relationship dissatisfaction, poorer health, depression, drug use, and loneliness. Increased sexual incompatibility and marital problems in the sexualised societies might be expected as a result of reduced penile sensitivity, increased sexual dysfunction, PTSD, and low self-esteem among circumcised men. Increased antisocial behaviour may also be expected. Thus, we might expect to see higher levels of domestic violence, rape, child sexual abuse, suicide, and theft.22

Human rights

The fight against HIV-AIDS requires the careful protection of human rights. Among these human rights one finds the rights to security of the person and protection from degrading treatment. The unnecessary circumcision necessarily diminishes sexual sensation and function as described above and may constitute degrading treatment.

Through amputation of erogenous tissue, circumcision necessarily diminishes sexual sensation and function as described above and may constitute degrading treatment.

Law

Male circumcision is not unlawful, but valid consent must be obtained. This may be a problem in the case of circumcision performed on unconsenting minors, in the absence of any medical indication.

Atmosphere of a child have been heard in several nations.23 The cases agree that, in the absence of any medical indication, parents are not empowered to consent to the non-therapeutic, irreversible, surgical alteration of their child’s genitals. In the absence of a valid consent, a circumcision may constitute an assault.24

Conclusion

The value of male circumcision in preventing HIV infection remains unclear. Non-sterile circumcisions may increase the risk.

The proposal by Kebaabetswe and colleagues for the introduction of circumcision into Botswana is seriously flawed, and is irreproducible in failing to place the emphasis on a multidisciplinary approach to neonatal circumcision, and topical anesthesia for neonatal circumcision.

References

12. Ramos S, Huertas E, Isidro C, et al. Male circumcision: an illustrated textbook because it stands up in this multi-dimensional problem of the 1999 edition of Sexual Transmitted Diseases. Initially, the reader is struck by the clarity and the clinical photographs are generally of good quality, although a few require the eye of faith for interpretation. If the authors are aiming at the test book market, however, the success of the atlas will depend on more than its visual appeal. Clearly there are many aspects of our specialty that do not easily lend themselves to a pictorial format; history, political context, service provision, behavioural data come to

Atlas of Sexually Transmitted Diseases and AIDS


What is an atlas? My dictionary was of little help, referring only to the word in its geographical and mystical contexts. Medical atlases that come to mind are largely pictures of the common and the obscure, of varying quality, and accompanied by the minimum of text. Such books are useful when it comes to reassuring young men that pearly penile papules are common and of no clinical significance, and for showing students conditions which they are unlikely to see in real life; but otherwise they tend to sit on the bookshelf after a rash purchase at a medical conference.

The new addition of Morse, Ballard, Holmes and Moreland’s atlas is hardly in this category. Perhaps it might be better described as an illustrated textbook because the text is not an insignificant part of the whole. How then does it stand up in this context? To answer this question I compared it with the Iofuninary physician’s bible, the 1999 edition of Sexually Transmitted Diseases. Initially, the reader is struck by the clear layout and larger font size, certainly an advantage for the ageing clinician. The use of colour in charts and diagrams adds to the clarity and the clinical photographs are generally of good quality, although a few require the eye of faith for interpretation. If the authors are aiming at the test book market, however, the success of the atlas will depend on more than its visual appeal. Clearly there are many aspects of our specialty that do not easily lend themselves to a pictorial format; history, political context, service provision, behavioural data come to

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mind. These are missing. But a direct comparison of the treatment of a common condition, such as vaginal discharge, between the two books points up considerable differences. Whereas Sexually Transmitted Diseases tackles in admirable detail the microbiology, epidemiology, diagnosis, management, and complications of the various infections, I looked in vain in the atlas to find out whether sexual partners of women with bacterial vaginosis should be treated. There are however novel aspects of the atlas that should be applauded. I especially liked the opening chapter on genital and dermatological examination that brings together the normal and the abnormal in a particularly useful way, especially for physicians with a limited knowledge of dermatology.

Clearly, the general attractiveness of this atlas will ensure its place on the bookshelves of most specialist departments. As an introduction to the specialty, it fills an important niche and might be an ideal purchase for trainees. It is also a short book aimed at practitioners. It could be used as a resource for serious clinicians seeking further information. Those inclined to seek further information in detail might consult the more comprehensive textbooks such as the US travel health guide. It is also highly readable and easy to use. I have no hesitation in recommending this book for the general practitioner’s shelf and for the reference collection of the hospital library. In a book this compact the authors clearly did not intend to address comprehensively all the aspects raised, as indicated by the widespread referral to reviews and specialist books and use of up to date references for those inclined to seek further information. The length I think is more a strength than a weakness although it must have been difficult to decide what aspects of the disparate infections to include and what to leave out. However, perhaps because of the wider audience, when discussing certain pathologic states some information on, or illustrations of, normal state or function would have been helpful. For the same reason legends explaining some of the abbreviations used (for example, for recently defined cytokines and cellular molecules) would not have been remiss.

