Global views

Gonorrhoea control programme in Athens, 1974–98

Introduction
A prominent theme today is the influence of dynamically changing demographic and sociocultural forces on the spread of sexual transmitted diseases (STDs). In most industrialised countries the incidence of classic STDs such as gonorrhoea has been declining rapidly among the educated middle and upper classes.1

The aim of this study was to evaluate a gonorrhoea case finding programme which took place in Athens from 1974 to 1998 (25 years).

Patients and methods
The study was approved by the Greek ethics committee.

The gonorrhoea case finding and treatment programme took place between 9 am and 12 noon on 6 days per week between 1 January 1974 and 31 December 1998. People were recruited for examination in “A Syngros” Hospital, Athens, then taken to the same hospital for further investigation and treatment.

Diagnostic tests
Direct microscopy and culture were the mainstay of gonorrhoea diagnosis. Samples could be Gram stained and examined by light microscopy to yield a diagnosis within 5 minutes. Accuracy varied with the site sampled and the experience of the microscopist. If there was a strong likelihood of infection and if presumptive treatment had not been given, a second or even third set of cultures performed on subsequent occasions maximised detection.

Isolation of gonococci was also improved by the parallel use of selective and non-selective media. In practice, acceptable results were active with moderately selective media. Carbohydrate utilisation tests or newer methods such as co-agglutination and chromogenic enzyme substrates were used.

Treatment
Patients were interviewed, informed of potential side effects, and asked to sign a form allowing treatment. Penicillin cured more than 90% of all gonorrhoea infections. By the late 1980s, penicillin therapy for gonorrhoea was no longer recommended because of widespread gonococcus resistance. Instead, another relatively inexpensive drug, such as tetracycline, ciprofloxacin, ofloxacin, ceftriaxone, or quinolones, became widespread in Greece. Because clinical series have historically documented coinfection with Chlamydia trachomatis in patients with gonorrhoea—as high as 20%—routinely co-treating for chlamydia in all cases of gonorrhoea has been an important public health measure for chlamydia control. Consequently, either azithromycin or doxycycline should be given.4

Results
Figure 1 shows new gonorrhoea cases for each year between 1974 and 1998 in men and women. During this programme 1 643 823 subjects were examined, of whom 858 879 (52.7%) were males and 784 944 (47.8%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females. Among positive cases 9834 (98.6%) were males and only 143 (1.43%) were females.

Discussion
During the past 25 years major changes have been made in the notification of new gonorrhoea cases, especially those related to the male population. From 1974 to 1984 the new cases among males were over 450 per year and thereafter gradually declined.

In contrast, during the same period of study the number of cases among women remained almost stable. It is estimated that the affected males visited our hospital much more often because their symptoms were obvious and severe and they had not been afraid of social stigma associated with their examination for the disease. Interestingly, the observed very small number of female patients could be because of self treatment, the fear of a social stigma, and/or a general unwillingness to be examined by a doctor.

As was expected urethritis was the predominant clinical finding (95%) among men followed by a gonorrhoea infection of the rectum which was very common among male homosexuals (41%). The cervix was most often affected in women (43%).

Additionally, data available from this programme for active gonorrhoea among occupational groups are presented in table 1.

