

NATIONAL COALITION OF GAY STD SERVICES

This Newsletter is published by the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS). Suggestions for articles on STDs in gay people, questions about the venereal diseases, literary contributions; and inquiries about membership in the Coalition [Associate/Corporate membership--\$250/year; Gay or Nongay Group Medical Practice--\$50/year; Gay or Nongay Individual Physician or Other Health Practitioner--\$25/year; Gay STD Service--\$20/year; Individual (not in other categories)--\$10/year; and Subscription Only--\$8/year] may be addressed to Mark P. Behar, Chairperson, NCGSTDS, P.O. Box 11532, Milwaukee, WI 53211. Please credit the NCGSTDS when reprinting items from the Newsletter.

Volume 3 #2

November, 1981

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NCGSTDS ANNUAL MEETING AT APHA IN LOS ANGELES, NOVEMBER 4th

The NCGSTDS's Annual Meeting is scheduled for Wednesday, November 4, 1981, 8:30-12 noon, at the Men's Linc--Gay & Lesbian Community Services Center, 1213 N. Highland Av., Los Angeles, CA 90038 (phone 213/464-7480 or 665-8943). Dr. Gene Washington, MD, of the CDC's VD Control Division will be attending to field questions. Among topics of discussion: importance of national networking; political & practical consequences to gay STD programs of national and municipal monetary cuts; status of the hepatitis B vaccine and Merck Sharp & Dohme's relationship to the NCGSTDS; the 4th National Gay & Lesbian Health Conference this spring in Houston and the possibility of STD workshops in conjunction with; discussion of the Guidelines & Recommendations for Healthful Gay Sexual Activity and the STD Roundtable later in the afternoon; election of Coalition Chairperson; and reports of activities from gay STD services, providers, and researchers, among other things. Tours of the Men's Clinic will follow the meeting, and refreshments will be served. Transportation to and from the meeting (from the downtown Biltmore Hotel (APHA Convention Headquarters) will be arranged at the Hospitality Suite of the Caucus of Gay Public Health Workers (GPHW) at the Biltmore. Additional information about the GPHW or the NCGSTDS will be available during the Convention either at the Convention Hall Exhibit Booth of the GPHW (booth #333) or at the Hospitality Suite.

GAY ACTIVITIES AT THE APHA--TENTATIVE SCHEDULE

Please consult the Official Schedule or the Gay Public Health Worker's Hospitality Suite at the Biltmore Hotel or their Exhibit Booth (#333) in the Convention Hall for last minute changes.

- Sunday, 11/1--Hospitality Suite Hours 6-8pm; Exhibit Booth #333 hours 12noon-5pm
 - 3-5pm GPHW Steering Committee Meeting
 - 7:30-9pm GPHW Hospitality Suite Open House with Wine & Cheese
- Monday, 11/2--Hospitality Suite Hours 12noon-6pm; Exhibit Booth hours 9am-4pm
 - 4-5:30pm Roundtable: "Gay People, Straight Health Care"
 - 6-7pm GPHW/Women's Caucus Joint Social Hour with cash bar
- Tuesday, 11/3--Hospitality Suite Hours 12noon-6pm; Exhibit Booth hours 9am-4pm
 - 8:30-10am "Alcoholism & Substance Abuse Among Gays"
 - 8:30-10am Workshop: "Effects of Physical Illness on the Lesbian Relationship"
 - 2-5pm "Homosexuality and the Health Care System"
- Wednesday, 11/4--Hospitality Suite Hours 12noon-6pm; Exhibit Booth Hours 9am-4pm
 - 8:30-12noon NCGSTDS Annual Meeting, followed by tour of the Men's Clinic (see above for details)
 - 2-4pm GPHW Annual Meeting & Elections
 - 4-5:30pm STD Roundtable (NCGSTDS co-sponsored with GPHW)
 - 6:30-10:30pm GPHW Annual Fundraising Dinner & Open Bar (\$30 per person, \$20 for students, low income). Acquire tickets from Ron Vachon or at the Exhibit Booth.
- Thursday, 11/5--Hospitality Suite & Exhibit Booth Closed
 - 9:30-11:30am GPHW Steering Committee Meeting

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FOLLOWUP ON KAPOSI'S SARCOMA AND PNEUMOCYSTIS CARINII PNEUMONIA IN GAY MEN

Enclosed with this issue of the Newsletter are reprints from the August 28, 1981 issue of the Morbidity and Mortality Weekly Report [MMWR is the official weekly publication of the Centers for Disease Control (CDC)] featuring a clinical update of Kaposi's sarcoma and Pneumocystis carinii pneumonia (KS and PCP). This particular issue of MMWR (volume 30:33) supplements previous reports published on June 5 and July 3, 1981 (volume 30:21 and 25). *****All health care providers working with the gay community are asked to direct clinical inquiries concerning KS, PCP, and other opportunistic diseases to Dr. James Curran, MD, MPH, Chief, Operations Research Branch, VD Control Division, Centers for Disease Control, Atlanta, GA 30333, or by calling him directly, at 404/329-3935. Dr. Curran currently coordinates the work-group and task force investigating these illnesses.

KS AND PCP CASE-CONTROL STUDY BEGINS: A REPORT

by Robert K. Bolan, MD

Kaposi's sarcoma (KS) is a rare type of skin cancer that has been occurring recently in previously healthy gay men. Pneumocystis carinii causes a rare type of pneumonia (PCP) usually only seen in individuals with severely impaired immunity but recently is occurring alone or in combination with KS in gay men.

To begin the systematic search for answers to the multitude of questions that have been raised about the occurrence of these diseases in gay men, a KS and PCP case-control study began October 1, 1981, the details of which were discussed among officials of the Centers for Disease Control, the National Cancer Institute, and a small group of practitioners from around the country at the National Institutes of Health in Washington, DC, September 15. Local public health departments, private physicians and university centers in New York, San Francisco, Los Angeles, and Atlanta are cooperating with the CDC in carrying out this thorough and complex study. Each known person with either KS, PCP, or both will be matched with five presumably healthy controls. The gay male controls have been selected from VD clinic clientele, from private gay medical practices, and from the KS/PCP patient's circle of nonsexual-partner friends; the heterosexual male control will be selected from a private medical practice setting.

As of October 7, 1981, there were 60 KS, 55 PCP, and 13 KS & PCP cases. Mortality rates have been 22% for KS and 65% for PCP with an overall 42% mortality rate. Of the known cases, 94% are gay or bisexual; 75% are white, 15% are black, 14% are Hispanic. Eighty percent are between 25-45 years of age with a median age of 35-36 years, and 80% of the cases have been reported from New York.

Cases and controls are being interviewed in person, using a standardized questionnaire and clinical specimens for laboratory investigation are being requested from cases and controls. Serologic testing will be done for cytomegalovirus (CMV), herpes simplex virus (HSV), Epstein-Barr virus (EBV), hepatitis A and B, Entamoeba histolytica, and Pneumocystis carinii; in addition, sera will be banked for possible future examination. Quantitative immunoglobulins and a complete blood count will be done on all cases. Histocompatibility antigen (HLA) typing and lymphocyte testing will be done on selected cases. CMV isolation will be attempted in all cases and controls. Selected specimens will be studied for lymphocyte culture, electron microscopy of white blood cells and urine for herpes virus particles, direct fluorescent antibody studies of WBCs for CMV and EBV, and restriction endonuclease analysis of CMV deoxyribonucleic acid (DNA).

Over the past several years a liaison has been building between members of the gay medical community and the CDC; this liaison has been formed through the efforts of individuals and through groups such as the National Coalition of Gay STD Services and the Bay Area Physicians for Human Rights. The mutual respect and trust that has gradually built up will ensure the careful, sensitive, and orderly investigation of these serious health problems in the gay population.

[Direct correspondence with Dr. Bolan may be addressed to: 2252 Fillmore St., San Francisco, CA 94115. His attendance at the above meeting, and this report, is gratefully acknowledged!]

VD CONTROL DIVISION ASKED TO MODIFY CASEFINDERS' PERFORMANCE STANDARDS

[The following letter originated from Rosemary Busterna, US Public Health Advisor in Seattle. Her concern is greatly appreciated and gratefully acknowledged! Dr. Wiesner is the director of the CDC's VD Control Division.]

Dear Dr. Wiesner:

I propose that an addition be made to the Center for Disease Control's nationalized venereal disease casefinders' performance standards. Job element number one of page nine reads: "Treat all patients and workers equally regardless of age, race, sex, background, religion, or handicap." Considering the great percentage of non-heterosexual patients and health workers who participate in our Venereal Disease Control Program, I urge that the term sexual orientation be added to this job element, as well. We cannot afford the supposition that perhaps non-heterosexual persons are included in the term "background," and will hopefully not be discriminated against. Neither is this consistent with the specific expectation communicated within the hiring process to Program Representatives/Public Health Advisors that equal and quality treatment be afforded to people of all sexual orientations. Please demonstrate through this nationally utilized worker performance standard, for our considerable non-heterosexual constituency and for all health employees, the Center's sensitivity and commitment to equally responsive health care for all.

Sincerely,
Rosemary Busterna

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GAY PHYSICIAN WANTED IN LOS ANGELES

Dr. Paul E. Keith, MD, Medical Director of the Men's Clinic--Gay & Lesbian Community Services Center, is seeking to employ a gay physician for approximately 20 hours per week with the possibility of association after a reasonable length of time, in his gay family practice at 6200 Wilshire Boulevard, Suite 1510, LA, CA 90048 (213/931-1463). Dr. Keith is a member of the NCGSTDS, Southern California Physicians for Human Rights (SCPHR) and the Bat Area Physicians for Human Rights (BAPHR). Inquiries are invited.

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NEWS FROM PHILADELPHIA

by Alice Messing, Director, Philadelphia Community Health Alternatives

Philadelphia Community Health Alternatives (PCHA) is the new name for "Lavender Health." The address is still PO Box 7259, Philadelphia, PA 19101. PCHA is a non-profit corporation established "to provide clinical services, education, client advocacy, training and research in the field of health to meet the special needs of sexual minorities." PCHA is now filing for federal IRS 501(c)(3) tax exempt status.

PCHA's Gay Men's Clinic offers screening and treatment for syphilis and gonorrhea every Friday night and Saturday afternoon. We plan to expand services as soon as possible to provide a full range of STD services and to provide screening in areas of mental and emotional health, substance abuse, and other health problems, with the ultimate goal of providing comprehensive health care to lesbians and gay males. In addition to clinic hours, PCHA screens for syphilis and gonorrhea at two bathhouses in Phillie.

PCHA received a grant from Merck, Sharp, and Dohme Pharmaceuticals, in exchange for providing 2 cc of blood from each patient for testing for hepatitis B antigen. Each time Merck identifies a sample with a high enough antigen titer for their production needs, they provide additional compensation. PCHA provides information about the existence of plasmapheresis centers in Philadelphia, and the compensation that can be acquired by donors and the Clinic. We have separate arrangements with the plasmapheresis centers ranging from

NEWS FROM PHILADELPHIA, Continued

a corporate donation to the PCHA to referral fees. At the end of the year, Merck and PCHA will evaluate the benefits of these arrangements. I hope that this proves to be profitable to all concerned--Merck, PCHA, and the plasma donor. More news about PCHA in a future Newsletter!

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GUIDELINES & RECOMMENDATIONS FOR HEALTHFUL SEXUAL ACTIVITY

As reported in the last issue of the Newsletter, Robert K. Bolan of San Francisco's Bay Area Physicians for Human Rights (BAPHR) recently published a modification of the Guidelines for distribution at that city's Gay Pride Day Celebration, and to patients and fellow BAPHR members. A photocopy of the brochure is reproduced (slightly corrected & modified from the brochure published in the last Newsletter) at the end of this issue. Reprints are available at cost: \$135.75--1000 copies, \$78--500, \$59.50--250, and \$30.75--100, plus 6 1/2% California sales tax; folding (optional) costs 75¢ per 100. Please address inquiries or feedback to Dr. Robert Bolan, 667 Lakeview Av., San Francisco, CA 94112, or to the NCGSTDS, PO Box 11532, Milwaukee, WI 53211. Please let us know how your Service is helping to inform the gay community about these important Guidelines. Everyone is reminded that the Guidelines are copyrighted and that credit to the Coalition is required by law! Just a simple "© 1981 by the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS). Reprinted and/or modified with permission." will suffice! Thanks!

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NEW PUBLICATION BY BURROUGHS WELLCOME COMPANY

Sexually Transmitted Diseases Bulletin, a regular report of recent clinical developments in the field of STDs, recently began publishing for specialists and nonspecialists by Burroughs Wellcome Company. Requests for inclusion on the mailing list (which is free), should be directed to: Jerome Tovo, Ph.D., Editor, STD Bulletin, 15 Park Row, New York, NY 10038 (212/962-6575). Please mention the NCGSTDS in your request. Volume 1 Number 1 was dated June, 1981. Bimonthly distribution is expected.

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HELP FOR HERPES SUFFERERS

HELP, a program service of the American Social Health Association (ASHA) is targeted specifically to assist the millions of people with herpes simplex infections (HSV 2 is the genital herpes variety, HSV 1 is the cold sore variety, however both types may appear in either location). Membership provides THE HELPER, a quarterly journal that provides the most up-to-date medical, research, prevention, and other information about herpes; access to local support groups (California, Connecticut, District of Columbia, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Minnesota, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and Wisconsin); opportunities to participate in research and educational projects, among other things. For additional information, please contact: Carla F. Hines, HELP Program Director, ASHA, 260 Sheridan Av., Palo Alto, CA 94306. Mention that you heard about HELP from the NCGSTDS.

