LETTERS TO THE EDITOR

Methicillin resistant Staphylococcus aureus (MRSA) balanoposthitis in an insulin dependent diabetic male

EDITOR,—Balanoposthitis is a common condition affecting 11% of the male attendees at GUM clinics.1 It is an inflammation of the glans penis and the prepuce, and its causes include bacterial and yeast infections, parasitic infestations, trauma, and irritants.2 However, to our knowledge, no case has been reported to be caused by MRSA.

A 49 year old insulin dependent diabetic male presented as an inpatient for repair of an upper jaw fracture developed a penile itch with swollen foreskin, which was difficult to retract, together with longitudinal fissures on the prepuce and subpreputial discharge. In his recent past he had had two incidents of unprotected sexual intercourse with two known females. He was clinically diagnosed as having candida balanitis and was commenced on clotrimazole cream, which did not produce a clinical response over the course of a week. The swabs taken before the commencement of clotrimazole cream failed to grow candida; however, MRSA resistant to erythromycin, penicillin, and flucloxacillin was isolated.

Screening tests for chlamydia, gonorrhoea, and trichomonas were negative. A 10 day course of mupirocin 2% ointment completely resolved his symptoms. Subpreputial swab after treatment was negative.

MRSA has been a well recognised cause of hospital acquired infections worldwide since it was first detected in Europe in the 1960s.3 It is an organism to consider in patients who have been in hospital and might be the cause of: wound infection, bacteraemia, and tricomas.4 Several reports have suggested that diabetic patients are more susceptible to Staphylococcus aureus bacteraemia4 MRSA has been isolated from different sites in diabetic patients but not the genitalia.5 MRSA rarely invades intact skin; however, it can give rise to severe infections—for example, wound infection, bacteraemia, endocarditis, and osteomyelitis.6 This case illustrates the fact that MRSA is an organism to consider in patients who develop balanoposthitis while in hospital or shortly after discharge especially those whose immune system is incompetent.

There may be implications of spread of MRSA in the community for sexual contacts of patients carrying MRSA in the genital area.


Chlamydia trachomatis reinfection rate: a forgotten aspect of female genital chlamydial management

EDITOR,—Hills et al reported that repeated episodes of infection of female genital tract with Chlamydia trachomatis increase the risk of hospital admission for pelvic inflammatory disease and ectopic pregnancy. The first diagnosed attack of genital infection with chlamydia presents the clinician with a unique opportunity to implement measures to minimise the risk of reinfection—that is, health promotion and contact tracing.

During April–June 1998 we reviewed the case notes of female patients who were diagnosed with genital chlamydia at Leicester Royal Infirmary and Derbyshire Royal Infirmary GUM clinics in the year 1996 for evidence of repeat episode of genital chlamy- dia. We also noted the following data: age for presentation with the first episode of infection, time for presentation with reinfection, test of cure if performed, co-infection with gonorrhoea, review by health adviser, contact(s) trace, and time for presentation with the first attack of genital chlamydia 30 days after diagnosis. For the purpose of the study we defined reinfection as a patient testing positive for genital chlamydia 30 days or more after the completion of treatment. We also looked at the genital chlamydia treatment protocols in both clinics.

A total of 540 female patients were diagnosed with chlamydia (311 at Leicester and 229 at Derby). The patients’ mean age at first episode was 22.6 years for Leicester and 21.4 years for Derby. The health advisers had made contact with 94.5% (294) in Leicester and 97.8% (224) in Derby; 85.2% (265) of the patients diagnosed at Leicester returned at 30 days or more and were retested for chlamydia compared with 87.3% (200) at Derby; 9% (24) episodes of repeat infection were identified in Leicester group compared to 17% (34) episodes in the Derby cohort. The mean period for presentation with reinfection was 9.4 months (range 3–25) at Leicester and 9.8 months (range 2–24) at Derby. At Leicester the contacts of 66.5% (207) patients were traced and treated compared to 64.6% (148) at Derby. A test of cure was performed on 282 patient in Leicester (where it was routine practice); 2.5% (seven) were found to be positive for chlamydial infection, while the test of cure was performed on 22 patients in Derby (where it was performed selectively) revealed no positive cases.

Of the reinfeected patients 58.3% (14) at Leicester were reinfected because of failure to trace and treat their partner(s) compared to 35.3% (12) at the Derby clinic.

Both clinics manage genital chlamydia with what was considered standard treatment and perform contact tracing wherever possible.

