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 treating 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 infection¹ 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) guidelines² address the issue.

In preadolescent children sexual abuse should always be considered when a diagnosis of *C. trachomatis* has been made, although there are reports of perinatally transmitted infections up to the age of 3⁴ and in our department a family cluster of *C. trachomatis* infection has recently been reported, including a 6 year old girl in whom there was no evidence of sexual abuse.⁵

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, whether symptomatic 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.

C OROZ
K A M PORTER-BOVERI
C THOMPSON

Department of Genito-Urinary Medicine, Victoria
Hospital, Hayfield Road, Kirkcaldy, Fife KY2 5AH,
UK

Correspondence to: Dr Oroz

- Centres for Disease Control and Prevention. *Guidelines for treatment of sexually transmitted diseases*. Atlanta, GA: US Department of Health and Human Resources (CDC), 1998.
- UK national guidelines on sexually transmitted infections and closely related conditions, sexually transmitted infections. *J Sex Health HIV* 1999;75(Suppl 1).
- Scottish Intercollegiate Guidelines Network. *Management of genital chlamydia trachomatis infection. National Clinical Guideline*. March 2000, Pub No 42.
- Schachter J, Grossman M, Sweet RL, et al. Prospective study of perinatal transmission of *Chlamydia trachomatis*. *JAMA* 1986;255:3374-7.
- Thompson C, Macdonald M, Sutherland A. A family cluster of *Chlamydia trachomatis* infection. *BMJ* 2001;322:1473-4.

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 signs and symptoms and unprescribed use of antibiotics may select for resistance among strains of *Neisseria gonorrhoeae* and other bacteria residing within and outside the genital tract.¹ 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

medications 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.² 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 people 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 there is good understanding of the role of antibiotics.

M K PITTS
S CANNON
G SINGH

Australian Research Centre, sex, Health & Society,
La Trobe University, 215 Franklin Street, Melbourne,
Victoria 3000, Australia

Correspondence to: Professor Pitts
m.pitts@latrobe.edu.au

- Gordon SM, Mosure DJ, Lewis J, et al. Prevalence of self-medication with antibiotics among patients attending a clinic for treatment of sexually transmitted diseases. *Clin Infect Dis* 1993;17:462-5.
- Irwin D, Thomas JC, Spitters CE, et al. Self-treatment patterns among clients attending sexually transmitted disease clinics and the effect of self treatment on STD symptom duration. *Sex Transm Dis* 1997;24:6:372-7.

Accepted for publication 30 August 2001

Circumcision and STD in the United States

EDITOR,—The study by Diseker *et al.*¹ 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,² 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 Wolbarst,³ a NY urologist examining 1500 cases, reported a ratio of syphilis and chancroid to gonorrhoea of 0.36:1 for circumcised men and 0.78:1 for uncircumcised men (only 5-25% of American men were routinely circumcised in the late 19th century/early 20th century).⁴ 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

and 0.09:1 for uncircumcised men, while Table 4 (Cohort analysis—new STD) reveals 0.07:1 for circumcised men and 0.11:1 for uncircumcised men.

While the foregoing is obviously a very limited statistical analysis and other factors may play a part, it is nevertheless fascinating to see the consistently lower syphilis:gonorrhoea ratio in circumcised men, indicating a potential protective effect by circumcision against syphilis far more so than against gonorrhoea. Secondly, the syphilis:gonorrhoea ratio would appear to have decreased dramatically over time, which raises a question: if circumcision is more effective against syphilis than it is against gonorrhoea and considering the popularity of neonatal circumcision in the United States over many decades, would we not expect—*ceteris paribus*—to see in time a general decrease in the United States of syphilis in both relative and absolute terms?

I would encourage Diseker and colleagues to follow up their interesting study with further research on a larger scale into the relation between circumcision and STDs in order to establish more precisely the degree of protection, if any, afforded by circumcision as a prophylactic health measure.

STEFAN A BAILIS

Research and Education Association on Circumcision
Health Effects, Bloomington, MN, USA
sabailis@mindspring.com

- 1 Diseker RA, Perman TA, Kamb ML, *et al.* Circumcision and STD in the United States: cross sectional and cohort analysis. *Sex Transm Inf* 2000;76:474–9.
- 2 Hutchinson J. On the influence of circumcision in preventing syphilis. *Medical Times & Gazette* 1855;11:542–3.
- 3 Wolbarst AL. Does circumcision in infancy protect against disease? *Virginia Med Monthly* 1934;61:723–8.
- 4 Wallerstein E. *Circumcision, an American health fallacy*. New York: Springer, 1980.

