

Highlights from this issue

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We are increasingly recognising that re-infection is common, and so strategies to re-test individuals who have already tested positive are an important part of STI control. This is well recognised in sexual health services, which are increasingly using recalls and messaging to encourage re-attendance. As Bowring *et al* show this month,¹ this message needs to be promoted to all sexual health providers. In a population of women testing positive for *Chlamydia* in Australian general practice, 40% attended and were re-tested over the following year, but another 40% re-attended and were not re-tested. Sixteen per cent of those re-tested were diagnosed with *Chlamydia*.

The question of where care is, and should be, provided continues to inspire a wide range of research. Obviously patterns of accessing care depend on health systems, accessibility and individual preference. Green *et al*² demonstrate the wide range of services accessed by young women diagnosed with pelvic inflammatory disease in the UK. Four fifths had attended general practice, with 23% attending accident and emergency or an NHS walk-in clinic, and a sixth genitourinary medicine clinics. Women with more partners were more likely to attend both genitourinary medicine or accident and emergency/walk in.

University and college centres, with large concentrations of students, remain a tempting location for STI interventions. Jenkins *et al*³ report a comparison of two different approaches to distributing chlamydia kits on a US campus, with disappointing results. Participation was extremely low, and many students remained unaware of the project. Importantly—and this is an increasing challenge for cost-effectiveness—many women had been tested elsewhere. Duplication across health systems is costly, and needs to be taken into account in designing interventions. Another evaluation of a chlamydia screening service is reported by Bracebridge *et al*.⁴ The authors report uptake of a postal chlamydia screening and treatment service in a region of England, within the National Chlamydia Screening Programme. Of nearly 30 000 individuals sent a kit, around 10% had a test—however the costs were high compared to other forms of screening provision.

Thomas *et al*⁵ report a ‘mystery shopper’ study in which clinician reported accessibility of the clinic for young people was compared with the accessibility of the clinic by telephone, using medical students to make calls. Clinicians’ expectations were overoptimistic, and there was substantial difference between the four UK countries—England, which until recently had an access target, performed best.

We have several clinically focused papers this month. Zhou *et al*⁶ report cases of secondary syphilis that progressed to neurosyphilis despite apparently adequate therapy - they emphasise the need for vigilance and investigation post-treatment. Some years after the re-emergence of lymphogranuloma venereum in Europe, we report the a symptomatic female case.⁷ Not everything that affects the genitals is a conventional STI, and we also report a case of epididymitis associated with Panton-Valentin leucocidin *Staphylococcus aureus*.⁸ Wilkinson *et al* report factors for chlamydia infection in Australian MSM (men who have sex with men), helpful in targeting chlamydia testing in this population.⁹

Access to HIV testing remains restricted to medically overseen settings in many countries. Greacen *et al*¹⁰ report on use of unauthorised HIV tests, obtained online, among French speaking MSM using the internet. Very few reported using an online HIV test, but those who had reported high rates of unprotected anal intercourse, and were more likely to conceal homosexual behaviour. Access to online testing may be particularly important for this vulnerable population.

As always, we report a range of global research, including Wang’s interesting systematic review on partner notification in China¹¹ which also describes current policy and operation across China. Wu *et al* describe clustering of syphilis in China, and present a spatial approach to targeting interventions.¹² Chacko *et al*¹³ present a systematic review, that demonstrates generally poor adherence to post exposure prophylaxis, which was nevertheless higher in developing countries and has implications for prescribing. Finally, a peer education programme for male sex workers in Kenya provided good access to a stigmatised and marginalised population¹⁴ with promising results, but needs to be part of a wider programme of prevention activities.

Provenance and peer review Commissioned; not peer reviewed.

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