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Highlights from this issue

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Clinicians will want to take an early look at this month's Clinical Roundup,¹ now an established series which is proving popular thanks to its authors Sophie Herbert and Lewis Haddow. This month, we have also rushed into production for our clinical readers a BASHH column,² which introduces the new position statement on the treatment of co-incident rectal chlamydia and gonorrhoea. With the looming spectre of gonococcal antimicrobial resistance, we are likely to see more rapid changes in guidelines and develop a more proactive approach to stewarding the antibiotics that we still have available. Clinicians might be forgiven for thinking that gonorrhoea is a common infection, given the strikingly high prevalence in some clinical populations—especially men who have sex with men (MSM). An interesting modelling study by Hui in this issue³ concludes that oral sex is central to the maintenance of gonorrhoea in MSM populations despite prompt treatment of urethral infections and that even relatively low rates of use of condoms in this context would do much to control its transmission.

There are, however, very few studies of gonorrhoea in a population-based sample. The UK's National Survey of Sexual Attitudes and Lifestyles⁴ is one of very few, and this month Field *et al* present a detailed analysis of gonorrhoea prevalence and test performance in this large sample.⁵ The positive predictive value of a nucleic acid amplification test for gonorrhoea is only 19%, by contrast with 95%, due to the rarity of gonorrhoea in an unselected UK population. This analysis should confirm growing misgivings about the routine addition of gonorrhoea tests to chlamydia tests outside clinical populations. Conversely, a study of *Trichomonas vaginalis* (TV) in a Croatian clinic population of symptomatic and asymptomatic men suggests that there may well be value in providing nucleic acid testing for this pathogen. The difficulty of testing reliably for TV, together with low prevalence in women in many developed world settings, has led to a decline in testing in many settings. However Sviben *et al*'s data suggest that detection in men could reach worthwhile levels⁶ in symptomatic men. The question of what pathogens we should test for is further complicated by an RCT by Khosropour *et al*,⁷ showing that while

persistence of ureaplasma species was common after treatment with standard therapies, it was not associated with persistent urethritis.

How can we optimise STI and HIV testing? Desai *et al* present a systematic review of active recall,⁸ which suggests that generally recall is indeed associated with higher rates of re-testing. However this may well vary by context, with some uncertainty about when SMS testing and home sampling are of value. Some populations of course may be particularly vulnerable to poor access to testing due to provider weaknesses or differences in health seeking behaviour. Schick *et al*⁹ explore the acceptability of self-collected testing in women who have sex with women, advocating for such facilities to be available beyond traditional clinical settings to improve access. We are also reminded of the need to maintain vigilance for STIs acquired non-sexually by Dharmasena's analysis of surveillance data for "ophthalmia neonatorum" which demonstrates massive under-ascertainment, then the cessation of a surveillance system.

A number of studies explore structural determinants of STI, which are increasingly recognised as critical to transmission. Winston *et al* describe high rates of STI and HIV in Kenyan street-connected youth, a situation affecting millions of vulnerable young people across the globe,¹⁰ while a Stoltey *et al* in the USA describe a strong correlation between incarceration rates and diagnosed chlamydia incidence.⁹ A US report by Mansergh *et al*¹² reports that internalised homophobia is associated with increased sexual risk among black MSM but not Latinos. Meanwhile, a study of Portuguese sex workers by Dias *et al* demonstrates its highest rates of HIV at 17.6% among transgender participants,¹³ while Schneider *et al* describe inequalities in vulnerability to HSV in India.¹⁴

Finally a sobering report by Carlos *et al*¹⁵ reminds us of the need for continuing efforts are needed—in different ways across the globe—to counter misconceptions about HIV.

In September, we are looking forward to attending the ISSTD conference in Brisbane and look forward to keeping you up to date as we did at the Glasgow BASHH conference. Keep an eye on our website, blogs, podcast and twitter via @sti_bmj!

Competing interests None

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