementation of the Parsonnet system would represent a great improvement in the audit of cardiac surgery over crude mortality figures.

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- 1 Nashef SAM, Carey F, Silcock M, Oommen PK, Levy R, Jones MT. Risk stratification for open heart surgery: trial of the Parsonnet system in a British hospital. *BMJ* 1992;305:1066-7. (31 October.)
- 2 Allan A, Forsyth AT. Risk stratification for open heart surgery. *BMJ* 1992;305:1500. (12 December.)
- 3 Spiegelhalter DJ. Risk stratification for open heart surgery. *BMJ* 1992;305:1500. (12 December.)
- 4 Taylor KM, Walton PKH. Risk stratification for open heart surgery. *BMJ* 1992;305:1500. (12 December.)

Laser treatment of port wine stains

EDITOR,—M J C Van Gemert and colleagues echo the opinion of most of those who use laser treatment for port wine stain malformations that pulsed tunable dye lasers with a wavelength of 577 or 585 nm are the best choice for treating children.¹ Their suggestion that pulsed dye laser treatment should be offered as first line treatment for port wine stain malformations whenever possible, however, is controversial with respect to adult patients and ignores the complex nature of these lesions and their treatment with lasers.

Although many port wine stains in adults can be effectively treated with a pulsed dye laser, this may not be the most effective treatment and a considerable proportion of lesions do not respond. Port wine stains are heterogeneous, and responses to different lasers vary considerably.

My experience suggests that many lesions that are macular and blanch on direct pressure respond more favourably to pulsed dye lasers than to alternatives such as copper vapour lasers,² although in many cases responses are similar. Lesions that do not blanch on pressure (which are often dark in