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US POSTAL SERVICE: 9 DIGIT ZIP IMPLEMENTATION DELAYED & POSTAL RATE INCREASE

The US Postal Service is delaying the implementation of the 9 digit zip code until the Fall, 1983. The NCGSTDS will no longer use its 9 digit zip (53211-0532)--53211 is sufficient and less confusing (entire address: POB 11532, Milwaukee, WI 53211). As of November 1, 1981, first class mail will cost 20¢/oz. This increase will obviously raise the cost of Coalition mailings, and as a consequence, membership dues may have to reflect these changes. *****

WALTER LEAR WRITES TO THE AMERICAN JOURNAL OF PUBLIC HEALTH (AJPH)

[The following letter was written to the American Journal of Public Health by Walter Lear, MD, Convenor, National Gay Health Coalition (NGHC) in response to articles written by William W. Darrow, et al. and H. Hunter Handsfield in the September, 1981 issue of the AJPH (Volume 71:9, pp. 989-90, and pp.1004-11): Editorial--STDs in Homosexual Men, by Handsfield, and The Gay Report on STDs, by Darrow, et al. (The NCGSTDS has reprinted both articles at the end of this Newsletter, for your review.) Incidentally, the NCGSTDS is an affiliate of the NGHC.]

The article by William W. Darrow and colleagues on STDs in gay men and the related editorial by H. Hunter Handsfield in the September issue of the AJPH are timely, useful and uncommon contributions to a scientific approach to this subject.

The relatively small body of published scientific material on the special health concerns of the ten to twenty percent of the population with homosexual and bisexual orientations reflects the minimal attention they receive from many practitioners and from most health service, education, and research organizations including governmental health agencies. Despite the substantial efforts of the Gay Caucus of the APHA [American Public Health Association; the Gay Caucus is also known as the Gay Public Health Workers (GPHW). --Editor] since 1975 and of other groups of gay nurses, physicians, psychologists and health professionals, the health status and health service needs of lesbians and gay men--in fact, their very existence--are frequently kept in the closet. They are considered too hot to handle for synergistic moral and political reasons incompatible with the traditional ethical perspective of the health field.

This then is the fundamental, most important health concern of lesbians and gay men: a humane, informed approach from health service providers. This concern is, of course, shared by all other minorities, women, and low income persons; they too have protested for many decades the wide prevalence of irrational prejudice, demeaning of individuals and service inequities.

Handsfield's first proposed goal for the 1980s: appropriate education of "practicing physicians," is a step in the right direction. However, the experience of gay health professionals indicates that education "to nonjudgementally inquire into alternative life styles" is of limited value in the absence of education about sexuality in general, and in fact, a theoretical understanding about sexuality in general is not too effective without personal acceptance of one's own sexuality.¹ Moreover, as is obvious, nurses, receptionists, administrators, etc. play such a major role in health care delivery that similar education should be available to them also; preferably this should be done as part of their basic professional training.

Handsfield's second proposed goal: improving the quality of medical care and his related negative comments about the "technical" quality of care provided by gay clinics are made within the typical academic frame of reference about quality: namely, assuming that the significant factors are certain of the inputs, especially the professional qualifications of the physicians and the immediate availability of high technology, ignoring or devaluing both process and outputs. Even within his narrow definition of quality, Handsfield's opinion may be gratuitous in the absence of specific quality studies. It certainly overlooks the facts that most of the nurses, physicians, physician assistants and other staff of gay STD clinics are young, well-trained and highly motivated and that these clinics generally take a "comprehensive" approach to STDs. In addition, the volume of gay STD seen at the gay clinics is quite large and their experiences across the country have been extensively shared at national conferences of the [National] Coalition of Gay STD Services and at the annual meetings of the APHA and the American Venereal Disease Association [AVDA].²

Lastly, Handsfield both writes off education and periodic screening of gay men as ineffective and asserts that "the only viable control measure" is good care of those with STDs. As there is little rigorous evidence for either statement, his logic completely escapes me.

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WALTER LEAR, Continued

Perhaps this is due to my public health bias which leads me to view primary and secondary prevention as the logical way to "control" an epidemic in contrast to good medical care as the proper response to a case of illness.

The [National] Coalition of Gay STD Services recently published "Guidelines and Recommendations for Healthful Sexual Activity."³ A number of years are needed before this is widely disseminated among sexually active gay men and understood by them, and before its several innovative and promising control measures are implemented. Regardless of the eventual conclusion about the degree of effectiveness of these Guidelines, as well as of early detection programs, they do prevent cases of STD "here and now." Immunizations, which Handsfield also dismisses because none are "on the immediate horizon," is a third basic method of prevention which with respect to STDs has historically been denied adequate resources for research and development because of strongly voiced moralistic views towards people with STDs.

Public health has a proud tradition of fighting for the health of people against ignorance, irrational prejudices and anachronistic mores in society at large and in the medical profession in particular. This kind of traditional commitment is now required to improve the health of sexual minorities. As with other major public health efforts, the benefits will in the long run accrue to all.

--Walter J. Lear, MD

Convenor, National Gay Health Coalition

Footnotes

¹"Professional Guidelines for Helping Mainstream Mental Health Services to be Responsive to the Needs of Gay People" by the Guidelines Task Force of the National Gay Health Coalition. Available from the National Association of Gay Alcoholism Professionals, POB 376, Oakland, NJ 07436, \$2.

²These comments should not be misinterpreted as my view that gay STD clinics are the answer to the need for good STD services for gay men. "Even in the large cities represented in this symposium, only a fraction of the gay men receive their health care from the gay sponsored programs. These separatist programs are essential today, but we fervently hope they will be an anachronism tomorrow." "Venereal Disease and Gay Men: Opening Remarks," by W.J. Lear, Sexually Transmitted Diseases, volume 4:2, p. 49, April-June, 1977.

³Available from the NCGSTDS, POB 11532, Milwaukee, WI 53211, \$1.

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NEWS FROM BOSTON'S FENWAY: COME CELEBRATE AN OLD FRIEND'S BIRTHDAY. . .

Fenway Community Health Center (FCHC) recently celebrated its tenth anniversary, distinguishing itself as a primary care program that integrates its nationally recognized commitment to Boston's gay and lesbian community along with a commitment to its local elderly and young adult population. A broad range of services is offered on site, including adult medicine and STDs, geriatrics, gynecology, pediatrics, psychiatry, podiatry, minor surgery, nutrition and clinical laboratory. FCHC operates several satellite clinics including one for the elderly, two at gay baths, and at other mobile screening sites. Over the past five years Fenway has grown an average of 22.3% per year, and now serves over 15,000 patients per year, with a full and part-time staff of 45. Fenway is a beehive of productive activity, according to staff physician Ken Mayer. "We have started a wide-ranging epidemiology project, assessing all facets of the STD diagnosis and treatment at the Fenway, now that we have two well qualified volunteers--a brilliant 'lesbian epidemiologist' from Yale, and a fantastic gay physician assistant, also from the New Haven, CT area. The chart review will take a while, but whenever we have any interesting data, we'll be in touch with the NCGSTDS!"

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NCGSTDS MEMBER SERVICES--OCTOBER, 1981

The following is a list of NCGSTDS member Services, as of October 20, 1981, alphabetized by state and city. Please keep the Coalition advised of address & telephone changes!

1. Gay Community Services VD Clinic of Tucson. POB 2809, Tucson, AZ 85702.
602/888-0638.
2. Berkeley Gay Men's Health Collective. 2339 Durant Av., Berkeley, CA 94704.
415/548-2570.
3. Men's Clinic--Gay & Lesbian Community Services Center. 1213 N. Highland Av., Los Angeles, CA 90038. 213/464-7480.
4. Whitman-Walker Gay Men's VD Clinic. 2335 18th Street, NW, Washington, DC 20009.
202/332-5295.
5. Howard Brown Memorial Clinic. 2676 N. Halsted Street, Chicago, IL 60614.
312/871-5777.
6. Physical Health Committee--Atlanta Gay Center. 931 Ponce de Leon, NE, Atlanta, GA 30324. 404/876-5372.
7. Fenway Community Health Center. 16 Haviland Street, Boston, MA 02115.
617/267-7573.
8. Gay Community Center of Baltimore VD Clinic. 2133 Maryland Av., Baltimore, MD 21218.
301/837-5446.
9. Gay VD Clinic of Ann Arbor. 207 Fletcher Av., Student Health Services Bldg., Ann Arbor, MI 48109. 313/763-4186.
10. Metro Detroit Gay VD Council. 681 Covington #D5, Detroit, MI 48203.
313/ 861-3969.
11. Gay Community Services, Inc. of Minneapolis. 2855 Park Avenue South, Minneapolis, MN 55407. 612/827-2821.
12. Gay Men's Health Project. 74 Grove Street, #2RW, New York, NY 10014.
212/691-6969.
13. St. Marks Gay Men's Health Center. 88 University Place, 9th Floor, New York, NY 10003.
212/691-8282.
14. Gay Community Health [formerly Robert Livingston Health Center]. c/o 506 W. 42nd Street, Apt. #E5, New York, NY 10036. 212/563-6313.
15. Philadelphia Community Health Alternatives [formerly Lavender Health]. POB 7259, Philadelphia, PA 19101. 215/642-6485.
16. Pittsburgh Free Clinic. 121 S. Highland Av., 2nd Floor, Pittsburgh, PA 15206.
412/661-6604.
17. The Montrose Clinic. 3317 Montrose, #1090, Houston, TX 77006.
713/522-7360.
18. Seattle Clinic for Venereal Health. 105 14th Av., Suite B, Seattle, WA 98122.
206/329-8390.
19. Blue Bus-Renaissance Gay VD Clinic. 913 Spring Street, Madison, WI 53714.
608/262-5889, -7330.
20. Gay Peoples Union/Farwell STD Clinic. POB 208, Milwaukee, WI 53201.
414/372-8932.

[The Next listing of member services will attempt to list hours of operation to help facilitate communication among staff. It will be published prior to the NCGSTDS's next meeting in Houston.]

NEXT ISSUE OF NEWSLETTER

The next issue of the Official Newsletter of the NCGSTDS is expected to be mailed in late December or early January, and will include a revised mailing list of all nonconfidential Coalition members and friends. Please mail contributions to the Coalition by December 5th!

IN MEMORIAL

Our condolences to the friends, colleagues, and loved ones of Richard Hannemann, who passed away June 15th, at the age of 33. Richard served on the Board of Directors of New York's St. Marks Clinic and was an important factor in its growth and development.

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LESBIAN & GAY PEOPLE IN MEDICINE/AMERICAN MEDICAL STUDENT ASSOCIATION

Lesbian and Gay People in Medicine (LGPIM), a task force of the American Medical Student Association (AMSA), was formed to improve the quality of health care delivered to gay patients and to improve conditions for gay medical students and physicians. As one of the few organizations addressing these needs, LGPIM has gained wide recognition for its highly successful programs, workshops, printed resources, and speakers' bureau. Since its founding in 1976, LGPIM's membership has increased dramatically, and it has been instrumental in the creation of numerous local gay health groups across the country.

LGPIM's current activities include sponsoring educational workshops on homosexuality and gay-related health needs for physicians' groups, student conferences, and health education institutions; disseminating research and preparing materials on gay health issues; and reviewing the admissions and hiring policies of the medical schools, hospitals, and residency programs as they relate to sexual orientation.

In addition to these efforts to educate and sensitize our predominantly heterosexual health care system to the needs of the approximately 10% of patients and health professionals who are gay, LGPIM attempts to offer a support and communications network for gay physicians and medical students. Future activities include a survey of the curricula on homosexuality in American medical schools and development of an educational videotape series on homosexuality and gay-related health needs for distribution to health education institutions nationally.

Membership is open to all medical students, physicians, and others interested in gay-related health issues. A quarterly newsletter is available for a minimum contribution of \$2.50 for AMSA members, and \$5 for nonmembers, renewable each November, but larger contributions are needed to carry on the programs and projects of the task force. For further information, please write to LGPIM/AMSA, 14650 Lee Road, PO Box 131, Chantilly, VA 22021 (703/968-7920). All inquiries and the mailing list itself are confidential.

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CORRECTION: REGRETS TO THE HAWORTH PRESS

[In the last issue of the Newsletter, The Haworth Press was erroneously reported as having closed their book publishing division (page 9). We regret the error, and are glad to print the following clarification:]

The Haworth Press, Inc., has not closed its book division in favor of its journals. We currently publish about 15 hardcover titles per year, and shall be expanding our book program in 1982 and 1983, covering the areas of health care management, medicine, research on homosexuality, and the behavioral and information sciences. The Press is known mainly for its journals because it is the largest independent publisher of journals in several fields.

Best wishes, Bill Cohen, Publisher

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VD HANDBOOK

The publication of the VD Handbook in 1972 (latest edition, 1975) was a contribution by the Montreal Health Press to begin a mass education program for attacking the ignorance

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VD HANDBOOK, Continued

and confusion surrounding the venereal diseases. All men and women have the human right and responsibility to have scientific knowledge about their bodies, their sexuality and the diseases related to sexual intercourse. We cannot rely on government health services to conduct such mass education programs, for they are crippled both by a lack of confidence in the public's ability to understand the scientific information and by an incredibly antiquated moralistic attitude. Community clinics and youth clinics have a special role in organizing people to demand that government, health departments and hospitals answer to our human needs. Not only must community and youth clinics take the lead in mass education, they must also provide exemplary medical care, to demonstrate what all medical care should be like.

To obtain a free, complementary copy of this excellent resource, please write: Montreal Health Press Inc., PO Box 1000, Station G, Montreal Quebec H2W 2N1 Canada (514/272-5441), with 50¢ per copy to cover postage and handling. Bulk orders available. [Excerpts from the VD Handbook reproduced with grateful acknowledgement.]

