MATTERS ARISING

Women’s health: potential for better co-ordination of services

We agree with the article by Queen et al. that the opportunities presented at genitourinary medicine (GUM) clinics to reduce the incidence of unwanted pregnancy should not be missed. Co-ordination of family planning and GUM services would provide a much-needed opportunity to boost the effectiveness of both.

Unwanted pregnancy is a major problem in the Riverside Health District. As part of the investigation of this we carried out a survey of contraceptive use by 100 consecutive women attending the three GUM clinics in the District. Women who were sexually active at the time of the study were asked if they were using contraception and if so whether this was employed every time they had intercourse. Coitus interruptus was not considered an adequate method of contraception for the survey. Women not using contraception were asked if they were planning to conceive and if so whether this was employed every time they had intercourse.

Figures for pregnancy terminations strongly support our findings. In 1988, 2564 terminations of pregnancy were performed in the Riverside. This figure represented 40% of all conceptions in women aged between 15 and 44 years. The termination rate was 29.8 per 1000 women compared with the national rate of 12.1 per 1000. For younger women (aged 20 to 24) the rate in Riverside was 73.9 per 1000 compared with 23.6 per 1000 nationally.1

Under-use of available health services must contribute to the demonstrably poor record of contraception (as seen by the positive relationship between non-registra-
tion with a general practitioner and risk of unwanted pregnancy in the paper by Queen et al.). The John Hunter Clinic is at present isolated from a general hospital. The installation of a family planning clinic within the same building may possibly have contributed to the reduction in the number of women at risk of unwanted pregnancy. The Westminster clinic has an integral family planning clinic to which all women can be referred and the Charing Cross clinic has easy access to the family planning clinic held within the hospital.

We believe significant ground can be made by co-ordination of genitourinary medicine and family planning services with potential social, medical and economic benefits.

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Table: Contraceptive use in sexually active women attending GUM clinics

<table>
<thead>
<tr>
<th></th>
<th>Always using Contraception</th>
<th>Sometimes using Contraception</th>
<th>Never using Contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Hunter Clinic</td>
<td>86</td>
<td>51</td>
<td>25</td>
</tr>
<tr>
<td>(1990)</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Charing Cross Hospital</td>
<td>102</td>
<td>75</td>
<td>12</td>
</tr>
<tr>
<td>Westminster Hospital</td>
<td>93</td>
<td>73</td>
<td>10</td>
</tr>
</tbody>
</table>

Chlamydia trachomatis detection

Recently there have been two encouraging reports for solid phase antigen detection systems in this journal.2,3 Although this technique is best suited to clinic testing neither group of authors appears to have appraised the method directly in this setting.

At our clinic we have investigated the use of a solid phase antigen detection system (Clearview Chlamydia, Unipath, Bedford UK) as an instant bench test performed by our nurses. Two sequential cervical swabs were taken specifically for the study from all new female attendees. One swab was tested by Clearview and the other by a conventional enzyme linked immunosorben assay (Phar-
macia BV). The order of swabbing was ran-
don and both tests were carried out accord-
ing to the manufacturers instructions.

Paired samples from 108 women were obtained. The test was found easy to perform by our staff and the results clinic ready in all cases within 30 minutes. Tests for C trach-

matis were positive in 12 patients and negative in 93 patients by both methods. Discrepant results occurred for 3 patients, all of whom were Clearview positive but Pharamcic negative. The sensitivity and specificity of the solid phase antigen detection system in our hands were 100% and 96% respectively compared with the standard enzyme immunosassay. We would suggest from this small pilot study that solid phase antigen detection systems are as accurate as some EIA methods and that they certainly warrant further assessment to determine their exact role. Further, since this product is best suited to an outpatient environment, further assessment should be made in as close to a clinical setting as possible.

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STDs in injecting drug users

The description of the source of information on HIV-1 status in our report on STDs in injecting drug users is open to several interpre-
tations. As clarification, sources of HIV-1 estimates were either the dried blood spots or, following the method of McCusker et al.2 in a major national study in the United States, results reported by respondents who had already tested HIV-1 seropositive using conven-
tional serum tests. This decision was based on standard practice and the fact that in a previous study in this city, self-reports of serostatus by 132 injecting drug users were 100% concordant with their sub-
sequent serological testing. Thus, HIV-1 prevalence data were based on laboratory analysis of dried blood obtained at interview for 14 of 696 respondents (dried blood spot seroprevalence = 2.0%), and for the remain-
der data were based on report of previous laboratory analysis (combined prevalence = 6.9%, combined n = 939).

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