Table 1 Reported gonorrhoea cases by sex, drug use, involvement with prostitution and other occupations (where available). Programme cases (n = 9977)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No of cases</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>9834</td>
<td>98.57</td>
</tr>
<tr>
<td>Females</td>
<td>143</td>
<td>1.43</td>
</tr>
<tr>
<td>Users of any illicit drug</td>
<td>783</td>
<td>7.84</td>
</tr>
<tr>
<td>Homosexuals</td>
<td>696</td>
<td>6.98</td>
</tr>
<tr>
<td>Prostitutes and clients</td>
<td>2248</td>
<td>22.6</td>
</tr>
<tr>
<td>Food retailers</td>
<td>56</td>
<td>0.56</td>
</tr>
<tr>
<td>Wholesalers</td>
<td>34</td>
<td>0.34</td>
</tr>
<tr>
<td>Nurses</td>
<td>28</td>
<td>0.28</td>
</tr>
<tr>
<td>School workers</td>
<td>12</td>
<td>0.12</td>
</tr>
<tr>
<td>Hotel workers</td>
<td>1285</td>
<td>12.87</td>
</tr>
<tr>
<td>Seafarers</td>
<td>1771</td>
<td>17.75</td>
</tr>
<tr>
<td>Other (clerks, nurses, drivers, etc)</td>
<td>1616</td>
<td>16.18</td>
</tr>
<tr>
<td>Unknown</td>
<td>1448</td>
<td>14.51</td>
</tr>
</tbody>
</table>

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In addition, the observed continuing decline in the incidence of the disease as well as in the absolute number of the identified cases, especially in men, from 1984 up to the end of 1998 could be due to the following reasons: (a) the better standard of living, (b) the use of a condom as a preventive measure against AIDS, (c) a higher education level, and/or (d) the opportunity of a medical examination in a private venereal clinic, avoiding self presentation to our department.

On the other hand, the median age of gonorrhoea cases as well as the number of the identified cases showed a continuing decline, which stopped from 1981 to the end of 1984, when a strong wave of immigration from eastern Europe, especially from Russia, moved to Greece. It is well documented that

Figure 1 Gonorrhoea case finding programme.
Prevalence of Chlamydia trachomatis infections in women attending six women’s healthcare units in Kaunas, Lithuania

Introduction
Knowledge about the morbidity caused by Chlamydia trachomatis in eastern Europe is still insufficient. Reporting systems of sexually transmitted diseases and diagnostic tools, especially for the diagnosis of chlamydial infections, are still suboptimal, epidemiological studies are costly, and national resources devoted to STD prevention and control are small.

The aim of this study was to investigate the prevalence of C trachomatis infections in Lithuanian women, attending six main healthcare units in Kaunas, the second biggest Lithuanian town (500,000 inhabitants) and to learn about risk factors related to genital chlamydial infections.

Materials and methods
Women (n=1008) attending four gynaecological outpatient clinics and two antenatal clinics in Kaunas (Lithuania) between November 1999 and December 2000 were enrolled.

Study participants were given a standardised questionnaire concerning social status, sexual behaviour and contraceptive habits, medical and sexual history, and presence of genitourinary symptoms. Pelvic examination was carried out using a standardised examination protocol.

Direct microscopy of the vaginal wet mounts, methylene blue stained urethral and cervical smears was done “bedside.” The direct immunofluorescence (DIF) test (Syva MicroTrak Chlamydia trachomatis Direct Specimen Test, Trinity biotech, Ireland) was used for chlamydia antigen detection.

Results
The median age of the population tested was 25 (mean age 26.1) years. Of the patients who answered the question about the reason of visiting, 513 (59.2%) came for symptom evaluation, 300 (34.6%) for a regular check up, and 53 (6.1%) for a test of cure. There was no significant difference in the reason to attend different clinics.

The overall prevalence of C trachomatis infection was 8.4%. The highest prevalence of C trachomatis was observed in women below 19 years of age (17.4%), in women 20–40 years decreasing to 6.1–7.9%. In women older than 40 years, there was seen to be a further decrease to 2.9%.

There was a significant difference between the medical facility and the prevalence of C trachomatis infections. Thus, C trachomatis positive patients were: 6.7% of the women consulting OPGC I; 4.5%, OPGC II; 4.0%, OPGC III; 11.3%, OPGC IV; 9.5%, AC I; and 13.5%, AC II; respectively (p<0.001).

Figure 1 demonstrates the association between the percentage of young people (below 19 years of age) attending a certain health facility and the prevalence of C trachomatis infection.

