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Same day testing for HIV: 1 year's experience in a district general hospital and at an alternative site

In the Department of Health's white paper, the Health of the Nation sexual health, including HIV and AIDS, is identified as one of the key areas of health targeting. Counselling and screening for HIV forms an important part of sexual health and the service should be widely available. Experience suggests, as stated in HIV/AIDS and Sexual Health, that where available many would prefer to attend a clinic separate from current services. In response to the executive letter from the Department of Health, a same day HIV counselling and testing service was developed at Bolton General Hospital, and at an alternative site in the town centre. We present the results of this service over a 12 month period.

In May 1994, a same day testing service was introduced in addition to the routine clinic testing, available 1 day a week by appointment only, both in the hospital department and also at an alternative (town centre) site. The same day service was advertised locally. All patients attending for HIV testing were given pre- and post-test counselling and sexual health advice at both sites.

Over the 12 month period, 218 patients made appointments for same day HIV antibody testing. The default rate for the same day testing service was 22.5% (n = 49). The same day test site had a higher attendance rate than the alternative site (table). There was one positive HIV antibody result in a homosexual man who was asymptomatic. Six patients requested testing because of a possible risk of HIV infection from non-occupational sexual medical treatment. All of these opted to be tested at the clinic site, their choice perhaps reflecting concerns which they felt might be better addressed in a hospital setting. Some day testing accounted for 41.8% of the total number of HIV tests within the department.

The current arrangement for HIV antibody testing in genitourinary medicine clinics within the hospital setting has the advantage that the service is widely available and testing is performed in an anonymous and confidential manner. This testing service may have its drawbacks for certain patients who find attending a genitourinary medicine clinic a daunting prospect, especially if the department is based inside a large hospital which is not readily accessible from the local town centre. Other authors have reported successful same day testing services within city centres; however, this is the first paper to report results from a district general hospital setting together with the use of an alternative site. Our results show that a significant proportion of patients opted for the same day testing service and when given the choice of site, patients were more likely to attend the same day hospital service than the alternative site. Further work is required to ascertain reasons behind the high default rate of patients requesting same day HIV testing, as little is known about the sociodemographic details and risk factors among this group. Future evaluation should include qualitative feedback from patients on the issues surrounding same day testing within the optimal testing procedure and site.

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Who goes to sexually transmitted diseases clinics? Results from a national population survey (Genitourin Med 1996;72:197-202)

We read with great interest Dr A M Johnson and colleagues' sexual behaviour survey of GUM clinic attenders, published in Genitourin Med. The findings of the study now make available good population based data on the characteristics of genitourinary medicine clinic attenders, which will be applicable to many aspects of further research and service planning.

However, we wish to comment on one point made by the authors, they saw a reduction in median survival over time in their patients.

Furthermore, the authors suggest that in our study we both failed to acknowledge improvements in survival made before the study period from St Mary's Hospital and did not adjust for case mix in the two arms. In fact, earlier data were acknowledged and referenced and the case mix of the two arms was described in detail.

Hillman et al conclude in their paper that small differences may now a more informal and intimate setting for patients to be treated. This, however, is not supported by their data and is, therefore, only an unsubstantiated assertion. Others, we are sure, would argue against it.

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MATTERS ARISING
Although the authors Matters now collect statistics from Scottish using unique July we hope in tandem with due attention to behaviour and non-bacteriuric categories. find had a "two glass urine test" was used among male GUM clinic attenders in Glasgow compared with a control population (in a nearby family planning centre) and we hope that many similar developments will be possible in the future, as a result of this fundamental improvement in the methodology of our data collection.

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Urinary symptoms, sexual intercourse and significant bacteriuria in male patients attending STD clinics

We read with interest the recent paper by David et al.1 on urinary symptoms and bacteriuria among male STD clinic attenders. The authors state that urethritis and UTI cannot be distinguished on clinical grounds and/or urethral smears. We were surprised that no mention was made of the "two glass urine test" as a means of distinguishing pure urethritis from a combined urethritis/cystitis. We find this a useful test—since July to this year 11 men attended our department with a documented UTI; nine of these had a cloudy second catch urine (not due to phosphaturia). We would, therefore, be interested to hear whether the authors can provide details of the two glass urine test results in their patients with both bacteriuric and non-bacteriuric urinary symptoms.

