(PID) in women.³ Infection during pregnancy may lead to postpartum endometritis in the mother and may be transmitted to the infant causing pneumonia or eye infections.

Prevalence of *Chlamydia trachomatis* genital infection in different populations of women in Africa range between 4.9% and 26%.^{1,2,4} Studies from western countries showed a prevalence rate of between 3% and 5% in asymptomatic pregnant women and in women attending the gynaecology or family planning clinics to over 20% in women attending sexually transmitted disease (STD) clinics.^{5,6}

There are no known studies on the prevalence of *Chlamydia trachomatis* infection from the northern part of Nigeria. The aim of this study was to determine the prevalence of *Chlamydia trachomatis* genital infection in an unselected group of women in our hospital.

The patients for the study were recruited from those attending the antenatal and the gynaecology clinics of the University of Maiduguri Teaching Hospital, Maiduguri, Nigeria. They were randomly selected. Information regarding patients' age, parity and marital status was obtained. Specific complaints of vaginal discharge and/or lower abdominal pain, infertility and previous history of STD/PID were recorded. Cervical swabs were taken after cleaning excess mucus. The swab was rotated for about 20 seconds, 1–2 cm into the endocervix. The swab was then withdrawn without touching the vaginal wall. The samples were processed using the Syva MicroTrak (Syva Co, California, USA) and Clearview (Unipath, UK) test kits according to manufacturers' recommendations. All the tests were carried out by one of the authors (JDA) after checking for intra-observer error.

A total of 138 women were tested for the chlamydia antigen. One hundred and seven (77%) of the women were attending the gynaecology clinic while 21 were attending the antenatal clinic. The age of the patients ranged between 17 and 42 years with a mean of 24 years. One hundred and twenty six (91%) of the women were married among whom 23 (18%) were in polygamous type of marriage (more than one wife to a husband). Seventy four (53%) of the women had one or more of the following complaints; vaginal discharge, lower abdominal pain and infertility. The remaining 64 (46%) were visiting the clinic for routine antenatal care or other gynaecological complaints (table). Fifty four (39%) of the women had a history of STD or PID.

For the Syva MicroTrak test, using 10 elementary bodies (EBs) as the cut off point in compliance with the manufacturer's recommendations, 12 samples (9%) were positive with between 11–19 EBs except for one which had more than 25 EBs. All those positive for the Syva MicroTrak test were also positive for the Clearview test. However, a further sample was positive only for the Clearview test. Nine (69%) of the positive samples were from women with symptoms. The others were all asymptomatic. Four

(31%) of the positive samples were from pregnant women and included the one with the highest EB count.

Chlamydia trachomatis infection is generally considered a silent infection in women. This study consisted of unselected patients attending our gynaecology and antenatal clinics. They could therefore be considered to be a low risk group. The prevalence of genital chlamydia infection in this study was 9% which is similar to the figure of 10% reported from Ibadan in western Nigeria.² Positive samples were particularly high in women with symptoms of genital tract infection or a past history PID or STD. This agrees with earlier reports which showed the association between *C trachomatis* and salpingitis and subsequent tubal blockage. In a central African study, antibody to *C trachomatis* was detected in 86% of patients with acute salpingitis diagnosed at laparoscopy.⁷

Among pregnant women tested in this study, 13% were positive. This figure is much higher when compared with those from developed countries.^{5,6} However, the prevalence rate compares favourably with detection rate of 11.4% among antenatal patients in a rural South African community.⁴ This observation emphasises the relevance of *C trachomatis* as a possible causative factor in postpartum sepsis which is a leading cause of maternal morbidity and mortality in many developing countries. It also has significant implications in terms of perinatal transmission. About 60–70% of exposed infants acquire the infection and develop a number of diseases including conjunctivitis and congenital pneumonia.³ The potential for spread of the infection in our environment is high because of the widespread practice of polygamy in this part of the world.

In conclusion, it is apparent that there is a high prevalence of genital *C trachomatis* infection in our low risk study population and we propose to carry out larger studies of different risk groups.

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Provision of diagnostic services for genital chlamydial infection in genitourinary medicine clinics: England and Wales 1996

A substantial prevalence of genital chlamydial infection has been reported among both men and women attending genitourinary medicine (GUM) clinics.^{1,2} The majority of genital chlamydial infections are asymptomatic and a substantial reservoir of asymptomatic infection exists in men attending GUM clinics.² Consequently, screening for infection among all GUM clinic attenders represents an important intervention strategy for the control of what is the commonest, curable sexually transmitted infection in England and Wales.³ Several authors have described a rapid expansion in the availability of diagnostic facilities for genital chlamydial infection in GUM clinics over the past 12 years.^{4–6} However, to date, audits of diagnostic services have only assessed the availability of services for female clinic attenders. We report a study of the provision of diagnostic services for genital chlamydial infection among both men and women in all GUM clinics in England and Wales.

All GUM clinics in England and Wales were contacted and a telephone questionnaire administered covering the following questions: was a routine screening service for the diagnosis of genital chlamydial infection available, who was screened, which site was sampled and what testing strategy was used? Information was available for 235 of the 242 GUM clinics contacted. Routine screening of all new attenders and re-attenders with a new episode was undertaken for women at 98% of clinics, for heterosexual men at 94% of clinics and for homo/bisexual men at 93% of clinics. The selective criteria used by clinics not offering universal screening varied from screening only men with urethritis to screening men who did not have urethritis. Two centres undertook urine testing for male attenders, none used urine testing for female attenders (62% cervix only, 38% cervix and urethra). Enzyme immunoassay, direct fluorescent antibody and culture are used as initial tests in 77%, 15% and 6% of clinics respectively. One clinic used DNA amplification tests (ligase chain reaction), although two sites hoped to instigate the new technology in the immediate future.

