PostScript

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Diagnosis and exclusion of gonorrhoea in women

The recent report¹ of the death of rectal and throat sampling in women was an exaggeration. I write lest anyone think there has been a conversion from long held,^{2,3} and recently reiterated^{4,5} views. Bradbeer and Mears questioned the utility of taking rectal and throat swabs in female gonorrhoea contacts by reference to a poster presentation, of which I was a co-author, at the IUSTI Asia-Pacific Conference 2002.⁶

In this poster the conclusion stated that: "At this clinic rectal microscopy and culture, and throat culture in women did not aid diagnosis. There appears to be a general reduction in the usefulness of these tests since the last major assessment." The authors offered one possible explanation (of several) for this but did not conclude (as implied by Bradbeer and Mears' citation) that these investigations could be abandoned.

While it is vital that we have sensitive and specific methods for diagnosing STIs, including gonorrhoea, we have always, even during the post-war mode of gonococcal incidence, the mid-1970s, spent most of our time excluding gonorrhoea. We need to be able to tell, with confidence, those who ask us, that they have not got gonorrhoea. Further, we need to be able to reassure those treated that the infection has been eliminated. One conclusion from our study, which we hope to publish after peer review, may well be that the testing protocols adhered to in 2001 were inadequate to exclude gonorrhoea. Their adequacy would not improve were we to abandon samples from rectum and oropharynx.

For the record, the correct citation (their reference 11) and order of authors is as given here.⁶ We did not suggest limiting swab sites to the urethra and cervix; the number of rectal investigations was not (as implied) 338, but 115 by culture and 94 by microscopy; throat swabs numbered 119. Finally, we did not see "338 cases of female contacts of GC." The number of female contacts of gonorrhoea seen and reported in our series was 101.

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References

- 1 Bradbeer C, Mears A. STI services in the United Kingdom: how shall we cope? *Sex Transm Infect* 2003;79:435–8.
- 2 Barlow D, Phillips I. Gonorrhoea in women – diagnostic, clinical and therapeutic aspects. *Lancet* 1978;i:761–4.
- 3 Barlow D, Ison C. Neisseria gonorrhoeae. In: Weatherall, Ledingham, Warrell, eds. *Oxford textbook of medicine*. 3rd ed, 1995;i:544–50.
- 4 Barlow D. Neisseria gonorrhoeae. In: Ledingham, Warrell, eds. *Concise Oxford textbook of medicine* 2000:1599–16.
- 5 Barlow D, Ison C. Neisseria gonorrhoeae infection. In: Warrell, Cox, Firth, eds. *Oxford textbook of medicine*. 4th ed. 2003;i:486–9.
- 6 Watson J, Cormack I, Barlow D. Method of diagnosis and sexual behaviour of women with gonorrhoea. Poster presentation. Beijing: IUSTI Asia-Pacific Conference, 2002.

Barriers to HIV testing: a survey of GUM clinic attendees

HIV testing forms an important part of the national strategy for sexual health and HIV of the UK government. It proposes that all genitourinary medicine (GUM) clinic patients who are attending for "their first screening for sexually transmitted infections" should be offered an HIV test. Previous research has suggested that uptake of HIV testing in antenatal clinics is midwife dependent and possibly doctor dependent within the context of the GUM clinic.^{2,3} The aim of this study was to identify factors associated with being offered an HIV test and having an HIV test in an inner city sexual health clinic with a universal HIV testing policy before publication of the government's national strategy for sexual health and HIV.¹

We conducted a prospective questionnaire based survey of all patients of unknown HIV status presenting over a 2 month period. All patients who saw a doctor, except those attending for follow up, were invited to participate. The main outcome measure was the offer and uptake of HIV testing.

