

Highlights from this issue

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An epidemic of *Lymphogranuloma venereum*, previously considered a near-extinct and largely 'tropical' STI persists in Europe following the recognition of ongoing transmission in 2003. Hughes *et al* present a detailed analysis of the UK outbreak¹, exploring changes in the characteristics of affected men in the different phases of the epidemic. Their demonstration of the value of enhanced surveillance data in disease control sits nicely alongside De Vries *et al*'s description of the clinical features of this epidemic, emphasising the variety of symptoms (or none). They emphasise that the diagnosis can easily be missed, and consider that it should be excluded in all chlamydia positive men who have sex with men (MSM). On a related note, Jurstrand *et al*³ present a study demonstrating through analysis of archival samples new variant *Chlamydia trachomatis* in Sweden was present in 2003, some 3 years before it was detected. With increasing dependence on nucleic acid tests, there is no doubt that we will in future see organisms slip under the diagnostic net.

This month's editorials are complementary, focussing on the provision of effective and appropriate services for vulnerable sexual minorities. Cohen *et al*⁴ focus on the 2011 WHO recommendations for prevention of HIV and STI in MSM and transgender people. This provides a roadmap for implementation, in which we all have a part to play. International co-operation is equally demonstrated in a Schmidt *et al*'s comparison of STI testing services for MSM across Europe.⁵ The authors demonstrate wide variation in the accessibility and comprehensiveness of testing facilities, with implications for prevention and surveillance data. Nardone reflects on the implications of these findings,⁶ emphasising the need for leadership, resources and advocacy for best practice on an international level.

Patients are not always forthcoming about their HIV diagnosis, even in a sexual health setting as shown in a recent paper in this journal.⁷ Datta *et al*⁸ have taken this further, estimating the extent of STI testing away from usual HIV provider in a panel of MSM—this is relatively uncommon but not rare, though the extent probably varies by geography. The emergence of testing kits available over the internet will complicate STI

prevention in this group still further. A different aspect of reticence about an HIV diagnosis is explored by Rayment *et al*⁹ in a study comparing true late presenters with people with post-HIV diagnosis AIDS. Many of the latter had been lost to follow up for long periods, and the authors provide useful guidance on which patients could benefit from additional support with adherence and attendance.

Pharyngeal swabs are not much fun for clinician or patient, and this state of affairs will have to continue, according to Mitchell *et al*.¹⁰ In an analysis of their electronic records system, linked with physician report of changes in technique following training, they show increased isolation rates by those who reported increasing pressure and swabbing area. 'Deep throat' is the policy.

Neonatal herpes is relatively uncommon in the UK and many other Western countries, but remains a major problem in many settings. Sudfeld *et al*¹¹ have used seroprevalence in a cohort of young Malawian women to assess likely risk, concluding that there are high rates of seroconversion as childbearing begins. It seems likely that retention of girls in education could reduce neonatal herpes infection, by increasing the gap between sexual debut and childbearing.

Measurement of sexual behaviour remains a holy grail for STI and HIV researchers. Béhanzin *et al* demonstrate a striking increase in disclosure of stigmatised behaviours (extramarital, commercial and anal sex) using a polling booth technique, by contrast with face to face interviews.¹²

Last, but not least, we have a broad reaching meta-analysis of HPV acceptability in men,¹³ an interesting exploration of urethritis treatment by variety of Kenyan providers,¹⁴ STI testing after post-exposure HIV prophylaxis¹⁵ and our regular Programme Science column,¹⁶ BASHH column¹⁷ and correspondence.

Competing interests None.

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