MORE ABOUT HERPES: LASER AND ACYCLOVIR

The September 14, 1981 issue of Medical News & International Report (Volume 5:11) reports about the use of a carbon dioxide LASER (light amplification by stimulated emission of radiation) for treatment of genital herpes at New Yorks Mount Sinai Hospital. After one or two microsurgical treatments which must be preformed the same day or within 48 hours of when lesions appear, 65% of patients haven't had recurrence, according to Dr. Michael Truppin. Among 70 patients treated in the past year, 48 haven't had recurrence for 6 months, even though many had been plagued with monthly outbreaks apparently triggered by menstruation. A formal trial is expected soon, with over 700 patients. Dr. Joseph Bellina in New Orleans has been using LASER therapy since 1974. Washington, DC, Hartford, CT, and Phoenix, AZ are other cities where LASER therapy is used for herpetic infections.

The June 27th Lancet and the July 9th New England Journal of Medicine (NEJM) reported on clinical trials of acyclovir (manufactured by Burroughs Wellcome Co.) which suggested that the drug could eliminate active forms of herpesviruses for at least the duration of therapy. There is no evidence that the drug will eradicate the dormant (nonreplicating) form of herpes. The Federal Drug Administration may allow a topical acyclovir preparation on the market for restricted use by the end of the year according to Science (Volume 213:4507, July 31, 1981). The September, 1981 issue of The Helper (Volume 3:3; American Social Health Association) reprinted the NEJM study and asked Dr. Ronald Keeney, Clinical Coordinator of the Acyclovir Program, and Dr. Danni King, Head of the Virology Section at Burroughs Wellcome Company, several questions about the drug. Although acyclovir may not turn out to be the "magic bullet" for herpes infections, it will probably have considerable value for many patients, and certainly will help pave the way in antiviral research.

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CALL FOR PAPERS: FOURTH NATIONAL LESBIAN & GAY HEALTH CONFERENCE

A call for papers on topics and workshops has been announced for the Fourth National Lesbian & Gay Health Conference in Houston, June 4-6, 1982. Potential Presentors are asked to send a 1 page narrative abstract specifying the anticipated length, nature (paper or workshop), and topic of the presentation to: FNL&GHC, 900 Lovett Bldg. Suite 102, Houston, TX 77006, by Monday, January 4, 1982. Variable time slots up to 1 1/2 hours for papers, and up to 3 hours for workshops will be allowed. Presentors will be notified on or about February 15. The Conference will be held at the University of Houston Conference Center, and is cosponsored by the National Gay Health Education Foundation, Inc. Information about registration materials and housing will be forthcoming. Sites for the 5th NL&GHC in 1983 are presently being solicited by the Foundation. Contact Paul Paroski, NGHEF, 114 Willoughby Av., Brooklyn, NY 11205 (212/622-3000) for additional information.

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THE NATIONAL GAY HEALTH DIRECTORY--THIRD EDITION

The 3rd edition of the valuable National Gay Health Directory, a compendium of health care services for lesbians and gay men, is presently being prepared for a May, 1982 publication date. For inclusion in the new edition, please contact Jeanne Brossart, 80 S. Elliott Place, Brooklyn, NY 11217.

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SELECTIVE BIBLIOGRAPHY ON THE PHILOSOPHY OF HUMAN SEXUALITY

Drs. Lee Rice and Paul Linn of Marquette University's Philosophy Department have recently announced the availability of a nine typewritten page selective bibliography on the Philosophy of Human Sexuality. The bibliography makes no pretensions toward being complete or comprehensive, but is merely a listing of useful articles (not books) on the general topic of philosophy of sexuality. Inquiries may be directed to Dr. Lee Rice, Department of Philosophy, Marquette University, Milwaukee, WI 53233. Please mention the NCGSTDS in your inquiry.

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AVDA TO MEET AT FIRST STD WORLD CONGRESS IN PUERTO RICO

In recent years, attendance at the American VD Association (AVDA) session of the American Public Health Association's Annual Meeting has been disappointing. Many exciting simultaneous sessions compete for members' attention. In addition, the American Medical Association no longer conducts its spring clinical sessions, a forum at which the AVDA usually sponsored a course and meeting. This year, AVDA is holding its Annual Meeting in connection with the First STD World Congress to be held in Puerto Rico, November 15-21, 1981. It will be an opportunity to meet with colleagues from many nations; quite consistent with the new international posture of the AVDA, the Congress promises to be particularly exciting. Sessions will be devoted to recent advances in basic research, clinical aspects, epidemiology, control and education, legal-ethical issues, and training. Drs. David Ostrow (Howard Brown Memorial Clinic of Chicago), and Dan William (Gay Men's Health Project of New York) will be representing the NCGSTDS at the Congress, and a report will be published in the next issue of the Newsletter.

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TUCSON'S GAY COMMUNITY SERVICE VD CLINIC TO REOPEN

Due to the recent closing of the county's "Alternate Lifestyle Clinic," Tucson's Gay Community Service VD Clinic is expecting to soon reopen as a full service clinic, according to Director Al Obermaier. Details in a future Newsletter.

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GAY STD PRIORITIES

Included with the last issue of the Newsletter (Volume 3:1, July, 1981) was a survey requesting evaluation and rank ordering of several gay STDs in terms of their general clinical significance to the local community, and in terms of the need for further research and study. Response to the survey was disappointing, with only 5 returns from practitioners in Chicago, San Francisco, Sacramento, Los Angeles, and Milwaukee. Interpretation of the results should be done cautiously, therefore. Following is a list of ten STDs with two rank-orders, the first reflecting the overall clinical significance, the second, the research priority (1=highest). Gonorrhoea--1,3; syphilis--4,6; hepatitis B--3,2; condylomata accuminata (venereal warts)--2,2; amebiasis, giardiasis, shigellosis, other enterics--5,1; herpes--7,4; nongonococcal urethritis--6,9; nongonococcal proctitis--8,5; hepatitis A, non-A non-B--9,8; and Kaposi's sarcoma--not ranked, 7.

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DENVER'S PROJECT SAFE WEEK

[This article was compiled by information kindly provided by G. Barry Gaspard, OUT FRONT Magazine, and various promotional materials.] Recent statistics from the Colorado Department of Public Health point to an alarming increase in STDs among gay men in the Denver metropolitan area. Syphilis is up 42% over 1979 with gay men accounting for 71% of all cases. Gonorrhea rates are extremely high, and a newcomer to the scene of gay STDs, hepatitis A, has increased more than 100% over 1979. A group of concerned gay individuals including doctors, businessmen, and media representatives recently met with several members of the State VD staff to discuss the problem and to seek some solutions.

They have agreed that some members of the gay male community, while maintaining a high level of sexual activity, frequently fail to be responsible for the consequences of their action (i.e., a high VD rate), either through fear or through a lack of information. As a result of this, the SAFE WEEK Committee was formed as a coalition of gay men working on a gay problem through gay channels.

The project was a week-long SAFE WEEK, April 27-May 3, 1981, a community-wide event that stressed the reduction of STDs through gay pride and participation--blood testing during special functions at gay bars and continual STD screening at the bathhouses during the week. The effort to provide STD screening and education in comfortable gay surroundings was hoped to help desensitize those members of the community embarrassed or afraid of the reality of STDs in their life. It was hoped that exposure to this reality along side many of their friends, drinking buddies, business associates, sex partners, and even their lovers may awaken a new awareness of responsibility to the community.

SAFE WEEK

April 27 - May 3

A Denver community project stressing the reduction of STD (sexually transmissible diseases) through gay pride and participation.

Get tested and wear your SAFE button. It's your passport to special SAFE WEEK events...watch for dates and times at your favorite bar or bath.

"SAFE" buttons were offered to all participants tested during the week as a passport to special events and discounts offered by gay businesses. One campaign slogan was "Will you be safe on May Day?", May Day being a pagan celebration of the male principle. What better time to celebrate and claim responsibility for our sexuality? The button signified that the wearer was a health-conscious, social-responsive gay man, concerned for his own health and that of his community. The button did

not declare that the wearer free from or immune to STDs. It did signify that he was at lower risk because he was recently tested. All screening materials and laboratory work was provided free of charge by the Colorado Department of Health. Money for publicity and educational materials was raised by the gay community.

This was a first effort by the local community at self-determination and STDs. Response was very encouraging. A total of 35 gay men and five volunteers from Colorado's VD Control Program managed to screen 669 men for syphilis over the week-long period at bars, baths, bookstores, and the Gay and Lesbian Community Center. Initial hesitation on the part of some establishments dissolved as the week progressed and a festive atmosphere prevailed. Many establishments provided discounts and free drinks for patrons tested and wearing a SAFE button. Donations from businesses and private individuals covered costs of promotional materials, with enough left over to allow us to develop a good VD education poster aimed at gay men. Additionally, 233 men were tested for gonorrhea, and amoebic titers were run on all the bloods taken to establish some idea of infestation rates within the community.

Probably the most encouraging result of the project was the number of gay men who are

[CONTINUED on page 13]



Le Hunk Safe

THE ONLY DISEASES ARE FEAR, IGNORANCE AND GUILT

by Phil Nash

In America, we are not taught to understand disease; we are, rather, induced to fear it. . . . them. . . . all diseases. In both the public and private sectors, fund-raising organizations or foundations constantly seek funds from the government or from the general public to fight diseases, but their tactics are to foster a climate of terror, guilt, and anger around disease in order to motivate people to give money to end it. We believe that we must have hundreds of thousands of dollars worth of health insurance to cover us should any one of these dreaded calamities visit our lives. Disease has become a tool to make money.

Therefore, we do not think of illness as a matter with which we cope rationally and willfully. Rather, our sicknesses have become tragedies, defeats, demons with us. Disease turns us into losers, the unclear, the miserable. . . . and the unlovable. The only remedy is vast sums of money.

Each year, the media bombards us with the "heartbreak" of multiple sclerosis, badgers us with the "victims" of muscular dystrophy, the "tragedies" of cancer, the "painful" recoveries from those "ravished" by stroke. Ad nauseum.

Consequently, we Americans, naive and fearful of the medical establishment, are unwilling to be the leading players in tragic roles. Refusing the victimization we find throughout the media campaign about disease, we fail to take care of ourselves in a manner appropriate to our survival. Rather than seeking help when telltale symptoms appear, we frequently institute a somewhat bizarre and anti-survival coping mechanism called "denial." I recently heard two stories of denial, that are shocking in their own dimension. One woman who was told she had a malignant tumor of the neck failed to seek treatment to control the growth, and it eventually grew to be the size of her head. The horrid lump was infected and painful, but the woman naively believed that it would, at some point, shrivel away. She could not possibly have cancer. Another woman, fully aware of the symptoms of breast cancer, failed to seek treatment when those symptoms became apparent in her own breasts. Fearing the diagnosis, she continued to deny the problems. Eventually her hardened, in-

fectured breasts literally fell off. At that point, she finally sought treatment, only to learn that her disease had already metastasized to her brain and to her lungs.

In the gay community, we observe the denial process enter into our lives in a variety of pathological ways. Some people may have homosexual relations every day of their lives and consciously deny that they are anything other than healthy hetero-ees—and they might even bash a few queers to prove their machismo. Parents of gay children practice the art of denial with diligence through non-acceptance, or by adhering to belief in the powers of God, psychotherapy, time, or just a good heterosexual fuck to "heal the defect" in their child. Churches, the government, and the educational system vigorously practice denial by re-

SAFE

fusing to recognize our existence and by failing to provide for our needs.

And due in large part to the above-mentioned denial systems, we have come to practice some destructive forms of denial among ourselves. There are many areas where this may be applicable, but I wish to speak specifically about sexually-transmitted diseases.

I recently heard the story of a worker for the state health department who was visiting a gay bath house in Denver. He engaged one of the patrons in a conversation about the need for frequent testing for gonorrhea and syphilis if he had sex with a number of sex partners. The man literally reeled away. He said that VD had nothing to do with him. He didn't associate with "such people." (Remember, folks—the man was in a gay bath house!)

The health worker was taken aback. He reported that this was not an unusual experience, however. The man had internalized the fear of sexually-transmitted diseases with such vigor that he was unable to cope rationally with a simple

blood test and culture-taking procedure.

The two most contagious sexually-transmitted diseases are, in and of themselves, no big deal. Unlike cancer (a disease from which more people recover than not!) either syphilis or gonorrhea can be easily detected very cheaply. . . . if not free. They can be treated with a very simple administration of commonly available, inexpensive drugs. The amount, type, and cost of treatment varies from individual to individual and depends on such things as the site of treatment and factors relating to the participant's tolerance to various drug protocols. I consulted a local physician who said that even the most expensive detection and treatment procedure in his office would cost \$88, including office visits, laboratory work, and drugs. He said that almost all cases of symptomatic VD would be handled for somewhere between \$30 and \$50. For those who choose, free detection and treatment facilities are highly accessible in the city. In Denver, anyone discovered with clap or syph can receive free treatment through the Health Clinic at Denver General Hospital. Consult the Gay and Lesbian Community Center for details.

Through our own neglect, the incidence of syphilis is skyrocketing, and we show no improvement in our incidence of gonorrhea. In almost all cases, syphilis and gonorrhea are very easily detected and treated. Undetected and untreated, both can cause severe rashes, blindness, arthritis. Syphilis is known to cause mental deterioration and death over a period of years. Unwittingly, those of us who have sex with bisexual men run the risk of transmitting gonorrhea to women, for whom the consequences are much more severe than for men. Unfortunately, denial of the disease is more prevalent among the segment of the community which has intercourse with both men and women.