A total of 585 (49.4%) questionnaires were returned. There were no significant differences between responders and non-responders in terms of sex, age, STI, or HIV prevalence; 78.0% of eligible patients reported that they were offered an HIV test. The offering of an HIV test was associated with the patient's ethnicity, intention to test, use of class A/B drugs, and previous STI diagnosis (table 1). This difference remained after controlling for language. No significant difference was observed in patients' intention to have a test according to ethnicity (30.1% for white patients versus 21.0% for non-white patients, $p=0.103$). The offering of an HIV test was not associated with whether the doctor was in training, routinely conducted an HIV outpatient clinic, or was male or female.

The uptake of HIV testing (42% overall) was associated with an HIV test being offered, partner numbers, having new partners while abroad and/or unprotected sex, and previous STI diagnosis. None of the

patient's sociodemographic characteristics considered (including their ethnicity) were significantly associated with HIV testing uptake. Patients for whom English was not their first language were more likely to test than patients whose first language was English ($p=0.014$). There was no significant difference in uptake according to doctor's training status, or whether they conducted an HIV clinic.

Despite relatively high rates of offering and uptake of HIV testing, there were disparities between different groups within the population. Some of the more vulnerable groups within the community appeared less likely to be offered HIV testing despite having the same uptake if a test was offered. Factors that may contribute to the disparity in offering of HIV tests include the clinician's perception of the patient's risk, prejudice (both on a personal and institutional level) and time constraints of staff. The British Co-operative Clinical Group identified "lack of time" as the most common reason that HIV testing was not offered.⁴ With increasing numbers of healthcare practitioners becoming involved in sexual health care, appropriate standards of practice need to be maintained to ensure equity of access to HIV testing.

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References

- 1 Department of Health. *The national strategy for sexual health and HIV*. London: DoH, 2001.
- 2 Jones S, Sadler T, Low N, et al. Does uptake of antenatal HIV testing depend on the individual midwife? Cross sectional study. *BMJ* 1998;316:272–3.
- 3 Griffiths M, Stockdale H, Winter AJ, et al. Uptake of HIV testing in a genitourinary medicine clinic is affected by individual doctors. *Sex Transm Infect* 2001;77:143–4.
- 4 British Co-operative Clinical Group. Screening for HIV infection in genitourinary medicine clinics: a lost opportunity? *Sex Transm Infect* 2000;76:307–10.

Table 1 Variations in reporting of being offered an HIV test and HIV test uptake*