Accepted for publication 20 July 2001

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 liver 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 use 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), perinatal 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 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 antibodies were tested in serum samples 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 among general adult population was twice as high as in blood donors. Among schoolchildren, no difference was found between males and females. In adults, HCV was detected more frequently in males compared with females (8.2% and 3.3% respectively, $p < 0.05$). The association of both infections were found in 0.8% of adults, four times more frequently than in adolescents.

In the medical college students HBsAg was not detected, possibly because of the small number of people examined; HCV was found with the frequency similar to that in schoolchildren. On the other hand, in the medical university students, occurrence rates of hepatitis B and C markers were higher than in other groups.

In conclusion, seroprevalence of HBV in Novosibirsk is similar to that in central Russia; however, prevalence of HCV is higher than in the European part of Russia, especially among males.

Prevalence rates of viral hepatitis markers in the general population are 2–2.5 times higher than in blood donors. Blood donors could not serve as a basis for assessment of viral hepatitis prevalence in the community.

Medical students in last grades represent a risk group for the acquisition of the viral hepatitis infections.

OLEG V RESHETNIKOV

Institute of Internal Medicine, Novosibirsk, Russia

Table 1 Prevalence rates of HBsAg and anti-HCV antibodies among various population groups

Group	No	Mean age (years) (SD)	M/F (%)	HBsAg (%)	HCV (%)	Both markers (%)
School	423	15.5 (0.1)	43/57	2.1	2.6	0.2
Medical college	103	19.4 (0.1)	9/91	0	2.9	0
Medical university	173	21.4 (0.2)	23/77	3.5	6.4	0.6
Adults	374	42.0 (0.5)	43/57	2.4	5.3	0.8
Donors	4552	NA	66/34	1.1	2.1	NA

NA = data not available.

ALEXEI A KHRYANIN
Novosibirsk State Medical University, Novosibirsk, Russia

TATIANA R TEININA
Medical College, Novosibirsk, Russia

NIKOLAI A KRIVENCHUK
IRINA YU ZIMINA
ImDi Diagnostics, Novosibirsk, Russia

Correspondence to: Alexei A Khryanin, Main Post Office Box No 221, 630099, Novosibirsk, Russia

- 1 Hoofnagle JH. Hepatitis C: the clinical spectrum of disease. *Hepatology* 1997;26(Suppl 1):15S–20S.
- 2 Ramadori G, Meier V. Hepatitis C virus infection: 10 years after the discovery of the virus. *Eur J Gastroenterol Hepatol* 2001;13:465–71.
- 3 Maddrey WC. Hepatitis B—an important public health issue. *Clin Lab* 2001;47:51–5.
- 4 Crovari P. Epidemiology of viral hepatitis B in Italy. *Vaccine* 1995;13(Suppl 1):S26–S30.
- 5 Onishchenko GG, Shakhgil'dian IV. The current problems in the epidemiology and prevention of viral hepatitis B and C in the Russian Federation. *Zh Mikrobiol Epidemiol Immunobiol* 2000;1:50–4. (in Russian)

Accepted for publication 17 August 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.*¹ 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 minimum inhibitory concentration (MICs) equal to 1.0 mcg/ml. However, we would like to clarify that although on site susceptibility testing in Ulaanbaatar using disk diffusion suggested resistance to ceftriaxone in some isolates,² this was not confirmed by MICs.³ We agree with the authors that antibiotic resistance is a significant problem in Ulaanbaatar and that a surveillance system for antimicrobial resistance is needed.

J R SCHWEBKE
S H VERMUND
University of Alabama at Birmingham
703 19th St. South
Zeigler Research Building #239
Birmingham, AL 35294-0007 USA

- 1 Lkhamsuren E, Shultz T, Limnios E, *et al.* The antibiotic susceptibility of *Neisseria gonorrhoeae* isolated in Ulaanbaatar, Mongolia. *Sex Transm Inf* 2001;77:218–20.
- 2 Schwabke J, Aira T, Jordan N, *et al.* Prevalence of STD in Ulaanbaatar, Mongolia. Abstract P330 Proceedings, 12th meeting ISSTD, Seville Spain 1997;116.
- 3 Schwabke JR, Aira T, Jordan N, *et al.* Sexually transmitted diseases in Ulaanbaatar, Mongolia. *Int J STD & AIDS* 1998;9:354–8.