The results of this survey indicate that the provision of diagnostic services for female clinic attenders has improved since the last survey.⁶ However, it has also shown that a number of clinics appear to offer only selective screening policies for male clinic attenders. Strategies for contact tracing vary between clinics. A positive chlamydial test may result in partner notification whereas a diagnosis of urethritis may not lead to health adviser intervention. Equal emphasis needs to be placed on the detection of genital chlamydial infection in both men and women attending GUM services if infection

Associated factors in women with genital chlamydia trachomatis infection

Factor*	Total number	No positive	Percentage
Vaginal discharge	65	7	10.8
Lower abdominal pain	23	5	21.7
Infertility	23	5	21.7
History of PID/STD	54	9	16.7
Asymptomatic	64	2	3.1

*Most women had multiple factors.

is to be controlled in this high risk population.

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Same day testing for HIV: 1 year's experience in a district general hospital and at an alternative site

In the Department of Health's white paper, the *Health of the Nation*¹ sexual health, including HIV and AIDS, is identified as one of the key areas of health targeting. Counselling and screening for HIV forms an important part of sexual health and this service should be widely available. Experience suggests, as stated in *HIV/AIDS and Sexual Health*,² that where available many would prefer to attend a clinic separate from current services. In response to the executive letter from the Department of Health,³ a same day HIV counselling and testing service was developed at Bolton General Hospital, and at an alternative site in the town centre. We present the results of this service over a 12 month period.

In May 1994, a same day testing service was introduced in addition to the routine clinic testing, available 1 day a week by appointment only, both in the hospital department and also at an alternative (town centre) site. The same day service was advertised locally. All patients attending for HIV testing were given pre- and post-test counselling and sexual health advice at both sites.

Over the 12 month period, 218 patients made appointments for same day HIV antibody testing. The default rate for the same day testing service was 22.5% (n = 49). The same day hospital site had a higher attendance rate than the alternative site (table). There was one positive HIV antibody result in a homosexual man who was asymptomatic. Six patients requested testing because of a possible risk of HIV infection from overseas medical treatment. All of these opted to be tested at the clinic site, their choice perhaps reflecting concerns which they felt

Predominant risk factors and default rates for patients tested at the same day testing sites

	Clinic site (n = 94)	Alternative site (n = 65)
Default rate	22.3% (n = 27)	25.3% (n = 22)
Male	60	39
Female	34	26
Homosexual	9	14
Heterosexual	62	38
Bisexual	2	1
Intravenous drugs	9	9
Overseas medical treatment	6	0
Others, for example, occupational	6	3

might be better addressed in a hospital setting. Same day testing accounted for 41.8% of the total number of HIV tests within the department.

The current arrangement for HIV antibody testing in genitourinary medicine clinics within the hospital setting has the advantage that the service is widely available and testing is performed in an anonymous and confidential manner. This testing service may have its drawbacks for certain patients who find attending a genitourinary medicine clinic a daunting prospect, especially if the department is based inside a large hospital which is not readily accessible from the local town centre. Other authors have reported successful same day testing services within city centres⁴; however, this is the first paper to report results from a district general hospital setting together with the use of an alternative site. Our results show that a significant proportion of patients opted for the same day testing service and when given the choice of site, patients were more likely to attend the same day hospital service than the alternative site. Further work is required to ascertain reasons behind the high default rate of patients requesting same day HIV testing, as little is known about the sociodemographic details and risk factors among this group. Future evaluation should include qualitative feedback from patients on the issues surrounding testing to determine the optimal testing procedure and site.

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Survival and treatment of AIDS patients 1984-1993

Hillman *et al* seem somewhat confused with their contribution to the debate regarding the place and value of HIV service provision and whether this should be through larger or smaller centres.¹ Assessing survival from AIDS is not a measure of quality of service.

Indeed, survival from AIDS may decrease but quality of life and overall survival from HIV infection may be improved.² We have shown previously in a study involving a large number of patients that survival from AIDS may be influenced by the time of presentation—that is, that survival may increase if the AIDS defining illness occurs coincident with the first positive HIV antibody test.³ This does not mean, as Hillman *et al* assert, that we are questioning the benefit of medical intervention—quite the reverse. We propose that the development of AIDS has been delayed by medical intervention. Indeed, in their paper Hillman *et al* support the assertion that effective intervention may reduce survival from AIDS; they saw a reduction in median survival over time in their patients.

Furthermore, the authors suggest that in our study we both failed to acknowledge improvements in survival made before the study period from St Mary's Hospital and did not adjust for case mix in the two arms.³ In fact, earlier data were acknowledged and referenced and the case mix of the two arms was described in detail.

Hillman *et al* conclude in their paper that smaller units may allow a more informal and intimate setting for patients to be treated. This, however, is not supported by their data and is, therefore, only an unsubstantiated opinion. Others, we are sure, would argue against it.

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MATTERS ARISING

Who goes to sexually transmitted diseases clinics? Results from a national population survey (*Genitourin Med* 1996;72:197-202)

We read with great interest Dr A M Johnson and colleagues' sexual behaviour survey of GUM clinic attenders, published in *Genitourin Med*. The findings of the study now make available good population based data on the characteristics of genitourinary medicine clinic attenders, which will be applicable to many aspects of further research and service planning.

However, we wish to comment on one point made by the authors, in respect of data from GUM clinics being recorded on diagnostic cases rather than on individuals. It may not be widely known that, since April