Patient characteristics	Reported being offered an HIV test		p Value	Offered a test and having an HIV test		p Value
	n/N†	(%)		n/N†	(%)	
All patients	327/419	(78.0)	–	160/319	(50.2)	–
Sociodemographics						
Sex			0.387			0.613
Male	138/170	(81.2)		66/133	(49.6)	
Female	187/245	(76.3)		94/184	(51.1)	
Ethnicity			0.005			0.372
White	186/223	(83.4)		93/181	(51.4)	
Not white	136/189	(72.0)		65/133	(48.9)	
Among non-white patients:			0.073			0.283
Black Caribbean	63/82	(76.8)		28/61	(45.9)	
Black African	15/20	(75.0)		9/15	(60.0)	
Black British	29/40	(72.5)		11/28	(39.3)	
Asian	6/9	(66.7)		2/6	(33.3)	
Other ethnicity	23/38	(60.5)		15/23	(65.2)	
English is first language			0.360			0.014
Yes	280/353	(79.3)		129/274	(47.1)	
No	43/59	(72.9)		29/41	(70.7)	
Sexuality			0.497			0.060
Heterosexual	293/378	(77.5)		148/286	(51.7)	
Homosexual/bisexual	29/34	(85.3)		9/28	(32.1)	
Sexual behaviour						
Number of heterosexual partners, past year			0.667			<0.001
0/1	114/147	(77.6)		43/113	(38.1)	
2+	184/227	(81.1)		108/181	(59.7)	
Number of homosexual partners, past year			0.586			0.151
0/1	93/117	(79.5)		46/91	(50.5)	
2+	19/25	(76.0)		6/19	(31.6)	
New partner(s) while abroad in past 5 years			0.152			0.097
No	156/205	(76.1)		70/154	(45.5)	
Yes	82/99	(82.8)		48/82	(58.5)	
Unprotected vaginal sex with 2+partners in past year			0.847			0.002
No	162/210	(77.1)		72/161	(44.7)	
Yes	122/156	(78.2)		74/120	(61.7)	
Unprotected anal sex with 2+partners in past year‡			0.729			0.103
No	172/228	(75.4)		83/170	(48.8)	
Yes	13/18	(72.2)		9/11	(81.8)	
GUM clinic history						
Previous STI diagnosis			0.029			0.007
No	180/218	(82.6)		100/177	(56.5)	
Yes	112/157	(71.3)		44/112	(39.3)	
Last HIV test			0.207			0.093
1–5 years ago	77/97	(79.4)		47/76	(61.8)	
More than 5 years ago	18/24	(75.0)		6/18	(33.3)	
Never	226/291	(77.7)		104/220	(47.3)	
Intention to have an HIV test			<0.001			<0.001
No, not intention/don't know	231/314	(73.6)		70/225	(31.1)	
Yes, intention	95/103	(92.2)		90/93	(96.8)	
Clinician seen for consultation						
Clinician's training status§¶			0.079			0.536
Completed training	103/143	(72.0)		50/99	(50.5)	
In training	96/115	(83.5)		56/96	(58.3)	
Clinician's sex§			0.392			0.082
Male	88/119	(73.9)		46/86	(53.5)	
Female	107/132	(81.1)		60/105	(57.1)	
Clinician also runs an HIV clinic§			0.684			0.770
No	121/158	(76.6)		64/118	(54.2)	
Yes	74/93	(79.6)		42/73	(57.5)	
Drug use						
Used cocaine/heroin/speed/ecstasy/LSD in past year			0.028			0.722
No	202/270	(74.8)		99/200	(49.5)	
Yes	105/121	(86.8)		53/103	(51.5)	

*Patients who reported an HIV risk in the past 3 months, an HIV test in the past year, or that their reason for not testing was that they had tested recently, were excluded from the analysis. This was to ensure that only individuals in whom HIV testing would be unequivocally appropriate in terms of risks and resources were included in our analysis.

†Base (N) excludes patients who did not report a valid response ("yes", "no", "don't know") to whether or not they had been offered an HIV test, as well as item non-response.

‡Heterosexual and/or homosexual anal sex.

§Base (N) excludes 151 patients for whom data on their clinician's characteristics could not be obtained, in addition to 25 patients who did not report whether or not they had been offered an HIV test and whether or not they were having an HIV test, as well as item non-response.

¶Consultants and clinical assistants are considered as those who had completed their training, while specialist registrars, senior house officers, and gynaecological staff are considered as being in training.

Factors that may increase HIV testing uptake in those who decline to test

The aim of improving uptake of HIV testing is threefold: to reduce the proportion of undiagnosed HIV infection within the community; to ensure early access to treatment for those found to be infected; and to limit further transmission.¹ Little research has occurred within the United Kingdom to understand reasons why patients decline an offer of HIV testing. An aim of this study was to identify factors that would persuade patients who declined to have an HIV test, to test in an inner city sexual health clinic with a universal HIV testing policy.

We conducted a prospective questionnaire based survey of all patients of unknown HIV status presenting over a 2 month period. All patients who saw a doctor, except those attending for follow up, were invited to participate.

In all, 585 (49.4%) questionnaires were returned. There were no significant differences between responders and non-responders in terms of sex, age, STI, or HIV prevalence. Forty two per cent of all eligible patients reported that they were having an HIV test. Half (51.6%) of the patients who did not test for HIV reported that they felt at low risk of HIV as a reason for not testing. The second and third most common reasons were "being too scared of the result" (19.1%) and "not wanting to know" (14.2%). Reported sexual behaviours, previous STI diagnosis, and STI prevalence for patients who reported not testing because they considered themselves at low risk of HIV, were compared with patients who gave other reason(s) for not testing (table 1). In general, those who felt themselves to be at low risk of HIV tended to report fewer sexual risk behaviours.