It is a brave person who sets upon the task of writing a medical textbook, not least because it is such hard work, but also because the accelerating pace of change in the biomedical sciences can make an author seem more like an historian. Even in this up to date book there is information that needs revision already, in view of recent changes (for example, p 158 Management of Pneumocystis jiroveci. Arch Intern Med 2001;161:1529–33) The authors have acknowledged this to some extent, by the use of “evolving” references in many instances (p 151 UNAIDS website; www.hivmap.org for HIV treatment).

Long term utility of this kind of book depends, among other things, on how well it is researched and written, but also crucially on the pace of further progress in the field and thus how often it needs revision. Progress is bound to continue in many areas of STI epidemiology and clinical practice. It would seem that web based books in a state of perpetual revision (for example, www.hopkins-aids.edu/publications/book/book_toc.html) may go some way to addressing the question of whether a book survives as a useful text.

This book may not be the last word on the subject of STIs but it is certainly a good place to start.

P E Munday

Clinical Practice in Sexually Transmitted Infections


This book, aimed at doctors in training in genitourinary medicine, is highly readable and manageably sized. It is unlikely to be read cover to cover but it is a resource for serious clinicians seeking further information. Those inclined to seek further information might consult the more comprehensive textbooks such as the US travel health guide. It is also highly readable and easy to use. I have no hesitation in recommending this book for the general practitioner’s shelf and for the reference collection of the hospital library. In a book this compact the authors clearly did not intend to address comprehensively all the aspects raised, as indicated by the widespread referral to reviews and specialist books and use of up to date references for those inclined to seek further information. The length I think is more a strength than a weakness although it must have been difficult to decide what aspects of the disparate infections to include and what to leave out. However, perhaps because of the wider audience, when discussing certain pathologic states some information on, or illustrations of, normal state or function would have been helpful. For the same reason legends explaining some of the abbreviations used (for example, for recently defined cytokines and cellular molecules) would not have been remiss.

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Sylvia Ojoo

CORRECTIONS

In the STI supplement 1 this year, 80th MSSVD Spring Meeting held jointly with the 19th STI Congress of IUSTI Europe, the following abstract was omitted from the printed abstract book, with apologies to the authors.

Incidence and causes of peripheral eosinophilia in HIV-1 infected individuals attending a district general hospital

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Objectives: To determine the incidence of eosinophilia in a cohort of HIV-1 positive individuals and to compare the prevalence of positive parasite serology between African cases and controls.

Methods: Patients attending an inner city HIV clinic with peripheral eosinophilia (>0.5 x 10^7/l) on two or more occasions were identified as cases from a retrospective review of haematological records from October 1999 to August 2001. Controls (Africans without eosinophilia) were obtained from an ongoing prospective study. Demographic and clinical data were ascertained by case note review and patient questionnaire. Investigations for parasitic infections were undertaken (schistosomal, filarial, and strongyloides serology).

Results: 295 patients had haematological tests during the observation period, of which 67 (23%) had peripheral eosinophilia. 60/67 (90%) of the cases were of African origin, the mean nadir CD4 count was 195 and 25% were stage CDC C. Controls (n=159) were broadly similar. To date, 26/45 (58%) African cases had positive serological screens for parasites (23 schistosomal, 4 strongyloides, and 2 filarial infections), compared with 4–45 (9%) of controls (4 schistosomal infections) p<0.001, χ^2 test. There was no positive serology in 3/7 non-African cases screened.

Conclusions: Although previous studies have demonstrated a low incidence of parasitic infection in HIV-1 positive patients with eosinophilia, we have identified a high number of treatable parasitic causes. No case has been identified in 42%, suggesting that for a proportion of these HIV may be the cause. Despite this, routine screening for parasitic infection, guided by geographical exposure, is recommended in HIV-1 infected Africans with eosinophilia.

The following acknowledgement was omitted from the original article entitled Chlamydial infection: an accurate model for opportunistic screening in general practice, by Verhoeven, Avonts, Meheus et al (Sex Transm Infect 2003;79:313–317). We would like to thank Eddy Van Dyck and Hilde Smet from the Prince Leopold Institute of Tropical Medicine, Antwerp, for their help with setting up the diagnostic protocol and for performing confirmation tests, Joost Weyler of Antwerp University for his statistical advice, and all participating GPs in the field.

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