LETTERS TO THE EDITOR

Chlamydial infections in children

EDITOR,—We know that Chlamydia trachomatis infections (serovars D-K) are a significant cause of morbidity in the adult population, particularly young women. This justifies the considerable efforts and costs of preventing, diagnosing, and treating chlamydial infections. It is also well established that C trachomatis can cause conjunctivitis and pneumonitis in neonates and infants as a result of vertical transmission.

There is no doubt that symptomatic children should be treated but should we also treat asymptomatic carriers? What would be the benefit of screening asymptomatic children of mothers who were proved or have a history suggestive of C trachomatis infection during their pregnancy? Should we treat these children systematically? Up to what age? These questions have recently arisen in our department after the diagnoses of C trachomatis conjunctivitis in several small children.

The American guidelines for the management of sexually transmitted infection do not recommend prophylactic treatment to infants of chlamydia-positive mothers but close clinical supervision and treatment if symptoms develop. These guidelines do highlight the importance of antenatal screening as the main preventive measure in the vertical transmission of C trachomatis. Routine prophylaxis with silver nitrate or topical antibiotics would not prevent C trachomatis transmission. Neither the UK national guidelines nor the SIGN (Scottish Intercollegiate Guidelines Network) guidelines address the issue.

In preadolescent children sexual abuse should be considered when a diagnosis of C trachomatis has been made, although there are reports of perinatally transmitted infections up to the age of 3 and in our department a family cluster of C trachomatis infection has been recently been reported, including a 6-year-old girl in whom there was no evidence of sexual abuse.

We await with interest the results of the pilot chlamydial screening projects in Portsmouth and the Wirral but suggest that routine antenatal screening for C trachomatis infections with a nuclear amplification test (NAT) would reduce perinatal and infant morbidity and possible infection in children, who are asymptomatic or not. At the very least, targeted antenatal screening of higher risk groups (young pregnant women up to 25, or those with new or multiple partners, as recommended by the American guidelines) should be clearly specified in the current UK guidelines.

A negative reliable chlamydial test documented during a pregnancy would make a diagnosis of C trachomatis infection in a child less likely to be of vertical perinatal transmission.

In the meantime, what should we do? Investigating and treating asymptomatic children as "contacts" may cause unnecessary anxiety and unpleasantness to both child and parents. Epidemiological antibiotic treatment is not exempt of risks to the individual patient and is likely to increase resistance in the general population.

We would welcome the view of clinicians and thus perhaps open a debate in an area of sexually transmitted infections in which not much is known.

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Accepted for publication 30 August 2001

Self treatment among a sample of first time attenders at a genitourinary medicine clinic

EDITOR,—Many people self medicate or seek advice from others before attending a medical consultation and while this has been documented for a number of conditions, there is little reason to suppose the behaviour will be different for a sexually transmitted infection (STI). There may be specific problems with self medication for STIs since they may mask symptoms and syndromes and prescribed use of antibiotics may select for resistance among strains of Neisseria gonorrhoeae and other bacteria residing within and outside the genital tract. We examined all aspects of self care in a sample of first time attenders at a GUM clinic in the United Kingdom. There were 492 consecutive first time attenders in a 3 month period, of which we achieved the participation of 188 clients (128 females, 60 males).

Information was collected via structured interview carried out by a health adviser. We asked about a range of issues concerning treatment seeking and symptoms experienced by clients. We specifically asked clients what measures they had taken between suspecting an STI and attending the clinic. Forty four respondents (23%) reported using a medication or remedy before attending the clinic. A total of 80 remedies were mentioned. The most commonly reported treatment was the use of Canesten (n=15), followed by paracetamol (n=5), antibiotics (n=5), Diflucan (n=3), and unspecified pessaries (n=3). Sixteen other medications were reported, of which 12 were identified by brand name. Two respondents (one on the recommendation of her mother) reported drinking lemon barley water and one drank cranberry juice. One person drank more water than usual, another drank less. Avoiding milk and bread, eating live yoghurt, and taking bicarbonate of soda were all mentioned by at least one respondent. Most treatments were acquired either from the chemist or from trusted others; these latter included a wife, a sister, two friends, and two mothers.