Two reinfeected patients from each clinic were also co-infected with gonorrhoea.

Other risk factors for reinfection—for example, ethnic origin, number of sexual partners,7 were not analysed as these data was not discernible from the notes.

This retrospective study highlights the fact that a substantial number of patients get reinfected with chlamydia despite health education and counselling by health advisers. Though the figures (66.5% and 64.6%) for partner notification and treatment were close to that proposed by the Central Audit Group (70%),8 the proportion of patients who were still too high. Does the message that repeat episodes of genital chlamydia are more damaging get through to our patients or do we need a new health education strategy?

Currently, as the success of treatment of genital chlamydia is evaluated by the level of contact tracing, the number of patients referred to health advisers, and number of contacts per index patient seen and treated,9 we believe it is time to evaluate outcome measures in terms of reinfection rates. Large prospective studies need to be done to elucidate this aspect of chlamydial infection management.

Contributions: PS had the original idea; EH collected and analysed the data EH and JD wrote the manuscript.

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The Society of Apothecaries Diploma examination in Genitourinary Medicine: death of the viva voce?

EDITOR,—The London Apothecaries Diploma examination in Genitourinary Medicine held on September 2, 2003 by guests. Protected by copyright.
A pilot study was conducted to compare the sensitivity of LCR testing for genital chlamydial infection in men, taken from the meatus itself against the standard technique. All male patients attending the GUM clinic over a 3 month period were included in the study if they had symptoms or signs compatible with chlamydia, or if a contact of a known case of chlamydia. A swab was taken from the urethra in the standard fashion. A second swab was taken from the meatus. After the sixth week of the study the order of the first and second swabs was changed, in order to evaluate any bias related to the order of the swabs. Specimens were processed using Abbott Laboratories LCx Chlamydia and handled according to the manufacturer’s guidelines.

Twenty-five patients were asked to evaluate the swabs and to state which swab caused least discomfort or if there was no difference between them. A total of 208 men were recruited to the study. The overall prevalence of genital chlamydial infection in our population was 25% (52/208). A confirmed diagnosis was made if both of the samples performed from the same man were positive for chlamydia, or if one sample was positive together with an equivocal result. There were no false positive tests using these criteria giving all methods 100%.

There was no significant difference in detection rates between the subgroups where the order of swabs was changed.

A meatal swab for the detection of chlamydia is more acceptable to men and has a similar sensitivity to the traditional technique of urethral sampling

Detection of chlamydia on meatal swabs

EDITOR,—The advent of ligase chain reaction (LCR) and other DNA technologies and techniques is of increasing importance in the United Kingdom. It would be interesting to have some figures on the percentage of non-consultant grades who are expected to have to begin to think about performing slides a confrontational examination (i.e. "unsuitable" for projecting slides a confrontation mechanism). The Apothecaries’ Diploma Board rejected viva voce examinations some time ago as being prone to bias. This is consistent with much current research on examination techniques. Oral examinations are regarded as being inherently biased and of poor inter-examiner reliability. How much, however, is being inherently biased and of poor inter-examiner variation inherent in the viva, candidates for the Diploma in Venereology and Genito-urinary Medicine of Liverpool University, we find the viva a key mechanism to discriminate between candidates precisely because the examiner can adjust the level of difficulty of the questions to the ability of each candidate. The viva is a good instrument to measure clinical thinking, ability to take a sexual history, and counselling. Role play need not be unique to a province of doctors. The viva is particularly useful for borderline candidates—for example, those who are disadvantaged in essays which are notoriously dependent on proficiency in English (not to mention spelling!). In order to reduce interexaminer variation inherent in the viva, all candidates for the Liverpool Diploma are viva’d independently by both sets of (two) examiners. Clearly, this would be extremely cumbersome and time consuming for the current and anticipated numbers taking the Apothecaries Diploma.

The venerable Apothecaries’ Hall is apparantly “unsuitable” for projecting slides a convenient way of basing a clinical skills/data interpretation type examination for a large number of candidates—for example, MRCP Part 2 and many other postgraduate medical examinations. Will the examiners of the Apothecaries Diploma have to begin to think of more appropriate premises for their examination?