T. vaginalis was detected in the wet mounts of 2.9%, candida in 14.3%, and bacterial vaginosis in 14.1% of the women tested. Neisseria gonorrhoeae was detected in 0.4% of the cervical smears.

Smokers (n = 243; 24.3%) were significantly more often chlamydia positive compared with non-smokers (13.2% v 7%, OR 2.0, 95%CI 1.3–3.2; p<0.005). Smokers had significantly more often than two sexual partners during the last 2 months compared with non-smokers (41.3% v 23.6%, OR 2.3, 95%CI 1.2–4.2). Significantly more smokers had had their first sexual intercourse at below 18 years of age (p<0.001).

The median age at sexual debut was 18 years (mean 19 (SD 2.7)). The median number of partners during the last 6 months was 1 (range 1–2), during 12 months 1 (1–7), during their lifetime, 1 (1–50). Significantly more women who started their sexual life
before 18 and had more than one sexual partner during the 6 or 12 months had a chlamydial infection.

The reason for attending, marital status, education, occupation, past or present genitourinary symptoms, a history of reproductive tract infections, day of the menstrual cycle, child birth, legal abortions or miscarriages did not affect the incidence of *C. trachomatis* infection.

Approximately one fourth of the women could not answer the question about their sexual partner's genit symptoms, if any, or if he was tested for any reproductive tract infections, neither did they know if he had ever had any infection. *C. trachomatis* positive women more often had cervical discharge (44% v 22%, OR 2.7, 95% CI 1.7–4.4; p<0.000), which was mostly mucopurulent (37% v 10%, OR 3.0, 95% CI 1.3–6.1, p<0.000).

*C. trachomatis* positive women significantly more often had concomitant infections with *T. vaginalis* (7.1% v 2.5%, OR 2.9, 95% CI 1.1–7.1, p<0.02) and *N. gonorrhoeae* (2.4% v 0.3%, OR 7.3, 95% CI 1.0–43.1, p=0.02), as well as bacterial vaginosis (21.2% v 13.5%, OR 1.7, 95% CI 1.0–2.9, p=0.05) and cervicitis (32.9% v 10.5%, R 9.6, 95% CI 6.0–15.5, p<0.000). There was no significant difference in the number of candida infections or the finding of urethritis between men.

**Discussion**

In the present study we found the prevalence of *C. trachomatis* infection to vary between six different healthcare units from 4% to 13.5%. This difference was not caused by differences in reasons for visiting but by the proportion of visitors below 19 years of age. This group had a prevalence five to eight times greater than that of the following 5 years age groups. In a previous study conducted on the female population in Klaipeda,1 the prevalence peak was at 24 years of age. This exemplifies that when tailoring prevention programmes one has to be aware of the age specific prevalence.

In this study smoking was associated with chlamydial infection. Probably smoking itself was not a risk factor, but smoking women significantly more often had had more than two sexual partners during the last 6 and 12 months. They also became sexually active earlier—that is, smokers belong to a group with "risky behaviour," a fact also noted by others.1

The presence of current symptoms or a history of reproductive tract infections did not influence the presence or absence of *C. trachomatis* infections in the present study. This could reflect the women's awareness of symptomatology in general.

Cervical discharge, especially of a mucopurulent character,2 is a well known marker for having genital chlamydial infection. These signs were significantly more often expressed in *C. trachomatis* positive women in this study. Since most STDs have common risk factors, anyone with one infection diagnosed is at higher risk of having several infections.3 This is also supported by the present study.

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Conflict of interest: none.

**Contributors:** MD initiated, designed and supervised the study, worked on this paper, and conducted a statistical analysis; AH co-supervised the study and was working on the manuscript; RB was helping with the study design, its technical performance, data computing and interpretation; TS and VJ were helping with the study design, its laboratory performance, and interpretation; DM, RJ, VP, JB, and MG were responsible for sample collection and evaluation at the study site.

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