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The authors reply: Although the "two glass urine test" is a time honoured practical test in all house clinics, we did not include it in our study. This test in our opinion is subject to observational variation and interpretation. We think that looking under the microscope for qualitative assessment of cases, as the authors state, is less subject to observer variation and is more scientific. In the Cambridge group only nine of the 11 patients with urinary tract infections had a cloudy second urine, while all the 13 patients with urinary tract infection in our study were found to have pyuria.

LOAY DAVID DAN NATIN

Antibiotic treatment for gonorrhoea in the UK

The emergence of resistance to quinolones in Neisseria gonorrhoea was highlighted in the review by Ison2 and in the report by Abeyewickreme and others.3 However, in the UK quinolones are becoming ever more widely used and have now overtaken penicillin as the drug of first choice. The National Audit of gonorrhoea management questioned all clinics in the UK about cases diagnosed in the first three months of 1995 and received data on 1308 cases, 59% of all reported in the quarter. The antibiotics used fell into the following classes: quinolones 48%, penicillins 40%, spectinomycin 3%, others/not recorded 9%. For those patients known to have had gonococcal infection outside Europe, and when penicillin producing Neisseria gonorrhoeae (PPNG) was presumably thought to be more likely, the choice (ignoring single use and unspecified drugs) was: quinolones 73%, penicillins 23%, spectinomycin 4%.

Ciprofloxacin resistance is still rare in the UK, but in 1995 the highest ever annual total of ciprofloxacin resistant strains was identified by the Gonococcus Reference Unit, while PPNG isolates were still below their 1992 figure.1 The Reference Unit data rely on voluntary reporting with its attendant limitations. The National Audit figures show that antibiotic choice has moved away from penicillins, so it is now particularly important that information monitoring of the extent of ciprofloxacin resistance is available to UK genitourinary physicians.

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Epidemiology of gonococcal and chlamydial infections in Harrow and Brent

Matondo and colleagues report on gonococcal and chlamydial infections in Harrow and Brent.1 I would agree that it is important to perform such work since it can help "the quantification of the problem in the community" and allow for the development of "a profile of STDs in our catchment population". Sadly, they have done neither of these two since their sampling is limited solely to those using the genitourinary medicine (GUM) clinic at Northwick Park. An earlier study (not mentioned by the authors), also carried out in Brent and Enfield, was able to link to both of these.2 This study was conducted to identify and estimate the proportion of female patients suffering from gonorrhoea, trichomoniasis and candidiosis, both with and without any symptoms, and if they were failing to seek care at all. Samples of women in Brent and Harrow were studied in antenatal, gynaecology, family planning, and GUM clinics, and in general practice. This comprehensive study was made into a national survey with multiple agencies, subsamples of non-consultors on general practitioner lists, and residents seeking care at STD clinics anywhere in England, and thus gave a true prevalence incidence and prevalence.

The authors recognise that there are limitations to their study from only sampling attenders at one clinic within both Brent and Harrow, but they should not then make claims about asymptomatic cases being overtaken penicillin in the UK.

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Epidemiological treatment and tests of cure in gonococcal infection: evidence for value

In his otherwise excellent review article,1 Chris Carne makes the classic mistake in his conclusions of quoting somewhat spurious percentages rather than absolute values. He says that 42%-6% of treatment failures will be missed if tests of cure are not routinely performed on male gonococcal bacterial infection. However, a closer look at these figures shows that out of the original 4897 men, only 183 (3-7%) were treatment failures, of whom only 78 (1-6%) were asymptomatic; therefore 67 (1-6%) of the total would remain infected after treatment if a policy of test of cure for asymptomatic men were not followed; a more meaningful statistic. As Carne himself points out in the article, the cost of identifying each of these very small numbers of cases in America was estimated to be in the range $4900 to $109 800 per case. It might therefore be argued that a more cost effective use of this money would be to

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