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HIV positive and negative homosexual men have adopted different strategies for reducing the risk of HIV transmission

EDITOR,—To reduce the risk of HIV transmission, some homosexual men have adopted a strategy whereby they only have unprotected anal intercourse (UAI) with a person of the same HIV status (known as “discordant UAI”). In London, homosexual men in a relationship are more likely to know the HIV status of their UAI partner than men not in a relationship and so establish concordance. However, this was not examined for HIV positive and negative men separately. A survey conducted in January-February 2000 among homosexual/bisexual men attending one of six gams in central London, as part of an ongoing behavioural surveillance programme, has allowed risk reduction strategies to be considered by HIV status. A total of 792 homosexual men (median age 35 years) completed a confidential questionnaire (estimated response rate 50–60%); 126 (16.0%) were HIV positive, 477 (60.2%) HIV negative, while 169 (21.3%) had never had an HIV test (data missing for 20 men). Just under half the men (53/126, 42.1%) said they were currently in a relationship with another man; this did not differ significantly by HIV status (p=0.1).

Our analysis focused on how sexual risk behaviour varied both by HIV as well as by relationship status. For HIV negative and positive men, UAI was classified as either concordant (UAI with a partner of the same HIV status) or non-concordant (UAI with a partner of unknown or discordant HIV status). Men reporting more than one UAI partner were classified as concordant only if all UAI partners were of the same HIV status as themselves. Men also indicated how they thought they had had UAI with a main partner only, casual partner(s), or both. One third of all men (32.9%, 259) reported UAI in the previous 3 months; HIV positive men 42.1% (53/126), HIV negative 34.2% (49/143); data missing for two men (p=0.1). Overall, concordant UAI was reported by 18.7% (89) of HIV negative and 21.4% (27) of HIV positive men (p=0.4). For HIV negative men, concordant UAI was predominantly reported by those in a relationship and rarely by men who were not (28.6% vs. 5.0%, p<0.001) (table 1). Concordant UAI was usually with a main partner alone. By way of comparison, HIV positive men were just as likely to report

www.sextransinf.com
Table 1  Unprotected anal intercourse (UAI) in the previous 3 months

<table>
<thead>
<tr>
<th>Type of partner for UAI</th>
<th>HIV negative men (n=477)</th>
<th>HIV positive men (n=126)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Main only (%)</td>
<td>Casual† (%)</td>
</tr>
<tr>
<td>Men in a relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting</td>
<td>n=276</td>
<td>n=63</td>
</tr>
<tr>
<td>Concordant UAI</td>
<td>27.1 (75)</td>
<td>1.4 (5)</td>
</tr>
<tr>
<td>Non-concordant UAI</td>
<td>8.0 (22)</td>
<td>6.5 (18)</td>
</tr>
<tr>
<td>Total</td>
<td>35.1 (97)</td>
<td>8.0 (22)</td>
</tr>
<tr>
<td>Men not in a relationship reporting</td>
<td>n=199</td>
<td>n=63</td>
</tr>
<tr>
<td>Concordant UAI</td>
<td>2.5 (5)</td>
<td>5.0 (10)</td>
</tr>
<tr>
<td>Non-concordant UAI</td>
<td>1.5 (3)</td>
<td>16.1 (32)</td>
</tr>
<tr>
<td>Total</td>
<td>4.0 (8)</td>
<td>18.6 (37)</td>
</tr>
</tbody>
</table>

*Data on UAI or relationship status missing for two HIV negative men.
†Men reporting casual partners only or main and casual partners. Most men reported casual partners only.

No significant association between non-concordant UAI whether they were in a relationship or not was confirmed in a multivariate model.

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A mobile phone text message and Trichomonas vaginalis

Editor,—Over the past decade vast numbers of the general population have accepted the internet, email, and mobile phones. Among new patients attending our centre 70.3% (90/128) of men and 73.7% (90/123) of women provide mobile telephone numbers for contact. However, the use of mobile phones as a mechanism for contact tracing as far as I am aware has not been reported previously.

A 26 year old Afro-Caribbean man presented to our clinic and informed us that his girlfriend had attended a GUM clinic but unfortunately he did not know why. However, he informed us that he had a text message on his mobile. He duly brought up the message, which gave the woman’s clinic number and the KC60 diagnosis of C6A.

On examination there were no abnormalities seen, there were no polymorphs on microscopy, swabs for gonorrhoea, chlamydia, and trichomonas were all clear. He was treated with a 5 day course of metronidazole as per MSSVD guidelines.