The upcoming **Safe Week** (See times and places elsewhere in this issue of *Out Front*) is designed as an opportunity for gay men to integrate into their lifestyles the awareness that they need to be periodically checked for syphilis and for gonorrhea if they engage in sexual activity with more than one partner. Since we have more sex in more ways with

more people more often, we need to integrate this awareness into our highly sexualized lifestyle. Testing is necessary with regularity because a great number of cases are asymptomatic, but nonetheless contagious.

Those of us who are open and active in the gay male community have managed, often with a great deal of conscious effort, to realize that sex can be a casually pleasurable thing. We should also be smart enough to know that VD is only as dirty as we think about our sexual selves. Gay men are perfecting eroticism as an art form that straights may never experience on a mass level. To elevate

sensuality to this pinnacle requires discipline and self-respect. An important part of this self-respect is to ensure that we remain vigilant of the potential for infection by those microscopic beasts which enter us unnoticed in the moments of greatest ecstasy. These microbes are not to be feared, but they are not to be ignored either. They are fair game for murderous assault by easily available drugs.

Out Front encourages your participation in **Safe Week**. And afterward, get checked out often to make sure that your sex organs (which, for most of us, include our ass holes and our mouths) aren't

entertaining unwelcome visitors. Let's all respect our sexuality enough to keep from constantly infecting each other with parasitic microbes. And let's stop making such a big dirty deal about it when we do. If only we could treat our collective ignorance and fear along with the painless chancre or those few drops of pus! The pus can be gone within a matter of hours with proper treatment. VD itself could be gone if enough of us were smart enough to remember where we got it and patient enough to make sure we don't give it away in our haste to spread love throughout the world.

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Special thanks to PHIL NASH
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his thought-provoking
article.

PROJECT SAFE WEEK, Continued

sexually active, but for whatever reason had never had a VD test, who were tested for the first time. No hard data is available on these numbers, but anecdotally our screeners reported quite a few volunteering that information. This was precisely our goal in SAFE WEEK, to reach those men who are at risk but unaware of their responsibility to themselves and their community. Some of the establishments we tested at are those that cater to older men and married men who are very closeted. We are convinced of the need for an outreach program on a regular basis in these types of situations.

Thirteen cases of previously undetected syphilis were discovered through the screening, six of these were diagnosed as late latent cases supporting our feeling that we were able to tap a reservoir of men with poor health seeking behavior. We hope to continue this program annually, with publicity and positive peer pressure creating a climate of openness and individual responsibility among our gay brothers. Don't forget--your health is my responsibility, and my health is your responsibility!

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HEPATITIS B VACCINE UPDATE

by David Ostrow, MD, PhD, Research Director, and Harley McMillen, Executive Director, Howard Brown Memorial Clinic, Chicago, and Press Releases

Hepatitis B virus infects at least 200,000 Americans each year. About a quarter of those infected develop severe hepatitis with fever, nausea, vomiting, and jaundice. Others have no overt symptoms. Most of those infected eventually recover and are immune from future infections. However, between 5-10% become carriers of the virus which circulates in the blood stream for years, or even for life. These carriers are at high risk of developing later diseases associated with hepatitis B virus, namely chronic hepatitis and liver cancer. It is estimated that 5000 Americans die each year from hepatitis B virus-related chronic hepatitis and cancer.

The hepatitis B virus is spread either by direct needle injection [thus it was previously known as "serum hepatitis"] or through intimate contact--often sexual. Thus, certain professional or social groups are at high risk of acquiring infection. Any occupation that involves health or dental care, where blood contact is common, is at risk. Social groups like drug users, or sexually active groups, especially homosexual males are also at risk.

Since there is no treatment for the diseases associated with this virus, research efforts have been directed at vaccine development to prevent them. An American pharmaceutical company, Merck, Sharp, and Dohme, has developed a hepatitis B vaccine [HBV; Heptavax-B^R]. As the virus cannot be grown in the laboratory, vaccine material is made after extensive purification of viral components in serum obtained from donors at plasmapheresis centers. It is given in three doses, the first two a month apart, and the third 6 months after the first dose.

A study recently completed by the Centers for Disease Control was designed to see if the proposed-to-be-licensed vaccine would protect high risk individuals from infection. The study was conducted in five venereal disease clinics: The Howard Brown Memorial Clinic, Chicago (David Ostrow, MD, PhD, and Norman Altman); The San Francisco City Clinic (Erwin Bra-f, MD, Paul O'Malley, and Donald Hawkins); The Denver Metro Health Clinic (Franklyn Judson, MD, and Kent Penley); The Gah and Lesbian Community Services Center, Los Angeles (Thom Nylund, Graham Christie, and Frank Meyer); and the St. Louis STD Clinic (Joseph Moore, Jr., and Ann Gardener). Fourteen hundred sexually active homosexual males volunteered for the study. One-half received the HBV and one-half received a placebo. The difference in hepatitis B incidence in the two groups demonstrated its efficacy. After allowing 3 months for the vaccine to take effect, the incidence in the two groups was measured: 37 cases of hepatitis B occurred in the placebo group while only 8 occurred among the vaccinees. Overall almost 85% of those vaccinated produced antibodies to the virus. Only one mild case occurred among these successfully vaccinated individuals. Expressed in other terms, the

[CONTINUED]

HEPATITIS B VACCINE UPDATE, Continued

vaccine was 97% effective among those who produced antibodies.

This CDC sponsored study essentially replicated an earlier study reported in the New England Journal of Medicine (Volume 303:15, 10/09/80, pp. 833-41) and this Newsletter (Volume 2:3, January, 1981, p. 6) in New York City by W. Szmunes, et al. [Dan William and the Gay Men's Health Project of New York participated in the project.]

In summary, the HBV was found to be safe, to date. No serious side effects have been observed in recipients. Mild side effects were infrequent, of short duration, and generally limited to the site of inoculation. HBV is immunogenic. Two doses plus a booster induced antibody response in 85% of the recipients. HBV efficacy is a direct function of its immunogenicity. Recipients who responded with significant antibody production prior to virus exposure were highly protected. Recipients who failed to respond obtained no protection. HBV is efficacious. Efficacy in recipients who responded with anti-HBs prior to exposure was almost 100%. The vaccine also appeared to prevent or ameliorate the course of infection in recipients who were exposed to infection prior to or concurrent with inoculation.

The study generated several important questions that will require ongoing investigation.

- 1) Why do 5-15% of vaccinees fail to develop immunity to HBV? Things to consider: vaccine handling/storage conditions; "immunosuppressed group" (Kaposi's sarcoma, cytomegalovirus, and Pneumocystis infections); age/general health factors; dose of vaccine (20ug vs 40ug).
- 2) How long does immunity last and are booster vaccinations necessary?
- 3) Concerning chronic hepatitis B infection: long term sequellae (cirrhosis, liver cancer, other); can we "cure" or at least prevent sequellae? Non-invasive techniques to diagnose severity?
- 4) Concerning effective vaccination programs: How do we identify persons at highest risk? How will we support the vaccination of those persons?

As of next year, Federal support of hepatitis B research and testing at Howard Brown Memorial Clinic will be coming to an end. Persons already suffering from chronic hepatitis B infection will not be helped by development of the vaccine. Therefore, the Board of Directors of the HBMC is announcing a hepatitis vaccine fund raising program. The monies raised in this campaign will be used to support the two most important aspects of our Hepatitis Program during the next several years: 1) development of effective vaccination programs which will have the greatest impact on the spread of the disease, and 2) continued research on the diagnosis, treatment, and long term sequellae of chronic hepatitis B in our Clinic population. Anyone interested in this Project should contact the Clinic for details: HBMC, 2676 N. Halsted Street, Chicago, IL 60614 (312/871-5777).

NCGSTDS ANNUAL MEETING: PROGRAM ADDENDUM

Representatives from Merck, Sharp, and Dohme Pharmaceuticals will be attending the Annual Meeting to discuss clinical and marketing questions concerning their new hepatitis B vaccine.

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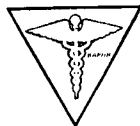
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[END OF VOLUME 3 #2; FOLLOWING PAGE 14, ARE SUPPLEMENTS: GUIDELINES & RECOMMENDATIONS FOR HEALTHFUL GAY SEXUAL ACTIVITY; AJPH ARTICLES: STD IN HOMOSEXUAL MEN--EDITORIAL, AND THE GAY REPORT ON STD; AND MORBIDITY AND MORTALITY WEEKLY REPORT.]

Guidelines and Recommendations for Healthful Gay Sexual Activity[©]

Modified and edited by Robert K. Bolan, M.D.



Sex education is inherently boring I think. In some way or another the message is always: "You shouldn't _____ because you might get _____." For some reason the concept of denying a certain, immediate good (sex) because of a potential, delayed evil (disease) has not enjoyed a massive following. Hence we have the school of hard knocks — in which bum fucks soon turn to sores, drips and rashes. Or perhaps an ill-advised slip of the tongue (in cheeks, that is) leaves you bloated and loose of stool with parasites abounding in your bowel. How were you to know?

It's quite likely that any sex education you had was heterosexually oriented or if related to a Gay sexually transmitted disease was probably after you'd had an infection, and then was presented with thinly veiled contempt or moralistic lectures.

I'm not saying all that is behind us now or that no one is doing anything to make reliable sex education available. However, there is considerable variability in information from one source to the next, sometimes the result of one health professional's opinions, experience or interests and sometimes the result of incomplete information on the professional's part.

Fortunately, this country is leading the world with the number of good, Gay-run sexually transmitted disease (STD) services and education efforts are a major part of these services. Knowledge of specific Gay sexual activities, and the ability to be support-

ive of Gay sexual expression while discussing health and avoidance of disease is absolutely essential if individual health education is to be effective. Therefore, competent Gay input into all sexually transmitted disease (STD) services is necessary for any education effort to work.

In order to take responsibility for one's choices regarding health, sexually active people must be well informed about: the signs and symptoms of the STD's, the increased risk factors associated with various sexual practices, and what type of services to request in case there is not access to knowledgeable health providers. Information received from health professionals must be accurate and non-moralistic: facts should be labeled as facts, opinions should be labeled as opinions. Only in this way can Gay people be able to responsibly use the knowledge to alter their risks for disease acquisition and spread.

In an attempt to accomplish this goal, experts in Gay STD's needed to meet, discuss the issues and come to agreement on the most important information to stress, which misinformation must be corrected, which "popular remedies" might be helpful, which harmful, and which had unknown or unproven effects.

The National Coalition of Gay STD Services (NCGSTDS), now comprising 24 member service groups and 28 individual members nationwide, was formed in 1979 at the first Gay STD medical conference in Chicago. Meet-

ing again in June 1980 at the second Gay STD conference in San Francisco, and again in October 1980 at the American Public Health Association's Annual Convention in Detroit, the NCGSTDS members worked on the development of guidelines and recommendations (G&R's) for Gay people in order to make them more aware of the health risks associated with Gay sexual activity and to suggest ways to minimize the risks of acquiring disease. Dissemination of these G&R's to the Gay community is the responsibility of the NCGSTDS members, so I'm presenting the San Francisco edition. What follows is directed to the Gay male population. Exclusively Lesbian women have virtually no incidence of STD's. This long held impression was recently substantiated by a study in San Francisco.

These G&R's are based on common sense, our current understanding about the occurrence and transmission of infections, and proven data. Occasionally they may represent what is thought to be a good idea but isn't proven. Therefore, the G&R's are subject to modification when new information becomes available.

Although this is not intended to serve as a self-diagnosis guide or a discussion of the specific infections we can acquire sexually, a brief definition of the main infections that will be mentioned follows:

Amebiasis, giardiasis: refers to bowel infection with parasites; usually cause diarrhea, gas, bloating, or alter-

nating constipation/diarrhea; may not cause any symptoms; difficult to diagnose and treat.

Shigella, Campylobacter: refers to bacterial bowel infections; usually quite severe with intense cramping, fever, bloody diarrhea.

Hepatitis A: used to be termed "infectious hepatitis."

Hepatitis B: used to be termed "serum hepatitis" and associated with needle (drug) use; now known to be sexually transmitted and of approximately 8 times higher prevalence in Gay men than straight.

Herpes: a viral infection which can cause recurrent ulcers in the external genital area or, if implanted inside the anal canal, can cause an intensely painful proctitis (rectal inflammation).

Gonorrhea: clap, drip; a bacterial infection which can be in the urethra (penis) where it usually causes symptoms (drip, burning) or in the rectum where it usually does not cause symptoms, or in the throat where it rarely causes symptoms.

Non-gonococcal urethritis: refers to infection in the penis caused by organisms other than gonorrhea.

Non-gonococcal proctitis: refers to infection in the rectum caused by organisms other than gonorrhea.

Venereal warts: refers to warty growths caused by a virus and which may occur on the penis or more frequently

in the warm, moist environment of the anus and rectum.

Syphilis: a bacterial infection very common in Gay men; begins as a sore which can be anywhere but usually in the mouth, on the penis, the anus or in the rectum; can cause rash and flu-like symptoms.

One very important fact to understand is that for virtually every STD there are asymptomatic carriers — those who have an infection and are transmitting it to their partners, but who have no symptoms themselves.

Health means much more than the absence of disease and the avoidance of STD's. It is the human condition in which the physical, mental, and spiritual needs of a person are in balance. Healthful sexual behavior is an expression of one's natural sex drives in satisfying, disease-free ways. Guarding your health and respecting the health of your sexual partners means, for one thing, being aware of your body and the messages it may be giving you.

