Whistlestop tour

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The public impact of human papillomavirus (HPV) figures prominently this month. Samaranayake (*see p 540*)[1] reports reduced diagnoses of genital warts following introduction of quadrivalent vaccine in Australia. Pirotta's study (*see p 508*)[2] of the psychosocial burden of HPV disease and screening interventions is timely, showing that external genital warts and cervical intraepithelia neoplasia 2/3 had similar negative psychosocial impact. This will re-ignite debate about quadrivalent versus bivalent vaccine.[3] Treatment of warts remains unsatisfactory. A randomised controlled trial of cryotherapy (*see p 514*)[4] with podophyllotoxin versus cryotherapy alone showed clearance of 68.6% and 64.3%, respectively, by 24 weeks. Larger trials are needed.

Prevention strategies for the longer term impacts of HPV on males, are poorly understood. Li *et al* (*see p 503*)[5] report a 27% prevalence of abnormal anal cytology in that MSM, higher among HIV positives and confirming the need for programmatic research. Worryingly, Lucky *et al*[6] report that genitourinary medicine clinics in the UK are a source of potential delay in diagnosis of penile cancer (*see p 527*). There is a need for improved dermatological training and experience for UK genitourinary physicians.

The Melbourne group reports a new source of pressure on services (*see p 499*).[7] 7.7% of consultation time was consumed by "swab only testing" of female sex workers (FSW) who were diagnosed with 4 sexually transmitted infections (STI) per 100 consultation hours, compared with 11 for all clients and 19 for MSM. The authors could have detected 205–417 more cases of STI over 3 years with 3-monthly testing of this low-risk population. In Kenya, by contrast, Mandaliya *et al*[8] report a herpes simplex virus 2 incidence of 23/100 person-years among FSW (*see p 489*). These papers contribute to the evidence-base needed to plan for prevention for sex workers, which must take a realistic account of their place in STI transmission and prevention. As Mandaliya *et al* point out, bar work was associated with higher transmission rates despite lower partner numbers at the individual level—an understanding of networks is essential to understanding risk.

Sexual network structures are given detailed treatment in Fichtenberg's study of American adolescents (*see p 493*).[9] Individual-based information underestimates the association between STI risk and network position, while being at the centre of a network increases odds of infection. There is growing consensus on the inadequacy of partner numbers to a measure risk. Translation of these insights into clinical practice and prevention interventions is overdue.

Decker's study of intimate partner violence in relation to STI/HIV diagnosis and a range of standard and "gendered" risk behaviours (such as condom refusal, of concurrent partnerships) (*see p 555*)[10] demonstrates increased STI/HIV risk among abusive men, with gendered risk behaviours partly responsible for this increased risk. The sexual networks associated with these behaviours create asymmetrical power structures and need further study.

Editorials explore disappointments in HIV testing both among MSM (*see p 487*)[11] and the wider population (*see p 486*).[12] A related paper by Mbonye (*see p 534*),[13] explores the potential of private midwives contributing to HIV testing in a setting where a fifth of HIV transmission is thought to be mother-to-child. Evans *et al* (*see p 543*)[14] further support the case for widening HIV testing by showing that when patients are known to the general practitioner to be HIV positive, their consultation rates approximate the wider population, providing opportunities for wider preventive health care. But only half of patients have their status recorded in the electronic record (*see p 520*).[15]

Finally, good news in the field of gonorrhoea. Gopal Rao *et al*[16] achieved culture confirmation of 87.2% of nucleic acid amplification test (NAAT) positive cases in community sexual health services through improved transportation (*see p 531*), enabling continued surveillance in the face of growing antibiotic resistance. Should we forget why this is important, a few minutes in the archive will provide some nostalgic reflections at Christmas time and remind us how far venereology has come…[17–20]