In all, 198/225 who were not testing reported at least one situation that would

make them consider testing. The main situations for which they would "very likely" consider testing were if a partner or ex-partner was HIV positive (97.1%, 95% CI: 93.2 to 99.1). Two thirds (63.6%, 95% CI: 52.7 to 73.6) of women were "likely" or "very likely" to test if they became pregnant. The availability of medicines to treat HIV would make half (49.2%, 95% CI: 35.7 to 61.3) "likely" or "very likely" to test, while a cure for HIV would make two thirds (69.1%, 95% CI: 56.4 to 79.1) "likely" or "very likely" to test.

Overall, the analysis of reasons not to test and patient's appreciation of risk suggests people test as a response to behaviour and are aware of the risks. However, a substantial proportion of patients perceiving themselves at low risk, the principal reason for not testing, did have significant risk factors (for example, 36.1% reported unprotected sex with two or more partners in the past year, 46.3% had a previous STI diagnosis, and 9.6% a current STI diagnosis). Although participants appeared to be largely aware of the risks associated with their behaviours they did not appear to be aware of many of the benefits of testing. A substantial proportion of patients appeared unaware of the benefits of testing in terms of pregnancy or the availability of medicines to treat HIV. In the age of effective antiretroviral therapies, approximately half of patients not testing were "likely" or "very likely" to test if medicines were available to treat HIV. Promoting the benefits of combination antiretroviral therapies may significantly increase uptake of HIV testing.

Contributors

FB and STS conceived and designed the study, helped to analyse and interpret the data, drafted and revised the article; CHM analysed the data and helped draft and revise

the article; DM helped in study conception and design, and revision of the article; BC and PK helped in design of the study and final revision of the article.

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- 1 Department of Health. *The national strategy for sexual health and HIV*. London: DoH, 2001.

HPV in cervix and vagina

Cervical cancer screening by Papanicolaou (Pap) smear has shown its use in reducing both incidence and mortality. Nowadays, cervical tumours are mostly diagnosed in women who were not, or not properly, screened. The invasive sampling method of screening is one of the reasons why women do not participate. The efficiency of cervical cancer screening could be increased if a less invasive test were available. Today, there is extensive scientific evidence that infection with high risk human papillomavirus (HPV) is associated with the development of cervical cancer. An international survey of more than 1000 cervical cancers showed that HPV DNA was present in 93% of all tumours.¹ Further investigation of the HPV negative carcinomas showed that, with improved methodology, 99.7% of all cervical tumours contained HPV DNA.² Recently, it has been suggested that self sampled vaginal material can be used for HPV detection. Several investigations—on a limited number of women—have shown a good correlation between self sampled vaginal material and a cervical sample taken by a professional.^{3,4}

This study aimed to investigate the HPV prevalence in cervix and vagina on samples taken by a professional. Between October 2001 and March 2003, 159 women were enrolled in this study. Of these women, 96 visited their GP for a routine Pap smear, whereas 63 women, working as prostitutes, visited an STI clinic. The study protocol was approved by the medical ethics board of Antwerp University. The GP or STI doctor first took a vaginal sample using a polyurethane tipped swab (Culturette EZ, Becton Dickinson) and then, after inserting a speculum, a cervical sample using a Cervex-Brush (Rovers, Oss, Netherlands). Samples were treated as described previously.⁵ HPV DNA amplification was performed using the GP5+/6+ HPV polymerase chain reaction (PCR).⁶ Detection of PCR products was performed in an enzyme immunoassay format.⁷ After detection of HPV with a HPV probe

Table 1 HIV risk perception by reported sexual behaviours and STI diagnosis among patients reporting that they were not having an HIV test (n = 218)