If this patient had turned up without a contact slip, epidemiological treatment of trichomonas is unlikely to have been instituted and contact tracing would have been impossible. Thanks to the use of text messaging on this man’s mobile phone, appropriate treatment was initiated. Certainly patients and health advisers appreciate the security offered by mobile phones (no other family members can take the calls), the instant access, and it avoids additional paper work. The use of text messaging and mobile phones for contact tracing may be considered as an adjunct to contact slips in GU clinics.

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kind of interference, and that basic common sense should prevail.

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Lichen sclerosus of the glans is significantly associated with penile carcinoma

EDITOR,—We read with interest the article by Riddell et al on men with penile lichen sclerosus (PLS) attending a department of genitourinary medicine. In this study, the authors found no cases of malignancy. We have previously reported a retrospective study on the incidence of cancer on 86 cases of PLS retrieved from our histopathological files over a 10 year period (1987–97). In that study, five cases showed malignant transformation—namely, squamous cell carcinoma (SCC) (three cases), in situ carcinoma (one case), and verrucous carcinoma (one case). Since that report, we decided to interview all PLS patients in order to rule out any further malignancy that occurred over time. Of 86 patients identified, 60 were evaluated at our clinic. Among these, we found three additional patients treated with partial penectomy for invasive SCC at other institutions. Their medical records were obtained together with paraffin embedded tissue samples to perform polymerase chain reaction (PCR) for human papillomavirus (HPV) testing. Clinical and laboratory information for these patients was obtained together with previously reported cases, and summarised in table 1.

In this current study, eight (9.3%) out of 86 PLS patients developed an epithelial cancer. Data analysis using the t test confirmed in our series a statistically significant risk of malignant degeneration (p < 0.05).

Clinically, the most common presentation of epithelial cancer arising with PLS was that of an infiltrated or ulcerated plaque followed, in decreasing order of frequency, by a nodular lesion or verrucous papules. The glans was the most commonly affected area. The average age of onset of PLS was 45 years, and that of development of cancer was 62 years. The average lag time from onset of PLS to cancer development was 18 years (range 10–34 years). This long latency time might explain the paucity of cases, mostly anecdotal, reported in the literature in the past 22 years (approximately 20) compared with our study, in which a long follow up disclosed 9.3% malignant degeneration in a series of 86 patients. Also, the latency time was shorter in the HPV positive patients (average 15 years) compared with the HPV negative patients (average 23 years). The role of HPV in the pathogenesis of penile cancer is not fully understood. Some HPV, such as type 16 and 18, are likely to play a part, but not all penile carcinomas are HPV positive, as shown in our study. Also, PLS is not commonly associated with HPV infection. In our study we found five patients positive for HPV 16 infection, and this may have hastened the progression towards cancer resulting in a shorter lag time. However, routine HPV testing on larger series is necessary in order to draw any definitive conclusion.

Similarly to vulvar lichen sclerosus, which has been observed to undergo malignant degeneration in 3–6% of women, a likely malignant evolution of PLS should be considered. Careful and systematic histopathological evaluation of any ulcerated or indurated plaques developing within PLS is therefore strongly recommended. The association between PLS and cancer may very well be underestimated and there is a need for further investigation that includes long term follow up and routine PCR analysis for HPV infection.

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Table 1 Clinical and histopathological features of eight cases of carcinoma on penile lichen sclerosus

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Age of onset of PLS (years)</th>
<th>Age of onset of Ca (years)</th>
<th>Lag time (years)</th>
<th>Site</th>
<th>Clinical aspect of malignancy on PLS</th>
<th>Histopathology</th>
<th>PCR testing for HPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>41</td>
<td>62</td>
<td>21</td>
<td>glans</td>
<td>fungating keratotic nodule with a white-yellowish hue slightly elevated verrucous papules</td>
<td>SCC well differentiated</td>
<td>negative</td>
</tr>
<tr>
<td>2*</td>
<td>36</td>
<td>59</td>
<td>23</td>
<td>glans</td>
<td>multiple erythematous, indurated, and ulcerated plaques sharply circumscribed, erythematous, oozing, and slightly infiltrated plaque</td>
<td>SCC well differentiated</td>
<td>positive</td>
</tr>
<tr>
<td>3*</td>
<td>41</td>
<td>55</td>
<td>14</td>
<td>glans, coronary sulcus glans, coronary sulcus upper aspect of the foreskin</td>
<td>SCC well differentiated</td>
<td>positive</td>
<td></td>
</tr>
<tr>
<td>4*</td>
<td>39</td>
<td>49</td>
<td>10</td>
<td>glans, coronary sulcus</td>
<td>In situ carcinoma</td>
<td>positive</td>
<td></td>
</tr>
<tr>
<td>5*</td>
<td>29</td>
<td>47</td>
<td>18</td>
<td>glans</td>
<td>exophytic verrucous whith node sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>HPV 16</td>
<td>positive</td>
</tr>
<tr>
<td>6</td>
<td>75</td>
<td>85</td>
<td>10</td>
<td>glans</td>
<td>sharply circumscribed, erythematous, eroded, crusted, and indurated plaque</td>
<td>HPV 16</td>
<td>negative</td>
</tr>
<tr>
<td>7</td>
<td>66</td>
<td>70</td>
<td>15</td>
<td>glans, coronary sulcus</td>
<td>HPV 16</td>
<td>negative</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>33</td>
<td>67</td>
<td>34</td>
<td>glans, coronary sulcus</td>
<td>un differentiated</td>
<td>positive</td>
<td></td>
</tr>
</tbody>
</table>