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REFERENCES

1. **Samaranayake A,** Chen M, Hocking J, *et al*. Legislation requiring monthly testing of sex workers with low rates of sexually transmitted infections restricts access to services for higher-risk individuals. *Sex Transm Infect* 2009;**85**:540–2.
2. **Pirotta M,** Ung L, Stein A, *et al*. The psychosocial burden of human papillomavirus related disease and screening interventions. *Sex Transm Infect* 2009;**85**:508–13.
3. **O'Mahony C.** Government decision on national human papillomavirus vaccine programme is a sad day for sexual health. *Sex Transm Infect* 2008;**84**:251.
4. **Gilson RJC,** Ross J, Maw R, *et al*. A multicentre, randomised, double-blind, placebo controlled study of cryotherapy versus cryotherapy and podophyllotoxin cream as treatment for external anogenital warts. *Sex Transm Infect* 2009;**85**:514–19.
5. **Li AH,** Phanuphak N, Sahasrabuddhe VV, *et al*. Anal squamous intraepithelial lesions among HIV positive and HIV negative men who have sex with men in Thailand. *Sex Transm Infect* 2009;**85**:503–7.
6. **Lucky MA,** Rogers B, Parr NJ. Referrals into a dedicated British penile cancer centre and sources of possible delay. *Sex Transm Infect* 2009;**85**:527–30.
7. **Fairley CK,** Hocking JS, Gurrin LC, *et al*. Rapid decline in presentations of genital warts after the implementation of a national quadrivalent human papillomavirus vaccination programme for young women. *Sex Transm Infect* 2009;**85**:499–502.
8. **Chohan V,** Baeten JM, Benki S, *et al*. A prospective study of risk factors for herpes simplex virus type 2 acquisition among high-risk HIV-1 seronegative women in Kenya. *Sex Transm Infect* 2009;**85**:489–92.
9. **Fichtenberg CM,** Muth SQ, Brown B, *et al*. Sexual network position and risk of sexually transmitted infections. *Sex Transm Infect* 2009;**85**:493–8.
10. **Decker MR,** Seage III GR, Hemenway D, *et al*. Intimate partner violence perpetration, standard and gendered STI/HIV risk behaviour, and STI/HIV diagnosis among a clinic-based sample of men. *Sex Transm Infect* 2009;**85**:555–60.
11. **Imrie J,** Macdonald N. HIV testing in men who have sex with men: are we ready to take the next HIV testing test? *Sex Transm Infect* 2009;**85**:487–8.
12. **Ma R.** Time to improve HIV testing and recording of HIV diagnosis in UK primary care. *Sex Transm Infect* 2009;**85**:486.
13. **Mbonye AK,** Hansen KS, Wamono F, *et al*. Increasing access to prevention of mother-to-child transmission of HIV services through the private sector in Uganda. *Sex Transm Infect* 2009;**85**:534–9.
14. **Evans HER,** Tsourapas A, Mercer CH, *et al*. Primary care consultations and costs among HIV-positive individuals in UK primary care 1995–2005: a cohort study. *Sex Transm Infect* 2009;**85**:543–9.
15. **Evans HER,** Mercer CH, Rait G, *et al*. Trends in HIV testing and recording of HIV status in the UK primary care setting: a retrospective cohort study 1995–2005. *Sex Transm Infect* 2009;**85**:520–6.
16. **Gopal Rao G,** Bacon L, Evans J, *et al*. Can culture confirmation of gonococcal infection be improved in female subjects found to be positive by nucleic acid amplification tests in community clinics? *Sex Transm Infect* 2009;**85**:531–3.
17. **Richards DT.** Stricture formation following sulphonamide therapy of gonorrhoea. *Br J Vener Dis* 1946;**22**:84–5.
18. **McLachlan AEW.** Stricture formation two years after sulphonamide treatment of gonorrhoea. *Br J Vener Dis* 1943;**19**:181.
19. **Harkness AH.** The cutaneous manifestations of gonorrhoea. *Br J Vener Dis* 1945;**21**:93–113.
20. **Purcell FWF.** Remarks on the treatment of acute gonorrhoeal urethritis in the male: with special reference to a series of cases treated at the salford municipal clinic on a method described by Pelouze. *Br J Vener Dis* 1931;**7**:187–208.