These findings fit well with data from other countries and support a large US study.1 The wide range of self treatments attests to the lack of knowledge about what might or might not “work” as a treatment for the symptoms of a sexually transmitted infection. The very large number of named “products” is striking. Remedies involving changing eating and drinking patterns are fairly common and are usually the consequence of advice from others. Given the stigma associated with having a suspected STI it is not surprising that only a few respondents discussed their treatment strategy with others.

It is important that genitourinary clinic staff recognise that a significant proportion of patients attending will have tried some form of self medication. It would be desirable to establish which products have been tried and how recently. There is also an opportunity here for offering advice and education for the future and ensuring that people have a good understanding of the role of antibiotics.

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Accepted for publication 30 August 2001

Circumcision and STD in the United States

EDITOR,—The study by Diseker et al.,2 though examining too small a study population to obtain statistically meaningful results in some aspects, is commendably objective. Their study tends to confirm previous research findings relative to circumcision versus syphilis and gonorrhoea, the majority of which indicate a strong (protective) relation between the non-circumcised state and syphilis and a weaker relation with gonorrhoea.

A brief examination of this and several previous studies going back 150 years on circumcision versus syphilis and gonorrhoea reveals an intriguing relation: syphilis is proportionally lower in circumcised men than it is in uncircumcised men. In 1855, Hutchinson,3 in England, reported a syphilis:gonorrhoea ratio of 0.23:1 for Jews and 1.54:1 for non-Jews (all ratios in this letter are my re-expressions of the original data). In 1934 Wollbarst,4 a NY urologist examining 1500 cases, reported a ratio of syphilis and chancreoid to gonorrhoea of 0.36:1 for circumcised men and 0.78:1 for uncircumcised men (only 5–25% of American men can were routinely circumcised in the late 19th century/early 20th century).5 I note from Diseker et al’s table 2 (Cross section analysis at baseline) that the ratio of syphilis to gonorrhoea is 0.06:1 in circumcised men

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Hepatitis B and C seroprevalence in Novosibirsk, western Siberia

EDITOR,—Chronic liver disease represents one of the major public health problems in Western countries. Hepatitis B and C viruses are becoming the main causes of cirrhosis and primary carcinoma. Hepatitis C virus (HCV) accounts for approximately 20% of cases of acute hepatitis, 70% of chronic hepatitis, and 30% of end stage liver disease in the United States.1 Today, injecting drug users and high risk sexual activity are the most frequently identified risk factors associated with HCV infection.2 Likewise, in areas of high endemicity of hepatitis B virus (HBV), potential transmission is the main route of transmission, whereas in areas of low endemicity, sexual contact among high risk adults is predominant.3

Epidemiology of viral hepatitis is studied mostly in blood donors and patients; however, it is unknown whether donors represent the general population. The prevalence of viral hepatitis among children and adolescents is rarely investigated. However, in Italy the highest incidence of new hepatitis B cases (approximately 10 in 100 000) currently occurs in subjects between 15 and 24 years of age,4 and in Russia young adults aged 15–29 account for 70–80% of acute viral hepatitis cases.5

The aim of the present study was to evaluate the occurrence of HBV and HCV markers among various population groups of Novosibirsk (western Siberia), Russia. Novosibirsk is the largest city in Siberia and the third one in Russia, with a population of approximately 1.4 million. The following groups of participants were examined in 1995–9:

- A random representative sample of adult population aged 25–64 years (161 males, 213 females).
- A random representative sample of school students aged 14–17 years (170 males, 226 females).
- Students of medical university aged 18–29 years (9 males, 94 females).
- Students of medical college aged 18–29 years (9 males, 94 females).
- Students of medical university (IV–VI grades) aged 17–31 years (40 males, 133 females).
- Blood donors (4552 people).

The study was approved by the local ethics committee, and each participant gave informed consent. HBsAg and anti-HCV antibody tests were performed using previously validated second generation ELISA kits (“Vector-Best,” Novosibirsk, Russia).

