LETTERS TO THE EDITOR

Survival of men and women with AIDS: a comparative study

Previous studies of survival after a diagnosis of acquired immunodeficiency syndrome (AIDS) have reported variation in temporal trends in association with age, gender, race, mode of transmission, lymphadenopathy, antiretroviral therapy, and presence of specific opportunistic infections at diagnosis. There are conflicting data, predominantly from the USA regarding survival of women with AIDS when compared with that of men. These studies have attributed a difference in survival between these two groups to factors such as age, initial diagnosis, antiretroviral therapy, CD4+ lymphocyte count at initial diagnosis and the use of health care resources. In the UK, preliminary survival analysis suggested a median survival time for women of 3-5 months. A more recent study, however, suggests mean survival in the region of 15 months. In this retrospective study we analysed the survival of all women diagnosed with AIDS from the beginning of 1990 until the end of 1992 in three major referral centres in London. The data are compared with a matched control group of male patients.

Forty one women were diagnosed with AIDS in our three units (Jeffersiss wing, St Stephens Clinic and Charing Cross Hospital, London) during the study period. Information regarding age at AIDS diagnosis, mode of transmission, ethnic origin, CD4+ lymphocyte count at AIDS diagnosis, the AIDS defining diagnosis and the use of antiretroviral therapy and Pneumocystis carinii pneumonia (PCP) prophylaxis were recorded on a standardised information collection sheet. The data were obtained from a computer database and supplemented by direct inspection of the notes. The control group of men was matched for year of AIDS diagnosis, age and CD4+ lymphocyte count. The collected data were analysed using the Kaplan-Meier curves and the logrank test.

The mean age of the women and men was 33-4 yrs and 35-6 yrs respectively. Thirteen women and seven men (not taking into account the patients with PCP at initial diagnosis) had PCP prophylaxis and 27 women and 22 men had AZT at some stage after AIDS diagnosis. Thirteen women and 19 men died during the period of study. There was no difference in survival between the two groups (logrank test: \( \chi^2 = 0.15, p = 0.6949 \)). The number of women presenting initially with AIDS was 8 (47%), 3 (30%) and 2 (14%) in 1990, 1991 and 1992 respectively. The reduction in the number of women presenting initially with an AIDS defining diagnosis is encouraging and suggests earlier diagnosis of HIV infection in this group. The commonest AIDS defining diagnosis in women was PCP (63-4%). Twelve (70%), 7 (70%) and 7 (50%) women had PCP as the initial diagnosis in 1990, 1991 and 1992 respectively. The reduction in PCP as an index diagnosis may reflect the increasing usage of effective PCP prophylaxis.

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Sexual health: a survey of knowledge, attitudes and practice of sexual health in adolescent females

It was interesting to read about similar unsafe sexual behaviour in patients attending clinics for genitourinary medicine (GUM), family
planning (FPC) and termination of pregnancy (TOP) in London.1 This may stem from inadequate education on sexual health provided in schools.

We recently looked at all new female patients aged 13–20 years attending two clinics, an FPC and a GUM clinic in Swansea. Patients were asked to complete a questionnaire concerning their knowledge of sexually transmitted diseases (STDs), contraception, and attitudes to sexual health education. Eighty-five patients from each clinic were enrolled between March and October 1992. Thirty-seven (43·5%) patients in the FPC group reported that they had no formal teaching on STDs and 26 (30·6%) said they had no teaching about contraception. Comparable figures for the GUM group were 49 (57·6%) and 29 (34·1%) respectively. Twenty-eight (32·9%) of women in the FPC group had obtained their information on sexual health from friends compared with 31 (36·4%) in the GUM group. No or inadequate contraception was used by 10 (11·7%) and 13 (15·3%) of the FPC and GUM groups respectively. In the FPC group, 49 (57·6%) said that they would prefer to have sexual health teaching from a school nurse or teacher (cf 49·5% in the GUM group) whilst 15 (17·8%) in each group indicated a preference to be taught by a visiting doctor.

Previous research carried out in the GUM department in Swansea showed a high incidence of genital infection in adolescents and lack of effective contraception with a particularly low rate of use of condoms.2 Our more recent data confirm a lack of education on both STDs and contraception in the local FPC and GUM clinic population. We agree with Radcliffe and colleagues1 that closer integration between GUM services and family planning clinics is desirable and our figures suggest that there is a need for health education in both groups. The need for closer cooperation between the medical and teaching professions has also been highlighted in a previous study3 and our current data would support this. If we are to achieve the targets on reducing teenage pregnancies and the incidence of gonorrhoea set out in the government white paper (Health of the Nation), there is an urgent need to improve sex education in our schools.

Audit of diagnosis of gonorrhoea at first visit to a London genitourinary medicine clinic

The rapid and accurate detection of *Neisseria gonorrhoeae* may result in reduced transmission and complications of gonococcal infection. Microscopy of Gram stained specimens remains important for early treatment of *N gonorrhoeae*. A survey at our clinic demonstrated that the sensitivity of microscopy for gonorrhoea was lower than the 70% detection rate for cervical infection and 50% detection rate for rectal infection reported in previous studies.12 Therefore, we undertook an audit to establish the sensitivity of microscopy in the diagnosis of *N gonorrhoeae* and to identify any factors associated with reduced accuracy of diagnosis.

The results of microscopy of all Gram stained smears were compared with cultures taken to diagnose gonorrhoea over a one year period. In addition, over a three month period the chief Medical Laboratory Scientific Officer (MLSO) reviewed all slides from specimens which proved culture positive for *N gonorrhoeae* but on which no gonococci were detected by nursing staff. The MLSO assessed the specimen content, spreading and staining of the slides. The notes of 96 of 114 cases of gonorrhoea presenting during this three months were reviewed. The slides on which Gram negative intracellular diplococci were identified by nursing staff, but for which the *N gonorrhoeae* culture was negative, were regarded as true positives when the findings were confirmed by the chief MLSO. The slides on which “suspicious pairs” of diplococci were seen were regarded as positive, as this increased sensitivity of the test and maintained adequate specificity.

The sensitivity, specificity and positive predictive value of the tests under scrutiny are presented in the table.

The chief MLSO detected *N gonorrhoeae* in 16 of 25 specimens in which no gonococci were identified by nursing staff. One third of these slides were considered inadequate by the chief MLSO; 66% of rectal slides were contaminated with excess faecal flora, 30% of cervical with excess vaginal flora, 15% were poorly stained and 5% had insufficient quantities of specimen.

Case note review demonstrated that 46 (96%) of 48 cases of symptomatic urethral infection and 7 of 9 cases of symptomatic rectal infection were diagnosed by Gram stained smear. Of the 96 patients, fourteen reported that they were contacts of gonorrhoea, 10

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