	Reported "felt at low HIV risk" as a reason for not testing for HIV				p Value*
	No		Yes		
	n/N	(%)	n/N	(%)	
Sexual behaviour					
2+ heterosexual partners, past year	52/86	(60.5)	42/104	(40.4)	0.006
2+ homosexual partners, past year	10/28	(35.7)	9/49	(18.4)	0.089
New partner(s) while abroad in past 5 years	26/75	(34.7)	22/87	(25.3)	0.192
Ever paid/been paid money for sex	4/96	(4.2)	9/113	(8.0)	0.257
Unprotected anal and/or vaginal sex with 2+ partners in past year	40/65	(61.5)	30/83	(36.1)	0.002
Unprotected vaginal sex with 2+ partners in past year	33/83	(40.2)	29/107	(27.1)	0.003
Unprotected anal sex with 2+ partners in past year	5/59	(8.5)	2/73	(2.7)	0.144
STI diagnosis					
Previous STI diagnosis	53/93	(57.0)	50/108	(46.3)	0.130
Current diagnosis†‡§	12/59	(20.3)	7/73	(9.6)	0.080
<i>Chlamydia trachomatis</i>	9/51†	(17.6)	7/60†	(11.7)	0.371
Genital herpes	1/5†	(20.0)	0/1†	(0.0)	0.624
Gonorrhoea	0/31†	(0.0)	0/39†	(0.0)	–
Trichomonas	5/50†	(10.0)	1/61†	(1.6)	0.053
Syphilis	0/50†	(0.0)	0/61†	(0.0)	–

*According to χ^2 statistic.

†Positive diagnosis within 1 week of completing questionnaire.

‡Not all patients tested for all STIs.

§Diagnosed with at least one of HIV, *Chlamydia trachomatis*, genital herpes, gonorrhoea, trichomonas, syphilis.

Table 1 HPV prevalence in vaginal and cervical samples

		Cervix		Total
		HPV+	HPV–	
Vagina	HPV+	25	2	27
	HPV–	6	112	118
Total		31	114	145

cocktail, typing analysis was performed for HPV types 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68. The correlation of HPV in the vagina and the cervix was determined with an unweighted kappa statistic to determine the percentage of correlation beyond that expected by chance.

In 145 of the 159 women HPV detection was complete. The overall HPV prevalence in this study was 22.8%; 14.1% in the general population, and 35.0% in sex workers. There was excellent agreement between HPV prevalence in vaginal samples and in cervical samples (table 1). The overall agreement was 94.5% (kappa 0.83, 95% CI 0.77 to 0.89). The HPV prevalence was slightly higher in the cervix than in the vagina (21.4% versus 18.6%, respectively). In all but one positive case at least one HPV type was present in both sites.

In conclusion, we have shown that there is a very high concordance between vaginal and cervical HPV prevalence when a polyurethane tipped swab is used by a professional. We are currently performing a field study to investigate the impact of self sampling by the women as well as that of transport and storage.

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References

- 1 Bosch FX, Manos MM, Munoz N, *et al.* Prevalence of human papillomavirus in cervical cancer: a worldwide perspective. International biological study on cervical cancer (IBSCC) Study Group. *J Natl Cancer Inst* 1995;**87**:796–802.
- 2 Walboomers JMM, Jacobs MV, Manos MM, *et al.* Human papillomavirus is a necessary cause of invasive cervical cancer worldwide. *J Pathol* 1999;**189**:12–19.
- 3 Hillemanns P, Kimmig R, Huttmann U, *et al.* Screening for cervical neoplasia by self-assessment for human papillomavirus DNA. *Lancet* 1999;**354**:1970.
- 4 Wright TC, Denny L, Kuhn L, *et al.* HPV DNA testing of self-collected vaginal samples compared

with cytologic screening to detect cervical cancer. *JAMA* 2000;**283**:81–6.