The prevalence rates of viral hepatitis B and C markers among various population groups are shown in table 1. Prevalence of HBsAg and anti-HCV antibodies were tested in serum samples using previously validated second generation ELISA kits (“Vector-Best,” Novosibirsk, Russia).

<table>
<thead>
<tr>
<th>Group</th>
<th>No</th>
<th>Mean age (years)</th>
<th>M/F (%)</th>
<th>HBsAg (%)</th>
<th>HCV (%)</th>
<th>Both markers (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>423</td>
<td>15.5 (0.1)</td>
<td>43/57</td>
<td>2.1</td>
<td>2.6</td>
<td>0.2</td>
</tr>
<tr>
<td>Medical college</td>
<td>103</td>
<td>19.4 (0.1)</td>
<td>9/91</td>
<td>0</td>
<td>2.9</td>
<td>0</td>
</tr>
<tr>
<td>Medical university</td>
<td>173</td>
<td>21.4 (0.2)</td>
<td>23/77</td>
<td>3.5</td>
<td>6.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Adult</td>
<td>374</td>
<td>42.0 (0.5)</td>
<td>43/57</td>
<td>2.4</td>
<td>5.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Donors</td>
<td>4552</td>
<td>NA</td>
<td>66/34</td>
<td>1.1</td>
<td>2.1</td>
<td>NA</td>
</tr>
</tbody>
</table>

NA = data not available.


Accepted for publication 20 July 2001

Antimicrobial resistance among Neisseria gonorrhoeae isolates from Ulaanbaatar, Mongolia

EDITOR,—We read with interest “The antibiotic susceptibility of Neisseria gonorrhoeae isolated in Ulaanbaatar, Mongolia” by Lkhamsuren et al.6 We also found high levels of resistance to penicillin, tetracycline, and ciprofloxacin. Of the 13 isolates which were successfully transported to our reference laboratory in Birmingham, Alabama, seven (54%) were PPNG, 3/13 (23%) were chromosomally resistant to penicillin, 2/13 (15.4%) were chromosomally resistant to tetracycline and 3/13 (23.1%) were resistant to ciprofloxacin with minimal inhibitory concentrations (MICs) equal to 1 mg/l. However, we would like to clarify that although on site susceptibility testing in Ulaanbaatar using disk diffusion suggested resistance to ceftriaxone in some isolates, this was not confirmed by MICs.7 We agree with the authors that antibiotic resistance is a significant problem in Ulaanbaatar and that a surveillance system for antimicrobial resistance is needed.

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Accepted for publication 30 August 2001

Dangers of the sexual health strategy

EDITOR,—The long awaited strategy for sexual health’ promulgates some shibboleths and proposes some targets, which may increase sexually transmitted diseases and associated suffering.
A statement such as: “Some genital wart infections are associated with cancer, as is Chlamydia” may contribute to the anxiety that constitutes much of the burden of morbidity which such mostly innocuous conditions often engender.1 The proposed target to increase uptake of HIV testing in GUM clinics may increase HIV neurosis.

Offering an HIV test on first screening may lead to false reassurance and increase the chance of undiagnosed HIV infection, since many patients attend within three months of sexual exposure. The unlinked anonymous HIV prevalence survey1 has shown little change in the rate of undiagnosed HIV infection in heterosexuals attending GUM clinics between 1990 and 1999. The most recent (1999) rate in heterosexual men outside London is 0.09%. Increasing the uptake of HIV tests to 60% by the end of 2007 may miss this tiny fraction; the total number of undiagnosed samples from heterosexual men outside London in 1999 was only 14. Efforts to increase awareness and professional training in sexual health services to meet targets set by the strategy will result in less energy and time available for more appropriate approaches to the burden of sexually related morbidity.

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1 The national strategy for sexual health and HIV. DoH 2001.

Accepted for publication 9 October 2001
Hepatitis B and C seroprevalence in Novosibirsk, western Siberia

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Sex Transm Infect 2001 77: 463
doi: 10.1136/sti.77.6.463

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