You should routinely examine yourself for any physical signs of infection, such as sores, rashes, or discharges. If you have rectal sex, learning to do a self-rectal examination with your finger while in the shower can be a useful way to discover early any abnormalities such as rectal warts or sores, even before they cause symptoms. Any symptoms such as burning on urination, pain with bowel movements, diarrhea, excess gas, or flu-like symptoms should be

acknowledged early and not denied. If a partner mentions that he is just recovering from the flu, it is important to find out what he means by "flu," since it may mean different things to different people. It might indicate diarrhea from amebiasis, giardiasis, bacterial bowel infection, or it might indicate the early flu-like symptoms of hepatitis or secondary syphilis. Virtually any ailment could be the manifestation of a sexually transmitted disease. Therefore, any persistent, abnormal bodily function should be viewed with suspicion. You should abstain from sexual activities if you recognize such signs or symptoms in yourself or in your partners.

Importance of Accurate Diagnosis and Adequate Treatment

Not all diseases have the same treatment. Penicillin does not cure everything. Taking medication only until symptoms go away will not reliably rid you of the infection.

Specific diagnosis of your problem by health practitioners competent in this area of medicine is essential. Many diseases have similar signs and symptoms because the body only has a limited number of ways to respond to the stress of an infection. You will have the best chance of being properly diagnosed and treated if you promptly seek appropriate medical care. Proper treatment also means carefully and completely following instructions for taking medication and avoidance of sexual activities (if so advised) for the duration of the recom-

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mended time. Take all medication as prescribed because infection may linger and recur if you stop treatment as soon as symptoms go away.

The Sexual Encounter

Always exchange your name and telephone number to facilitate contact in case signs or symptoms of an STD are later recognized or discovered. If your partner does not wish to give you his name and phone number, there is nothing to prevent you from giving him yours — that way, at least you may stand some chance of being notified if he should develop symptoms of something. It is also best to tactfully bring up health before sexual activity begins. If anything suspicious is discovered you might want to make this just a friendly meeting without sex and postpone the intimacies until later when the problem is resolved. When you do go to bed with someone, undressing in a lighted area will allow you to casually inspect for growths, sores or rashes, especially around the genitals. If no reasonable explanation is given, postpone the encounter. You might incorporate showering together before sex into your foreplay, that way you can wash and casually examine at the same time.

Hygiene

Medical opinions differ on the value of washing the genitals and anus with soap and water before and after sex to reduce the incidence of STD's. Although not proven, it is generally believed that washing of the genitals and anus may decrease the risk of acquiring certain diseases

such as the bacterial bowel infections (shigella and campylobacter), hepatitis A, amebiasis, giardiasis and pinworms.

Similarly, it is thought that urinating after sex may reduce the risks for acquiring gonorrhea and nongonococcal urethritis. Again, there is no evidence to support this. The role of inserting antibiotic solutions, soaps or other agents into the urethra (the urinary opening) is not at all known and may be hazardous.

Many think that rectal douching (with tap water) is an effective preventive measure against infection. In fact, there is evidence to suggest that it may actually increase the risk of some infections. Douching just prior to sex may alter the rectal mucous membrane barrier function and make the passage of the hepatitis B virus into the body easier; if one has an amebic bowel infection, douching may actually bring more infectious amebic organisms down into the rectum and around the anus, thus making you more likely to spread the infection to your partner.

Scented lubricants may cause a chemically induced proctitis (rectal inflammation), therefore the use of hand lotions and other scented products for these purposes are discouraged. In addition, the use of saliva as a lubricant may introduce other infections into the rectum.

It is not known whether the following measures have any role in reducing the acquisition or transmission of the STD's: hydrogen peroxide or

other mouthwash gargling to control oral gonorrhea; soap instilled into the end of the urinary opening to control gonorrhea and nongonococcal urethritis; antibacterial creams, lubricants, suppositories for inserting into the urethra or rectum; water soluble vs. edible vs. petrolatum lubricants (e.g., KY vs. Crisco/Lube vs. Vaseline) for rectal intercourse.

The use of condoms (rubbers) for anal intercourse will protect against the spread of syphilis and gonorrhea and may even offer protection against herpes, hepatitis B, nongonococcal urethritis and proctitis (these latter four claims are not proven). High quality condoms should be used since breakage may occur more frequently with anal intercourse than with vaginal intercourse.

Sexual Practices

Many factors must be considered when determining a person's risk for acquiring or transmitting any STD. Six major categories are listed below, describing the relative risk as high, medium, or low.

1. Frequency of sexual contact. **High risk:** more than 10 different sexual partners per month; **Medium risk:** between 3-10 different sexual partners per month; **Low risk:** less than 3 different sexual partners per month.

2. Type of sexual encounter. **High:** primarily one-time, anonymous encounters; group sex; **Medium:** several times with the same person over a period of time; sex within a small group of friends;

Low: primarily monogamous sex for both you and your partner.

NOTE: Anonymous sex makes interruption of the chain of disease transmission almost impossible and it is one of the most important reasons for the high prevalence of STD's in Gay communities. But for the individual, anonymous sexual contact represents high risk not only because you won't be notified if your partner discovers an infection shortly after your meeting. It is not likely that you will know much about your anonymous partner, such as his recent health, the number of different sex partners he had recently — in other words, his risk profile is more likely to be unknown to you than partners in the medium and low risk categories.

3. Place of sexual encounter. **High:** bathhouses; bookstores; **Medium:** public restrooms; parks; bars; motor vehicles; **Low:** private homes.

NOTE: Risk in this category is based largely on the number of contacts per visit, the likelihood of anonymity, and probably also because of incomplete or no cleansing between contacts. Assuming that bathing the anal and genital areas is helpful in reducing some infection spread, the "safest" place to meet someone at the baths is in the shower.

4. Drug use.

NOTE: Generally accepted medical opinion is that use of mood or consciousness-altering drugs (all drugs — alco-

hol, cocaine, valium, Quaaludes, etc.) that are affecting you while you are having sex may alter decision-making abilities about sexual activities practiced, having sex with more people, etc. Drug use becomes particularly dangerous with the use of toys, dildoes, and fistfucking; sensation of pain may be significantly diminished with chemicals (including poppers) so that injury may occur.

5. Geographical area where you and your partners live and have sex. **High:** New York City, Los Angeles, San Francisco, Chicago, foreign countries; **Medium:** other large urban areas; **Low:** small cities and towns, or rural areas.

6. Types of sexual activity practiced. **High:** active or passive rectal (fucking or getting fucked); rimming (asshole licking, oral/anal); scat (eating shit); fist fucking. **Medium:** active or passive oral (the one doing the cocksucking has a greater chance of getting something than the one being sucked); **Low:** masturbation only (J/O); body rubbing; water sports.

NOTE: Major surgery may be required to repair injuries sustained from fistfucking; any type of oral-anal-fecal contact carries a very high risk (in some places like San Francisco, the risk almost approaches certainty) for acquiring hepatitis A, hepatitis B, amebiasis, giardiasis, shigella, campylobacter. Another important aspect about fecal-oral contamination is that you don't have to rim someone to rim him. In a bathhouse or other setting in which numer-

ous sexual contacts per visit is the rule, if you suck a cock that has fucked someone with little/no bathing in between — Voila! And happy "indirect" infection! Also, roving, probing hands and fingers will spread potentially infectious material to other parts of the body where mouths and tongues will pick it up.

Rimming except in an exclusively monogamous relationship should be eliminated from the activities of everyone who is not interested in getting amebiasis, giardiasis, shigella, campylobacter bowel infections or hepatitis A or B. Those who have a stable, but open relationship allowing for outside contacts, and who enjoy oral-anal stimulation could limit this activity only to their primary relationship and thus decrease their risk from "outside" infection.

It is through getting fucked that you have the highest risk for acquiring hepatitis B; fucking (being the "active" partner) is also a risk for hepatitis B but less so than being fucked. Oral-genital and oral-oral contact is not associated with hepatitis B.

By getting fucked you can get rectal gonorrhea, rectal herpes, syphilis, non-specific proctitis (rectal infection from other organisms), and rectal warts. Rectal fissures and tears can also result.

In oral sex (cocksucking), gonorrhea and syphilis are the most likely infections to be transmitted. It is very unusual to get urethral gonorrhea from having your cock sucked by someone who

has pharyngeal (throat) gonorrhea.

Bathhouses

Bathhouse managements are asked to print up cards and/or matchbook covers to enable patrons to exchange names and phone numbers. The local VD clinic phone number should also be prominently posted on bathroom walls with slogans encouraging frequent VD testing and showering after each sexual encounter. Bathhouses are encouraged to exchange all soiled towels for free to allow for frequent showering and washing. On site testing for STD's at the bathhouses could be done by trained and supervised bathhouse employees. (Probably only syphilis and gonorrhea testing would be practical.) Management may further offer an incentive for onsite VD testing by offering free or discount locker passes (for the patron's next visit), free coffee, or membership reduction (4-5 onsite tests within a year might be the qualifying number).

Routine & Regular VD Testing

Routine VD testing should include a VDRL or RPR blood test for syphilis and trisite gonorrhea cultures (oral, urethral, and rectal), and preferably a rectal examination. Rectal cultures and rectal exams are not needed if you have no rectal sex. A first-voided morning urine specimen for detection of urethral gonorrhea may be substituted for the usual swab culture if practical and possible in the health care setting you at-

tend. Currently there are no easy, efficient diagnostic procedures for amebiasis and giardiasis, therefore routine asymptomatic (no symptoms) testing cannot be feasibly accomplished. Hepatitis B antigen and antibody and hepatitis A antibody testing is encouraged so that you will know if you are susceptible or immune to hepatitis. (You may have already had either infection without your knowledge and without symptoms of illness, and if you have your body might have made protective antibodies against the viruses, therefore giving you immunity to reinfection.) Hepatitis B vaccine will be available shortly and should be received by all those who have no antibodies against hepatitis B.

Frequency of VD testing depends on the risk factors associated with sexual activity discussed above. Monthly testing is urged for those at high risk; testing every three months is recommended for those at medium risk; semi-annual or annual testing is recommended for those persistently at low risk. If in doubt, or if symptomatic, get checked immediately! The doctor or testing facility you visit, even in San Francisco, may not offer adequate screening if they are not familiar with your sexual lifestyle and practices; therefore, it is imperative that you learn what types of testing are necessary for you. ■

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Sexually Transmitted Diseases in Homosexual Men

Recent studies have suggested that homosexual behavior in men is associated with significant personal and public health problems due to several sexually transmitted diseases (STD). Gay men appear to be at greater risk than heterosexual men or women for gonorrhea, syphilis, anorectal venereal warts, and perhaps for genital and anorectal herpes simplex virus infections,¹ as well as for several STDs outside the traditional sphere of venereology, including hepatitis A,² hepatitis B,³ amebiasis,⁴ giardiasis^{4,5}, shigellosis,⁶ enteritis due to *Campylobacter fetus*,⁷ genital and anorectal meningococcal infection,⁸ and cytomegalovirus infection.⁹ Most studies to date, however, have been conducted in STD clinics or at sites where persons congregate for anonymous sexual activity, such as steam baths, and the applicability of their findings to the homosexual male population at large is unknown.

Darrow and his colleagues, in a study published in this issue of the Journal,¹⁰ have attempted to address this problem by reporting the frequencies of several STDs relative to various risk factors in a large population of gay men in the general population. Critics will point out, and the authors acknowledge, that the results cannot be considered applicable to all homosexual men; the population sample included only 4,212 respondents (1.5 per cent) to 275,000 questionnaires published in a gay-oriented magazine or distributed through organizations relating to homosexual men. This study commands attention, however, because of the size of the population surveyed and because it was not conducted in an STD clinic. The fact that only 36 per cent of the respondents who had sought professional care for STDs had done so at public clinics supports the concept that this population sample is different, and presumably broader, than other populations of gay men studied to date.

The results contain no surprises, except perhaps that a full 78 per cent of respondents had experienced at least one episode of the STDs surveyed; and 2,228 (60 per cent) of 3,696 who answered the question fully had experienced an STD aside from pediculosis.* Although individuals who had been infected might have been more likely than other gay men to participate in the survey, this probably was not a major determinant, since only four of the 692 questions directly referred to STDs or to medical issues. The infections surveyed occurred with roughly the same relative frequencies that have been observed among gay clientele of STD clinics or steam baths.¹ The major risk factors—greater numbers of sexual partners and anonymous or "furtive" sexual encounters—were as expected. Significantly, the practice of anilingus also was an important risk factor. The opportunity during homosexual activity for both direct and indirect fecal-oral contamination undoubtedly explains the very high rate of hepatitis A² and various enteric infections in gay men.^{2,4,6,7} It was reported in 1977 that about 30 per cent of non-imported shigellosis in Seattle and King County, Washington, occurs in homosexual men,⁶ a rate that now

approaches 50 per cent**; a similar phenomenon has been reported from San Francisco.¹¹ At least 44 (43 per cent) of 102 reported cases of hepatitis B and 48 (22 per cent) of 217 reported cases of hepatitis A in Seattle-King County in 1980 occurred in gay men.**

What can be done to curb the STD epidemic in this population? Hepatitis B, probably the most important STD in gay men from the standpoint of overall morbidity and potential complications, may be amenable to control through immunization programs,¹² but no other vaccines for STDs are on the immediate horizon. Education of gay men to limit the nature and numbers of their sexual partners is unlikely to be productive on a large scale; screening of high-risk populations for gonorrhea, syphilis, and hepatitis B apparently is ineffective in reducing the prevalence of these infections¹³; and traditional contact tracing is not productive in populations with large numbers of anonymous sexual contacts. The only viable control measure that is applicable here and now is the provision of technically skilled and personally satisfying health care services for homosexual men with these infections.

