Highlights from this issue

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Last month we re-introduced Clinical Roundup[1] – a regular update on key research findings of relevance to our clinical readers. I'm delighted to introduce the next edition, which takes a tour of HPV vaccination, rectal chlamydia in women, and the targeting of diagnosis during primary HIV infection.[2] The authors are early career specialists in STI and HIV – Lewis Haddow works in a specialist centre, while Sophie Forsyth has recently moved to Derby where she works in both HIV and STI in a smaller centre. We are delighted with the response to Clinical Roundup, which is an important opportunity to engage with the priorities and preoccupations of our clinical readers within a journal which brings cutting edge research to practitioners.

Have you looked at our Blogs recently? At http://blogs.bmj.com/sti/ we provide commentary on topical issues in STI and HIV, focussing on relevance to clinicians, commissioners and policymakers. Do have a look…

Clinicians will be interested to see the evaluation of automated urine microscopy for the diagnosis of non-gonococcal urethritis, reported by Pond *et al*.[3] The authors report that this approach improves on the specificity of microscopy to detect *Chlamydia trachomatis* or *Mycoplasma genitalium*. They argue that this approach has potential to improve detection or urethritis in asymptomatic men.

We are always interested in novel methods for behavioural surveillance. New communication technologies provide innovative opportunities both for studies, and for biased results. This month, we publish an interesting study by Jorgϕnsen *et al*,[4] using a web-based questionnaire, addressing sexual behaviour in young Danish people. Inevitably in a web-based survey, the response rate was low, yet the reach of such methods is considerable. The authors recognise this, and address concerns about bias, representativeness and methods for correction in detail. The philosopher Wittgenstein reminded us that a newspaper report is not confirmed by buying extra copies of the same newspaper. So how do we validate behavioural surveys through self-selected samples? In an accompanying editorial, Manhart and Khosropour[5] discuss this interesting study, and explore the challenges facing us in a new era of behavioural research.

The targeting and reach of HIV testing in populations at high risk continues to be a major challenge across the globe. This month, Down *et al* report on the HIV testing experience of gay men recently diagnosed with HIV,[6] while in a report from Vietnam Pham *et al* report low levels of HIV testing despite high levels of risk behaviour.[7]

The disproportionately high levels of HIV and STI seen in indigenous communities in many colonial regions remain disturbing. Langnapi *et al* report on astonishingly high prevalence of STI in Papua New Guinea, and describe risk factors in this context.[8] On the Australian mainland, Guy *et al* report high rates of STI in aboriginal communities.[9] These inequalities are stark, compared to non-communicable diseases – and continue to be reflected in marginalised populations throughout the world. What can we do to break the vicious circle of stigma, inequality and suffering?

Competing interests None

Provenance and peer review Commissioned; not peer reviewed.

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