Accepted for publication 30 August 2001

Dangers of the sexual health strategy

EDITOR,—The long awaited strategy for sexual health¹ 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.^{2,3} 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 survey⁴ 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 by increasingly stretched professionals 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.

H BIRLEY
Glenfield, Cathedral Close
Cardiff CF5 2ED UK

- 1 The national strategy for sexual health and HIV. DoH 2001.
- 2 Duncan B, Hart G, Scouler A, Bigg A. Qualitative analysis of psychosocial impact of diagnosis of Chlamydia trachomatis: implications for screening. *BMJ* 2001;322:195-9.
- 3 Birley HDL. Continuing medical ignorance: modern myths in the management of genital warts. *Int J STD & AIDS* 2001;12:71-4.
- 4 Unlinked anonymous prevalence monitoring programme annual report to end of 1999. <http://www.phls.co.uk>

Accepted for publication 9 October 2001

NOTICES

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, regional office of the World Health Organization

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).

41st St Andrew's Day Festival Symposium on Therapeutics, 6-7 December 2001, Royal College of Physicians of Edinburgh

Further details: Ms Eileen Strawn, Symposium Co-ordinator (tel: 0131 225 7324; fax: 0131 220 4393; email: e.strawn@rcpe.ac.uk; website: www.rcpe.ac.uk).

International Conference on HIV/AIDS 16-19 December 2001, Mumbai, India

Further details: Dr Chander P Puri, President, Indian Society for Study of Reproduction and Fertility, Institute for Reserach in Reproduction, Jehangir Merwanji Street, Parel, Mumbai 400012, India (tel: 4137730 (Direct), 4132111-2-6-7; fax: 091-022-4964853 or 091-022-4139412; email: vinchin@bom4.vsnl.net.in OR dirirr@vsnl.com).

Second International Conference on Sexual Health, to be held in Bangkok, Thailand on 23-28 February 2002

Further details: European Secretariat, Dr Richard Burack (tel: +44 (0) 20 8599 8029; email: siamcare@aol.com).

7th Congress of the European Society of Contraception, "Changing attitudes to contraception and reproductive health," Genoa, Italy, 10-13 April 2002

Further details: ESC Central Office, Orgamed, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.uunet.be).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 1, Epidemiology of STIs and Bacterial Infections, 22-25 April 2002

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 2, Sexual Health and Sexuality, 26 April 2002

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 3, Viral Infections other than HIV, 20-21 May 2002

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 4, HIV Infections, 22-24 May 2002

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

10th International Symposium on Human Chlamydial Infection, 16-21 June 2002, in Antalya, Turkey

The scientific programme will encompass the breadth of chlamydial research from clinical and epidemiological studies to molecular and cell biology of all species of *Chlamydia*. Further details: Professor A Demir Serter, Department of Clinical Microbiology and Infectious Diseases, Ege University, Faculty of Medicine, 35100 Bornova, Izmir, Turkey (fax: 90 232 343 71 30; email: ISHCIX@itsa.ucsf.edu).

10th International Congress on Behçet's Disease, Berlin 27-29 June 2002

Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de).

20th World Congress of Dermatology, Paris, 1-5 July 2002

Further details: P Fournier, Colloquium, 12 rue de la Croix St Faubin, 75011 Paris, France (tel: +331 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fournier@colloquium.fr; website: www.derm-wcd-2002.com).

Correction

Barnett SD, Brundage JF. Incidence of recurrent diagnoses of *Chlamydia trachomatis* genital infections among male and female soldiers of the US army. *Sex Transm Inf* 2001;77:33-36.

On page 34 of the article, the authors state that reports of *C. Trachomatis* genital infections were confirmed with "Transcription Mediated Amplification" (Gen-Probe, San Diego, USA). For this study, cases were ascertained from notifiable medical event case reports from US military medical treatment facilities worldwide. The case reports did not document the specific tests that were used to confirm each diagnosis. The authors regret this error and any confusion it may have caused.