Because 79 per cent of their survey respondents reported positive experiences at clinics run by and for gay men, compared with 61 per cent for public STD clinics, Darrow, *et al.*, conclude that one way to improve care is for public health authorities to encourage the establishment of such gay clinics. However, the survey could not take into account the technical quality of care and did not assess the expectations of the respondents, which may have influenced the choice of medical care provider and inflated the approval rate for gay clinics. Thus, the data do not support the conclusion that gay clinics provide better care than public STD clinics or private physicians. In addition, one may ask whether those who responded negatively to public STD clinics did so because they experienced anti-gay prejudices or because these facilities are often overcrowded and understaffed or staffed by underqualified personnel. Given the low level of financial support for STD control in many local health districts, the 61 per cent positive rating for public clinics (or 82 per cent non-negative, if "neutral" responses are included) is surprisingly high; would heterosexual men and women rate them any better? I wholeheartedly agree that there is room for much improvement in health care services for gay men with STDs and that, if the need for gay STD clinics can be demonstrated (and I am sure that it can in many locales), such facilities may improve disease control in this population. However, the presence of such a need is *prima facie* evidence that the local health department and/or local physicians have failed an important responsibility.

A related issue concerns the future direction of public STD clinics. As the incidence and spectrum of sexually transmissible infections expands, the ability of traditional health department clinics to provide the comprehensive services needed is shrinking. How many public or gay clinics

* Darrow WW: Personal communication.

** Nolan CM: Personal communication.

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are equipped to diagnose and manage viral hepatitis, or to distinguish between proctitis or enteritis due to *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, herpes simplex virus, *Treponema pallidum*, *Shigella*, *Campylobacter fetus*, *N. meningitidis*, rotavirus, *Entameba histolytica*, *Giardia lamblia*, and idiopathic inflammatory bowel disease? Similar problems exist with respect to heterosexuals and the management of salpingitis, epididymitis, perinatal morbidity, and neonatal infection with sexually transmitted pathogens. Two major goals for the 1980s should be: 1) education of practicing physicians to nonjudgmentally inquire into alternative sexual life-styles and to recognize and appropriately manage the major STD syndromes; and 2) the development of strong affiliations between public STD clinics and comprehensive medical centers in order to provide the level of care necessary for control of these infections. Establishment of additional categorical gay clinics is likely to be counterproductive, because most would not be able to provide the comprehensive services necessary, and because they would tend to further stigmatize gay men and their unique health problems by removing them from the mainstream of medical care.

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The Gay Report on Sexually Transmitted Diseases

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Abstract: Most studies of sexually transmitted diseases in homosexual men have examined prevalence in clinic populations; for comparative purposes, we analyzed data from a survey of 4,329 gay men conducted in 1977.

Among 4,212 respondents to the self-administered questionnaire, 66.8 per cent reported previous infection with pediculosis; 38.4 per cent, gonorrhea; 24.1 per cent, nonspecific urethritis; 18.1 per cent, venereal warts; 13.5 per cent, syphilis; 9.7 per cent, hepatitis; and 9.4 per cent, herpes. Number of different lifetime sexual partners best predicted histories of syphilis ($r = .249$), gonorrhea ($r = .402$), and the other diseases; frequency of checkups, years as a practicing homosexual, and furtive sexual activities were among the many

other significant correlates of venereal infections. Respondents most often sought examinations from private physicians (39.4 per cent); those who visited gay clinics were examined most often and felt most positive about their medical care.

Gay men who participated in the survey reported frequent infections with many of the same sexually transmitted diseases often seen in private medical practices, public VD clinics, and gay health centers. Since high rates of disease are related to large numbers of different partners, frequent exposures with anonymous contacts, and anal intercourse, we recommend frequent examinations for those whose life-styles include these characteristics. (*Am J Public Health* 1981; 71:1004-1011.)

Before Goodman¹ described an outbreak of infectious syphilis among homosexual men in New York City, American physicians were either unaware of the venereal disease problem in this population or too reluctant to talk about it.² Since 1944, homosexual men have increasingly become acknowledged as a high-risk group, and efforts have been made to meet their special needs.³

Most studies of homosexual men to date have focused on syphilis and gonorrhea among public and gay clinic patients. We studied eight sexually transmitted diseases in 4,212 homosexual men who responded to a self-administered questionnaire in order to: 1) compare the distribution of self-reported sexually transmitted diseases with clinically reported distributions; 2) assess relative risk indicators for syphilis, gonorrhea, and other sexually transmitted diseases; and 3) evaluate reactions to medical care.

Address reprint requests to Centers for Disease Control, Attn: William W. Darrow, PhD, Center for Prevention Services, Technical Information Services, Atlanta, GA 30333. The co-authors' affiliations are: D. Barrett, Indiana University, Bloomington; K. Jay, Pace University, NYC; and A. Young, Orange, MA. A condensed version of this report was presented at the 107th Annual Meeting of the American Public Health Association, New York City, November 1979, and submitted for publication on August 20, 1980. A revised and expanded version was resubmitted to the *Journal* on February 6, 1981, and accepted for publication March 20, 1981.

Editor's Note: See also related editorial p 989 this issue.

Materials and Methods

Data collection instruments, survey procedures, and one-way frequency distributions have been published in *The Gay Report*.⁴ Here we only briefly describe the questionnaire, sample of respondents, variables selected, and statistical procedures used in our analyses.

The Questionnaire

The 16-page questionnaire developed for gay men was divided into two parts. Part I included 623 short-answer and single-response multiple-choice questions that covered 19 general topics (e.g., specific sexual acts, relationships, and venereal disease). Part II offered respondents an opportunity to write essays on four general topics (sexual experiences, interpersonal relationships, self-image, and social ostracism). Some of the quantitative data from Part I were presented in *The Gay Report* to provide the reader with a sense of the varieties of experiences and feelings reported by respondents, and to show that the people who participated in the survey were generally representative of the overall adult populations of the United States and Canada (in terms of age, place of residence, and religious background). However, by and large, the responses to Part II constituted the basis for *The Gay Report*.

Survey Respondents

Most of the 50,000 questionnaires that were printed in English for gay men were distributed through the 1,800

organizations listed by the National Gay Task Force. In addition, *Blueboy* (a national magazine sent to about 225,000 subscribers) published an abridged version of the questionnaire and invited its readers to respond. All who received questionnaires were told that the study was primarily to be regarded as a project in self-awareness; they were requested to complete the questionnaire and return it through the mail without any personal identifiers.

Questionnaires were returned from every state in the nation, the District of Columbia, Puerto Rico, the Virgin Islands, eight provinces of Canada, and several European, Asian, and African countries (see Appendix). Of the 4,329 questionnaires received, 4,212 (97.3 per cent) were regarded as suitable for coding. However, the number of respondents available for analysis for each question was usually less than 4,212 for two reasons: 1) over half of the questionnaires received (2,462) were the abridged version clipped out of *Blueboy*, and 2) respondents did not answer every question that was asked.

Variables

Of the 623 questions included on Part I of the questionnaire, we chose 168 for the statistical analyses that follow.

Major dependent variables were formed on the basis of responses to questions regarding the frequency of venereal infections ("How often have you had the following venereal diseases or sex-related maladies?"). Intervening variables included the frequency of checkups for venereal infections ("How often do you go for VD checkups?"), place of checkups ("Where do you go for VD checkups?"), and reactions to medical care ("In general, how do you feel about the way you are treated when you have VD checkups?"). All other variables included in our analyses were regarded as independent variables (e.g., place of residence, mode of entry into sample, age) or "controls" (e.g., whether the respondent lived in the United States or elsewhere, returned the complete or abridged questionnaire, was under 30 years of age or older).

Excluded from analysis were those questions that focused on feelings (e.g., "Whether or not you engage in any of the following, indicate how you feel about the idea of each of them"), or on behaviors thought to be unrelated to venereal infections (e.g., masturbation).

Statistical Procedures

Responses were coded, key-punched, and entered onto magnetic tape for computer-assisted analyses; they were then analyzed through the use of the Statistical Package for the Social Sciences (SPSS).⁵

To reduce the number of variables available to those significantly ($p < .05$) and most highly correlated with our dependent variables of interest, we used factor, stepwise discriminant, stepwise linear regression, and bivariate correlation analyses. After the 20 or so variables that seemed most important were identified, we continued our multivariate analyses by closely examining selected cross-tabulations and all statistics associated with each table.

Correlation and factor analyses revealed that many self-reported behaviors were highly correlated with one another, so we combined some of these to create indices of more general behavioral patterns. For example, men who frequently had sex in gay baths also tended to have sex in gay bars, public parks and bushes, public restrooms, and peep shows or pornographic movie houses, so we added the answers to these five original questions together and considered our new variable to be an index of furtive sexual activities. Similarly, we created additional indices to measure specific sexual practices, sexual activities associated with homosexual prostitution, and anonymous sociosexual encounters.*

Results

Pediculosis was the most common sexually transmitted disease reported by respondents (66.8 per cent of 4,179 respondents said they had been infested with lice or crabs at least once in their lifetime); herpes was least common (9.4 per cent of 4,160). Self-reports for the first seven diseases shown in Table 1 were highly correlated ($\rho = .750$) with the seven diseases diagnosed among homosexual men in a special study of six sexually transmitted disease clinics conducted in 1976.⁶ Hepatitis was not diagnosed in the 1976 study, but, based on estimates from a five-city clinic serologic survey,⁷ was probably underreported by our respondents.

*Further specifics available on request to authors.

TABLE 1—Self-Reported Venereal Infections: Answers to "How often have you had the following venereal diseases (VD) or sex-related maladies?"

Frequencies of Venereal Diseases	Pediculosis (N = 4179) %	Gonorrhea (N = 4187) %	Nonspecific Urethritis (N = 4158) %	Venereal Warts (N = 4161) %	Scabies (N = 4161) %	Herpes (N = 4160) %	Syphilis (N = 4175) %	Hepatitis (N = 4168) %
Never	31.9	60.0	72.7	79.6	80.7	87.1	85.2	87.7
Once	19.4	15.7	13.2	14.0	12.3	5.3	10.2	9.7
Twice	15.3	8.0	5.4	2.4	3.0	1.3	2.2	—
Three times	11.2	6.2	2.4	0.8	0.9	0.5	0.6	—
More than three times	20.9	8.5	3.1	0.9	0.8	2.3	0.5	—
Not sure	1.4	1.6	3.2	2.3	2.4	3.4	1.3	2.6

In the serologic survey, 21 per cent of clinic patients said they had been infected with hepatitis, but 61 per cent had serologic evidence of infections; only 17 per cent of respondents from four of those five cities in our survey said they had been infected with hepatitis.

Significant correlations were found among the eight sexually transmitted diseases; patients who reported previous infections with one disease tended to report previous infections with each of the others. Of the 160 independent and intervening variables examined, number of different lifetime sexual partners was most highly correlated with syphilis ($r = .249$), gonorrhea ($r = .402$), and hepatitis ($r = .272$).

Risk Indicators for Syphilis

Respondents ranged in age from 16 to 78 years ($\bar{X} = 33.0$, $SD = 10.2$) and had engaged in homosexual activities from less than one to 71 years ($\bar{X} = 13.1$, $SD = 11.3$). As age increased, the proportion who reported having had syphilis increased ($r = .119$, $p < .001$), but self-reports of syphilitic infections seemed to be even more closely tied to number of different lifetime sexual partners ($r = .249$), frequency of checkups ($r = .233$), and years as a practicing homosexual ($r = .202$). Specific sexual activities were also significantly associated with syphilis ($p < .001$): men who frequently engaged in furtive sexual activities ($r = .173$), particularly those who visited gay baths ($r = .183$), and men who frequently paid for sex with money ($r = .136$) had the most cases, as did men who most often engaged in anal intercourse ($r = .113$), and anilingus ($r = .123$). Size of city was significantly correlated ($p < .001$) with syphilis ($r = .105$), but not residency in the United States or elsewhere, completion of the entire or abridged (*Blueboy*) questionnaire, and many of the sociodemographic variables (e.g., education and religion).

The average number of different lifetime sexual partners had to be estimated ($Md = 49.5$) because some respondents reported "over 1,000" and a few simply provided a range (e.g., 400 to 500). The 272 men who said they had had "over 1,000" different sexual partners in their lifetimes accounted for at least 124 different infections with syphilis; in contrast, the 330 men with fewer than seven different partners accounted for only 17 different infections with syphilis. As shown in Figure 1, the relationship between number of different lifetime sexual partners and infections with syphilis held up for men under 30 years of age as well as those who were older, but was clearly stronger for older ($r = .256$) than younger ($r = .077$) men.

Age at first homosexual experience ranged from 3 years to 54 years ($\bar{X} = 16.2$, $SD = 6.8$); this variable was closely linked to place of residence and infections with syphilis. Of the 146 men who had had their first homosexual experience within the past four years and lived outside medium-sized cities or major metropolitan areas, none reported previous infections with syphilis, but 11 out of 156 men (7.1 per cent) who had had their first homosexual experience within the past four years and lived in medium-sized cities or major metropolitan areas reported syphilitic infections. Men with four or more years of homosexual experience reported

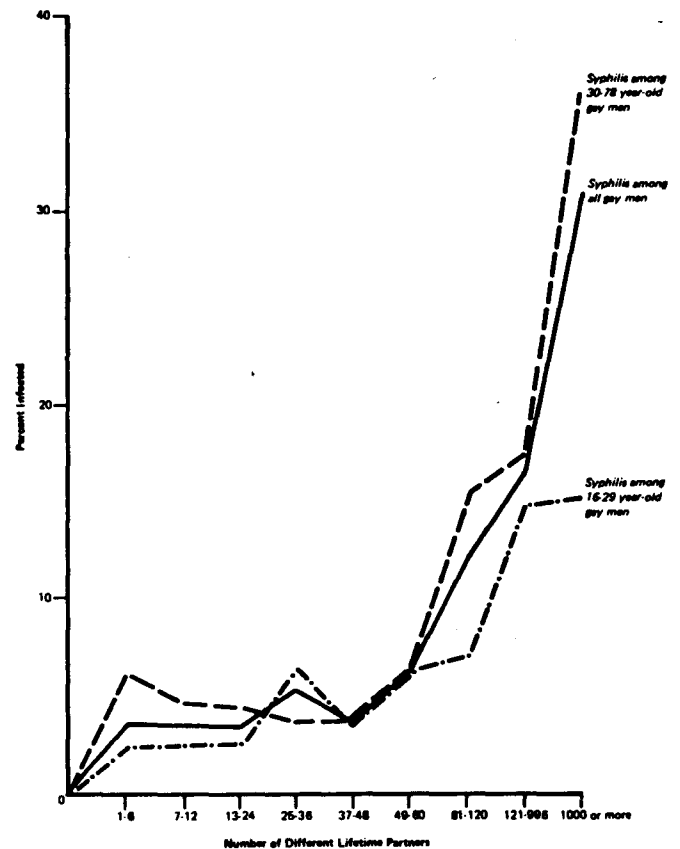


FIGURE 1—Number of Different Lifetime Sexual Partners and the Proportion of Homosexual Men Infected with Syphilis by Age Groups

previous infections of syphilis ranging from 11.0 per cent for those residing in small cities to 21.4 per cent for those living in major metropolitan areas.