- 5 Baay MFD, Smits E, Tjalma WAA, *et al.* Can cervical cancer screening be stopped at 50: the prevalence of HPV in elderly women. *Int J Cancer* 2004;**108**:258–61.
- 6 De Roda Husman AM, Walboomers JM, van den Brule AJ, *et al.* The use of general primers GP5 and GP6 elongated at their 3' ends with adjacent highly conserved sequences improves human papillomavirus detection by PCR. *J Gen Virol* 1995;**76**:1057–62.
- 7 Jacobs MV, van den Brule AJ, Snijders PJ, *et al.* A non-radioactive PCR enzyme-immunoassay enables a rapid identification of HPV 16 and 18 in cervical scrapes after GP5+/6+ PCR. *J Med Virol* 1996;**49**:223–9.

Chaperoning in GUM clinics

In the report by the MSSVD on chaperoning in genitourinary medicine (GUM) clinics, it was suggested that patient acceptability with regard to chaperoning needed to be assessed.¹

We have recently completed a survey on patients attending our GUM clinic looking at our practice for offering chaperones for intimate examinations.

A proforma was completed by senior full time doctors before clinical examination of patients requiring such procedures. The survey took place over consecutive clinical sessions in June 2003. The sheet documented the patient's details, member of staff examining, and whether a chaperone was offered. Reasons for either not offering a chaperone or the patient declining were recorded. The chaperone's details were also noted.

Patients were excluded from the survey if attending only for treatment or for an asymptomatic screen by a nurse, as GMC guidelines on performing intimate examinations have related to doctors but not other professionals.

Reasons given by patients for not accepting a chaperone included that they trusted the doctor, felt it unnecessary, wished privacy, felt embarrassed, or were simply not bothered.

Overall, significantly fewer male patients accepted the offer of a chaperone compared to female patients: 5% (95% CI 1 to 16) and 51% (95% CI 36 to 66) respectively. A significantly greater proportion of female patients accepted a chaperone with a male

doctor (100%) compared to a female doctor (20%) (table 1), $p=0.001$ using a χ^2 test statistics with Yates's correction.

These findings should be seen in conjunction with the findings of Miller *et al.*'s postal survey on chaperoning practice,² where chaperones were more likely to be provided for examination of female patients by a female doctor than by a female nurse. In our survey, the majority of patients declined the offer of a chaperone, except where the patient was female and the doctor male. This may mean that an increase in costs for the provision of chaperones may not be as high as previously anticipated. However, in light of the GMC guidelines, our clinic sheets now include specific boxes to allow doctors and nurses space for recording information relating to chaperones and notices have been displayed in consulting rooms informing clients about their right to request a chaperone. But despite our findings regarding patient preferences for examination without a chaperone, the issue for clinicians who perform an intimate examination without one remains unresolved. They could be placed in a vulnerable position if any allegations of misconduct were made, and it is for this reason that we advocate proper documentation in the notes. Furthermore, we believe that clinicians performing intimate examinations need to be able to reserve the right to insist on a chaperone to be in attendance in certain circumstances.

This project included only three men having sex with men (MSM), and more information is required addressing the acceptability of offering chaperones to this group who may require proctoscopic review, in addition to a genital examination. We hope to collect more data on MSM in a future survey.

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References

- 1 Rogstad KE. MSSVD report on chaperoning in genitourinary medicine clinics. *Sex Transm Infect* 2003;**79**:422–3.
- 2 Miller R, Jones K, Daniels, *et al.* Chaperoning in genitourinary medicine clinics. *Sex Transm Infect* 2003;**79**:74–5.

Table 1 Results of chaperoning survey

Type of consultation	Total numbers of patients seen by doctor	Chaperone offered		Chaperone accepted
		No	Yes	Number (%)
Female patient				
Female doctor	39	9*	30	6 (20)
Male doctor	23	4†	19	19 (100)
Male patient				
Female doctor	19	2‡	17	1 (6)
Male doctor	27§	0	27	1 (4)

*6 no reason given, 1 doctor forgot, 1 language difficulties so chaperoned, 1 mother present.

†4 considered necessary as male doctor.

‡1 doctor forgot, 1 examined by male doctor instead.

§24 heterosexual, 3 men having sex with men (MSM).