Asymptomatic women

*Most of PID/STD 54 Lower Letters to show '24 Studies from test the for the Clearview regarding patients' Maiduguri was were samples (9%) of the lower abdominal gynaecological complaints; positivity with symptoms of genital tract infection or a past history PID or STD. This agrees with earlier reports which showed the association between Chlamydia 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.

Among pregnant women tested in this study, 13% were positive. This figure is much higher when compared with those from developed countries. However, the prevalence of PID was comparably low with detection rate of 11-4% among antenatal patients in a rural South African community. 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. 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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Accepted for publication 4 September 1996

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. The majority of genital chlamydial infections are asymptomatic and a substantial reservoir of asymptomatic infection exists in men attending GUM clinics. 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. 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. 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 attenders and diagnostic testing was carried out in all clinics. A new episode was undertaken for women at 98% of clinics, for heterosexual men at 94% of clinics and for homosexual/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% cervical 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 (PCR amplification), although both 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. 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 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
is to be controlled in this high risk population.

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Accepted for publication 4 December 1996

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 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 general practice and sexual health and the service should be widely available. Experience suggests, as stated in HIV/AIDS and Sexual Health, 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, 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 testing site had a higher attendance rate than the alternative site (table).

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. If 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 at an AIDS diagnosis. If this is so, then the 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. 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 similar results show a more informal and intimate setting for patients to be treated. This, however, is not supported by our data, and is, therefore, only an unsubstantiated opinion. Others, we are sure, would argue against it.

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Accepted for publication 21 February 1997

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 the 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: they saw a reduction in the number of patients attending GUM clinics being recorded on diagnostic cases rather than on individuals. It may not be widely known that, since April

3 Department of Health Guidance: additional testing in genitourinary medicine. Department of Health, 1992 (PLCMO (923), appendix 1).

Accepted for publication 28 January 1997

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 the prevention provision and whether this should be through larger or smaller centres. 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. 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. If 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 at an AIDS diagnosis. If this is so, then the median survival over time in their patients.

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