Risk Indicators for Gonorrhea

In addition to number of different lifetime sexual partners, gonorrhea was highly correlated with frequency of checkups ($r = .335$), frequent visits to the gay baths ($r = .280$), and receiving money for sexual favors ($r = .153$). As was the case with syphilis, gonorrhea was closely associated with age ($r = .126$), years as a practicing homosexual ($r = .227$), and specific sexual activities ($r = .251$), especially anal intercourse ($r = .134$) and anilingus ($r = .166$). Gonorrhea was more prevalent than syphilis among residents of all places, but particularly major metropolitan areas (Figure 2); 11 of the 13 respondents who lived in major metropolitan areas and had all of their sexual exposures with other men in Turkish baths reported one or more previous infections with gonorrhea.

Risk Indicators for Hepatitis and the Other STDs

The other six sexually transmitted or sex-related maladies studied were also best predicted by number of different lifetime sexual partners (Figure 3), but furtive sexual activities ($r = .147$), especially frequent exposures in the baths ($r = .133$) and frequent contacts with male prostitutes ($r = .128$), were significant correlates of hepatitis.

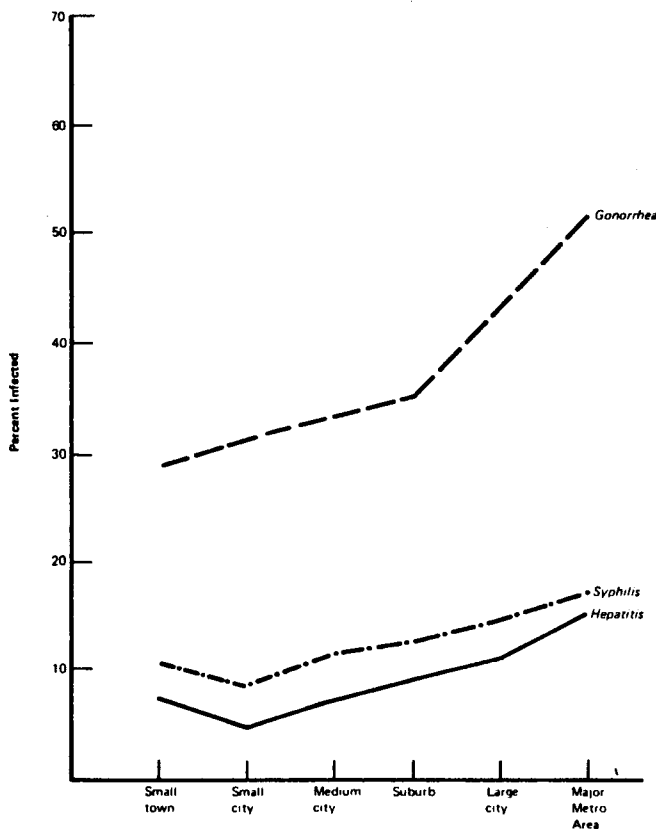


FIGURE 2—Size of Place of Residence and the Proportion of Homosexual Men Infected with Gonorrhea, Syphilis, and Hepatitis

As the frequency of sexual activities in gay baths, parks and bushes, public restrooms, bars, and peep shows or pornographic movie houses decreased (from "always" to "never"), so did self-reports of hepatitis (Table 2). This relationship was significant ($p < .001$) for younger ($r = .156$) as well as older (over 30 years of age) men ($r = .214$), for men with fewer than 100 partners ($r = .086$) as well as those with more ($r = .166$), and for men living in smaller places ($r = .228$) as well as in large cities and major metropolitan areas ($r = .247$). However, the correlation coefficient for hepatitis and furtive sexual activities was significant ($p < .001$) only for men who had been engaging in homosexual activities for more than three years ($r = .249$); it was not statistically significant ($p = .190$) for men who had been engaging in homosexual activities for less than three years ($r = .050$).

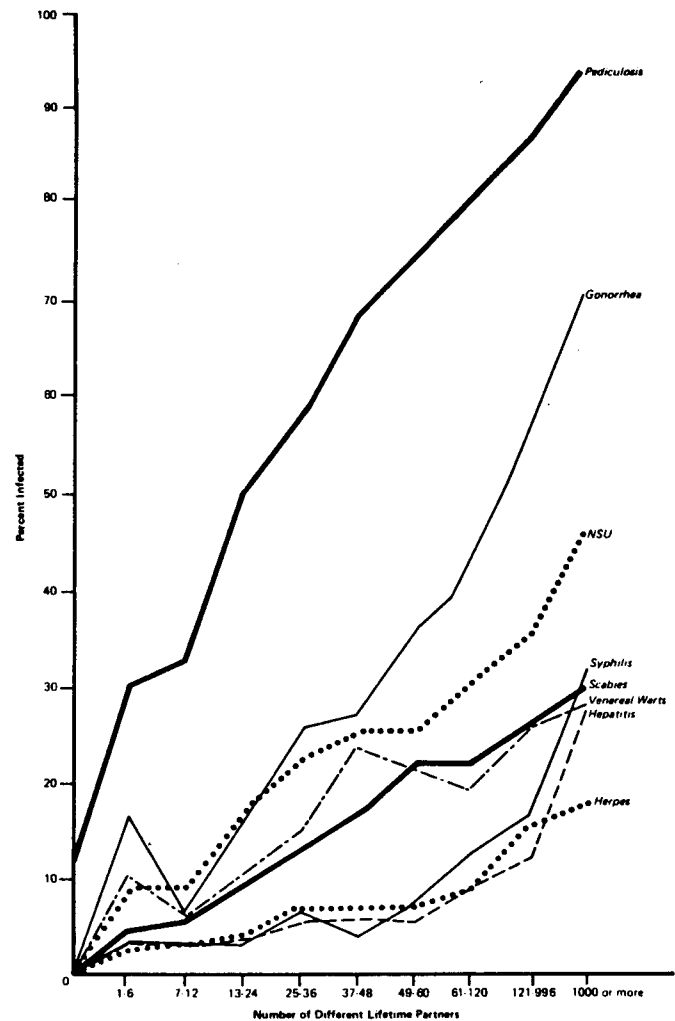


FIGURE 3—Number of Different Lifetime Sexual Partners and Proportion of Homosexual Men Infected with Sexually Transmitted Diseases

Medical Care

Frequency of checkups was considered to be a risk indicator for reporting a history of venereal infection, but it was also considered to be very important in terms of detecting these diseases before they could be transmitted to others. Fourteen per cent of respondents said they received VD checkups once every three months and 21.9 per cent reported having checkups once every six months, but 21.7

TABLE 2—Hepatitis History and Furtive Sexual Activities Reported by Gay Men: Index of Answers to "On the average, how often do you have sex in gay baths, bushes, public restrooms, bars, and peep shows (pornographic movie houses)?"

History of Hepatitis	Always (N = 65) %	Usually (N = 307) %	Often (N = 715) %	Sometimes (N = 751) %	Occasionally (N = 248) %	Rarely (N = 1050) %	Never (N = 906) %	Total (N = 4042) %
No	70.8	81.1	81.5	89.2	90.7	94.5	96.5	90.0
Yes	29.2	18.9	18.5	10.8	9.3	5.5	3.5	10.0

$\chi^2 = 177.2 (6), p < .01; \gamma = 0.447$

TABLE 3—Source of VD Checkups and Feelings about Care

Feelings about Medical Care	Health Care Provider				Total (N = 2768) %
	Gay Clinic (N = 376) %	Personal Physician (N = 1263) %	Other Doctor (N = 116) %	Public Clinic (N = 1013) %	
Very positive	58.0	54.0	37.1	34.2	46.6
Somewhat positive	21.3	14.9	18.1	26.6	20.2
Neutral	13.8	23.3	27.6	21.3	21.5
Somewhat negative	5.3	6.1	12.9	13.9	9.1
Very negative	1.6	1.7	4.3	4.0	2.7

$\chi^2 = 173.9 (12), p < .001$

per cent reported checkups less than once a year, and 22.7 per cent reported never having had a checkup. The more often respondents were examined for venereal infections, the more often they reported gonorrhoea ($r = .335$), pediculosis ($r = .251$), nonspecific urethritis ($r = .240$), syphilis ($r = .233$), scabies ($r = .208$), venereal warts ($r = .208$), hepatitis ($r = .165$), and herpes ($r = .152$).

The number of different sexual partners in the past year best predicted frequencies of VD checkups ($r = .259$). The most common response for number of different lifetime sexual partners was "over 1,000"; the mode (359 respondents) for number of different sexual partners in the past year was "one" ($Md = 9.6$). As number of partners in the past year increased from "one" to "over 100" (270 respondents), the proportion of gay men examined for VD at least once a year increased from 31.5 per cent to 77.4 per cent, and the proportion examined for VD once every three months increased from 6.2 per cent to 30.8 per cent.

Most of those having had VD checkups obtained them from either their personal physicians (39.4 per cent) or public clinics (31.0 per cent). The 376 (11.7 per cent) who attended gay clinics had VD checkups more frequently than others (31.6 per cent were examined once every three months, in contrast to 18.8 per cent for public clinic patients) and seemed to be most satisfied with their medical care (Table 3). The relationship between frequency of checkups and satisfaction with care was statistically significant ($p < .001$) for those examined at gay clinics ($r = .267$), by their private physicians ($r = .289$), and at public clinics ($r = .202$) as well.

Although more respondents sought care from private physicians, those examined in gay and public clinics tended to be examined more frequently ($p < .001$) than those examined by their own doctors ($r = .189$). A stepwise linear regression model showed that respondents with higher incomes ($\beta = .215$), who also tended to be older ($\beta = .039$) and have longer, more established sexual relationships ($\beta = .099$), were most likely to be examined by their personal physicians. Younger men ($r = .276$) who had just begun their homosexual activities ($r = .262$), had not established relationships with one male partner ($r = .230$), and had lower incomes ($r = .303$) tended to visit public clinics, and these clients of public clinics tended to be examined for venereal infections more frequently in spite of their more negative feelings about the way they were treated.

Places of residence and interest in keeping one's homosexuality a secret from neighbors were significantly related to frequencies of checkups, sources of health care, and reactions to medical care ($p < .05$), but these two variables entered stepwise regression equations after such variables as "income," "years as a practicing homosexual," and "number of different sexual partners in the past year." Men who lived in major metropolitan areas (especially, the District of Columbia, Los Angeles, and New Orleans) and small towns or small cities were more likely to visit private physicians than public clinics ($p < .001$); men who lived in major metropolitan areas (especially, Seattle, San Francisco, and Houston) were examined most often ($r = .197$), and residents of major metropolitan areas (especially, Minneapolis, New York, and New Orleans) were most satisfied with their care ($r = .140$). Those who wanted to keep their homosexuality a secret from neighbors tended to visit private physicians rather than public clinics ($r = .094$), tended to be examined less frequently ($r = -.157$), and tended to feel less positive about their care ($r = -.057$).

Discussion

All study samples of gay men are seriously flawed because no one knows the magnitude or basic characteristics of the homosexual population in the United States. Kinsey and his staff⁸ set out to interview 100,000 volunteers in 1938, offered a progress report on the sexual outlets of 5,300 White men in 1948, and were still 81,784 interviews short of their goal when data collection ceased in 1963. The homosexual sample of 2,066 men recently analyzed by Gebhard and Johnson⁹ is a curious mixture of men with 50 or more homosexual exposures or 20 or more different same gender partners gathered from three independent samples: the basic sample of 5,637 men recruited by Kinsey, *et al.*, (407 gay); a sample of 3,244 male prisoners (1,025 gay); and a special sample of 634 homosexuals "known for their deviant sexual bias."

One recent report from the Institute for Sex Research on societal responses to homosexual men was based on self-administered questionnaires sent to members of Mattachine Societies in New York and San Francisco and the Society for Individual Rights in San Francisco.¹⁰ Another report on clusters of homosexual life-styles was based on interviews

conducted with men recruited in the San Francisco Bay area.¹¹ The sample of 4,212 gay men we studied should not be considered as representative of all homosexual men in the United States; generalization to this population should not be made. However, our sample supersedes the sample created by Gebhard and Johnson⁹ as the largest and most diverse available, and offers a basis for comparison with other populations.

Unfortunately, comparisons are very difficult to make because different research investigators have been interested in different research problems at different times; consequently, homosexuals have been defined differently, major variables have been defined differently, and major variables have been measured differently.

In most studies of gay men, the theoretical concept of homosexuality is unclear, and its operational definition is imprecise. Kinsey, *et al*, considered exhibitionism, mutual manipulation of the genitalia, and other forms of preadolescent sex play to be homosexual when carried out in the presence of others of the same gender. Gebhard and Johnson focused on that subsegment of the homosexual population who reported 50 or more homosexual exposures or 20 or more homosexual partners. Weinberg and Williams tell us homosexuality refers to many different things besides sexual outlets chosen; they argue that the concept should apply to a status or roles, but it should not reflect a condition. In our study, anyone who completed a questionnaire and sent it to us was considered to be a homosexual. However, 99.9 per cent of these respondents reported having had sexual exposures with other men.

Of the four other major studies mentioned to this point, only the one that examined the problems of homosexual men (and their resolution)¹⁰ ignored the problem of venereal infections. In the original series of 521 items developed by Kinsey, four questions regarding venereal infections were asked: 1) How old were you when you first learned about venereal disease?; 2) What was the source of that knowledge?; 3) Has fear of venereal disease affected your decision to have premarital coitus?; 4) How many times have you had a venereal disease? Kinsey, *et al*, showed that men with lower levels of educational achievement had more fear of VD, but they never reported on VD knowledge and prevalence. Gebhard and Johnson showed that the 4,673 or so White college men they analyzed tended to learn about venereal disease at the age of 14 years (Md = 13.7); the primary source of information was a same sex peer (44.3 per cent); fear of venereal disease had no (58.5 per cent) or little influence (16.6 per cent) on their premarital behavior; and 0.3 per cent had syphilis, 3.6 per cent had gonorrhea, and 0.2 per cent had both diseases. In contrast, the 631 non-college White men showed 1.4 per cent infected with syphilis, 11.1 per cent with gonorrhea, 0.6 per cent with both diseases, and the 176 college Black men showed 1.1 per cent infected with syphilis, 27.3 per cent with gonorrhea, and 1.7 per cent with both. However, Gebhard and Johnson failed to publish similar results for their homosexual sample.

Bell and Weinberg added the observation that about two-thirds of their Bay-Area homosexual men had at some time contracted venereal disease, but did not crosstabulate

their reports of venereal disease with any of their other 527 questions or with their five clusters of homosexual men. Of the 4,212 men we studied, 2,789 said they had had at least 6,982 cases of pediculosis; 1,609 said they had had at least 3,529 cases of gonorrhea; 1,000 said they had had at least 1,807 cases of nonspecific urethritis; 752 said they had had at least 1,030 cases of venereal warts; 705 said they had had at least 1,001 cases of scabies; 563 said they had had at least 767 cases of syphilis; 403 said they had been infected with hepatitis; and 392 said they had been infected with genital herpes. Of the 4,080 who answered questions about venereal infections with certainty, 3.7 per cent said they had been infected with syphilis, 29.0 per cent said they had been infected with gonorrhea, and 9.7 per cent said they had been infected with both diseases.

Although no other survey has been able to show so clearly the serious problem of sexually transmitted diseases among gay men, retrospective studies of clinic populations have been suggestive. In the United Kingdom, homosexual men examined in 178 public clinics¹² and at the Newcastle,¹³ Charing Cross,¹⁴ and St. Bartholomew¹⁵ hospitals seemed to suffer from syphilis, gonorrhea, and nonspecific venereal infections more frequently than heterosexual men, and the proportion of homosexual men suffering from these diseases appeared to be increasing. In the United States¹⁶ and Canada,¹⁷ reported cases of infectious syphilis among homosexual men appear to be increasing, and many cases of gonorrhea, hepatitis, and anal warts have been reported by gay clinics in Los Angeles,¹⁸ Chicago,¹⁹ and New York.²⁰ The only American study of sexually transmitted diseases in a private medical practice demonstrated high rates of rectal, pharyngeal, and urethral gonorrhea in 79 White, middle-class, homosexual men.²¹ Screening activities at a gay bar in Cincinnati,²² in gay bathhouses in Denver^{23,24} and Los Angeles,²⁵ in gay bathhouses and at a dance in Seattle,²⁶ and at bars, in a bathhouse, and at a Winter Carnival in Chicago²⁷ tend to support our survey results and published findings for various clinic and outreach populations: homosexual men have extremely high rates of syphilis, gonorrhea, and other sexually transmitted diseases.

Recent editorials²⁸⁻³⁰ and a review article³¹ have proposed that homosexual men have higher rates of sexually transmitted diseases than heterosexual men and women because gay men tend to have larger numbers of different sexual partners, more often engage in furtive sexual activities, and more frequently have unprotected anal intercourse. Our data tend to support and extend these hypotheses.

In their analysis of 946 nondelinquent White homosexual men (Md = 26.7 years old), Gebhard and Johnson⁹ found the median number of different lifetime sexual partners to be 20; 8.4 per cent reported having had over 500 different lifetime sexual partners. In their study of 575 nondelinquent White homosexual men (Md = 33 years old) interviewed in the San Francisco Bay area some 20 to 30 years later, Bell and Weinberg¹¹ found the average to be much higher; 43 per cent of their respondents said they had had at least 500 different lifetime sexual partners. In our study of 4,212 homosexual men (Md = 30.7 years old and 95.9 per cent White), we found the median to be 49.5 different lifetime

sexual partners (Md = 200.3 for 195 White men in San Francisco), that 12.5 per cent reported over 500 different partners (32.7 per cent in San Francisco) and that the number of different lifetime sexual partners was the very best predictor of previous infections with syphilis, gonorrhea, and other sex-related infections.

Of the nonclinical studies, Saghir and Robins³² clearly showed more sexual partners among homosexual than heterosexual men: 94 per cent of the 89 homosexual men (Md = 33 years old) and 21 per cent of the 35 heterosexual men (Md = 28 years old) interviewed said they had had 15 or more partners. In clinical studies conducted in Denver³³ and Columbus,³⁴ homosexual men reported more partners in the past month than heterosexual men, but these men were considerably younger than men surveyed outside of clinical settings (about 85 per cent of patients in Denver were under 30 years of age). Gay men who were tested in bathhouses in Chicago tended to be older than those tested in gay bars and at the clinic; they also tended to have more partners and more venereal infections.³⁵

We found number of different lifetime sexual partners to be highly correlated with age ($r = .253$), place of residence ($r = .166$), and a number of other variables, including furtive sexual activities ($r = .514$), sex in gay baths ($r = .392$), and receiving monetary payment for sexual services ($r = .292$), but stepwise regression and discriminant analyses suggested that these variables often contributed independently to the number of venereal infections reported. Thus, homosexual men with large numbers of different sexual partners tended to be older, tended to live in major metropolitan areas, and more frequently engaged in furtive sexual activities. However, even those who had relatively few partners, were younger, and lived outside of large cities and major metropolitan areas still had significantly higher rates of disease if they frequently engaged in furtive sexual activities (especially if they went to gay bathhouses often or were involved in homosexual prostitution).

Although specific sexual activities such as anal intercourse and anilingus did not appear to be as important as number of different lifetime sexual partners and furtive sexual activities, they were significantly related to venereal infections, and often remained so when the effects of number of different lifetime sexual partners and furtive sexual activities were statistically controlled. For example, among 972 homosexual men who had never visited the baths and reported fewer than 100 different partners, number of gonococcal infections was significantly ($p < .01$) related to the frequency of receptive anal intercourse ($r = .078$) and history of syphilis was significantly ($p < .05$) related to frequency of anilingus ($r = .064$). Therefore, men with large numbers of different sexual partners, men who frequently had sexual encounters in gay bathhouses, were involved in homosexual prostitution, or engaged frequently in other furtive sexual activities, and men who often engaged in anal intercourse and anilingus appeared to be at greatest risk of contracting venereal infections; they should be examined more frequently than men whose life-styles do not include these characteristics.

Less attention has been given to questions of medical

care than has been given to questions of prevalence and risk indicators among gay men, but a recent study of 602 respondents to a self-administered questionnaire published in *Gay Community News*³⁶ showed only 49 per cent had shared knowledge of their sexual orientation with their primary health providers; those who had shared this information were more satisfied with their medical care, and, if men, were more likely to have been checked for VD.

In our study, number of different lifetime sexual partners best predicted number of venereal infections, but number of different sexual partners in the past year best predicted frequencies of checkup. Frequency of checkups was significantly correlated with reactions to medical care: those who were examined most frequently felt most positive about their care. Reaction to medical care was associated with usual source of medical care: gay men seemed more satisfied with the services they received in gay clinics. Therefore, public health authorities should improve their medical services for gay patients, and, if the need can be demonstrated, they should encourage qualified members of the gay community to establish and maintain their own VD clinics.

Finally, our data suggest that many gay men suffer frequently from sexually transmitted diseases and a sizable minority of these are never checked for VD. Researchers are challenged with the task of bringing public health workers and gay citizens together for the purpose of developing and implementing better methods of venereal disease prevention, early case detection, and effective treatment. Fortunately, one such effort, the hepatitis B vaccine trial, has just been completed.³⁷

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APPENDIX

As shown below, respondents were slightly more likely to reside in the Northeast and West than the single male adult population of the United States enumerated in 1970.³⁸ Many of the men in the Northeast (45.4 per cent) lived in the state of New York, and most of the men in the West (66.9 per cent) lived in California. Of the 4,329 men who responded, 90.0 per cent (3,898) lived in the United States, Puerto Rico, or the Virgin Islands, 7.6 per cent (329) lived in Canada, 0.5 per cent lived elsewhere, and 1.9 per cent gave no information about their state or nation of residence.

TABLE A—Region of Residence in the United States of Single Male Adults and Gay Male Respondents

Region	Per Cent Single Men 14 years old and older (N = 20,426,937)	Per Cent Single Men 30-34 years old (N = 601,868)	Per Cent Gay Male Respondents (N = 3,887)
Northeast	24.9	28.7	32.5
North Central	27.3	24.8	22.0
South	30.0	27.7	20.9
West	17.8	18.8	24.6

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MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Follow-Up on Kaposi's Sarcoma and *Pneumocystis* Pneumonia

Twenty-six cases of Kaposi's sarcoma (KS) and 15 cases of *Pneumocystis carinii* pneumonia (PCP) among previously healthy homosexual men were recently reported (1,2). Since July 3, 1981, CDC has received reports of an additional 70 cases of these 2 conditions in persons without known underlying disease. The sex, race, sexual preference, and mortality data known for 108 persons with either or both conditions are summarized in Table 1.

The majority of the reported cases of KS and/or PCP have occurred in white men. Patients ranged in age from 15-52 years; over 95% were men 25-49 years of age. Ninety-four percent (95/101) of the men for whom sexual preference was known were homosexual or bisexual. Forty percent of the reported cases were fatal. Of the 82 cases for which the month of diagnosis is known, 75 (91%) have occurred since January 1980, with 55 (67%) diagnosed from January through July 1981. Although physicians from several states have reported cases of KS and PCP among previously healthy homosexual men, the majority of cases have been reported from New York and California.

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Editorial Note: KS is a rare, malignant neoplasm seen predominantly in elderly men in this country. In elderly men the disease is manifested by skin lesions and a chronic clinical course; it is rarely fatal (3). In contrast, the persons currently reported to have KS are young to middle-aged men, and 20% of the cases have been fatal. Although some of the patients have presented with the violaceous skin or mucous membrane lesions

TABLE 1. Cases of Kaposi's sarcoma (KS) and *Pneumocystis carinii* pneumonia (PCP) reported to CDC with dates of onset between January 1976 and July 1981

Diagnosis (number of patients)	Sex		Race of men				Sexual preference of men			Fatality (percentage)
	Male	Female	White	Black	Hispanic	Unknown	Homosexual or bisexual	Heterosexual	Unknown	
KS and PCP (N=7)	7	0	5	0	1	1	7	0	0	3/7 (43%)
KS only (N=47)	47	0	41	3	3	0	44	1	2	8/47 (17%)
PCP only (N=54)	53	1	33	9	7	4	44	5	4	32/54 (59%)
Total (N=108)	107	1	79	12	11	5	96	6	6	43/108 (40%)

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typical of KS, many such lesions have been initially overlooked. Other patients have been diagnosed by lymph-node biopsy after a prodrome consisting of fever, weight loss, and lymphadenopathy. Seven (13%) of fifty-four KS patients also had PCP. In many cases the histopathologic diagnosis from skin, lymph node, or visceral-lesion tissue has been difficult even in specialized hands.

The occurrence of *Pneumocystis carinii* pneumonia in patients who are not immunosuppressed due to known underlying disease or therapy is also highly unusual (4). Although 7 (11%) of the 61 patients with PCP also had KS, in many instances pneumonia preceded the tumor. Although most of the patients with PCP reported recent respiratory symptoms, some gave a history of weeks to months of systemic symptoms including weight loss and general malaise, similar to the prodrome described by patients who developed lymphadenopathic KS. Several of the patients with PCP had other serious infections, including gastrointestinal candidiasis, cryptococcal meningitis, and disseminated infections with Mycobacteriaceae and herpes simplex. Many of the PCP and KS patients have had positive cultures or serologic evidence of infection with cytomegalovirus.

The apparent clustering of both *Pneumocystis carinii* pneumonia and KS among homosexual men suggests a common underlying factor. Both diseases have been associated with host immunosuppression (4-6), and studies in progress are showing immunosuppression in some of these cases. The extent or cause of immune suppression is not known. Physicians should be aware of the possible occurrence of these diseases and other opportunistic infections, particularly among men with symptoms suggestive of these disorders or their prodromes, since therapy is specific and verification of the diagnosis requires biopsy.

Several state and local health departments and CDC are conducting active surveillance for KS, PCP, and opportunistic infections in persons without known predisposing underlying disease. A national case-control study will be implemented shortly.

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