*Previously reported cases.1

PLS = penile lichen sclerosis; Ca = carcinoma; PCR = polymerase chain reaction; HPV = human papillomavirus; SCC = squamous cell carcinoma; VC = verrucous carcinoma.


Accepted for publication 22 March 2001

Third trimester screening or safer sex to prevent mother to child transmission of HIV

EDITOR,—Since 1992 Department of Health guidelines have recommended that HIV screening be offered to all pregnant women in high seroprevalence areas of high seroprevalence but implementation and uptake has been poor. In 1998 an intercollegiate working party recommended that HIV testing be integrated with antenatal screening for other infections and that the test should be offered and recommended to all pregnant women in high seroprevalence areas.1 In 1999 the Department of Health extended these recommendations to all regions aiming to reduce neonatal HIV infec- tion by 80% by 2002.2 We present the case of an infant with symptomatic HIV infection, whose mother’s antenatal HIV test was negative and discuss the implications.

A 3 month old female, born at term by spontaneous vaginal delivery and breastfed, presented with a 1 week history of increasing respiratory difficulty. Following further deterioration, she was transferred to St Mary’s Hospital and ventilated. Pneumocystis carinii pneumonia (PCP) was diagnosed on bronchoalveolar lavage. Anti-HIV antibodies were present in serum and HIV infection was confirmed by the detection of HIV-DNA in peripheral blood mononuclear cells (PBMC) by PCR amplification. HIV-1 infection was confirmed in both parents. Their asymptomatic mother had received antenatal care from the 12th week of gestation and was HIV seronegative at 29 weeks. To investigate a

Letters, Notices

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possible false negative result, other sera stored at various times were retrieved and tested. The results, which show seroconversion late in pregnancy, are summarised in table 1.

The HIV antibody test is usually performed at the booking visit with other routine antenatal screens. This allows the parents time to adjust to the diagnosis before delivery, to consider family planning issues and interventions to minimise the risk of mother to child transmission. In addition, mothers with advanced immunosuppression benefit from antiretroviral therapy.

Althought rarely reported, an HIV seronegative mother whose partner has undiagnosed HIV infection is at continued risk of infection from antiretroviral therapy. With advanced immunosuppression benefit from antiretroviral therapy.

Repeat antenatal screening late in pregnancy, as is recommended for syphilis in the United States, would identify some primary HIV infections during gestation. However, if maternal infection is not prevented transmission during lactation would remain a risk and there would be significant logistic and cost implications. The extension of testing for HIV (and other infections) to the partners of pregnant women is appealing as both maternal and infant infections could be prevented (and the infected male may benefit from earlier diagnosis and treatment) but would require a fundamental change to antenatal care. A practical approach, which may prevent maternal and neonatal infection (but not identify the infected male) is to use the opportunity, when giving negative HIV, hepatitis B, and syphilis results to the mother, to discuss the sexual transmission of infections, to emphasise that the negative results cannot be extrapolated to the partner, and advocate safer sex, which is commonly abandoned following conception.

Table 1  Peripartum HIV test results

<table>
<thead>
<tr>
<th>Time (in weeks of gestation)</th>
<th>1 T = 12 weeks (“Booking blood”)</th>
<th>2 T = 29 weeks</th>
<th>3 T = 33 weeks (“Booking blood”)</th>
<th>4 T = 13 weeks postpartum (child presents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital where blood taken</td>
<td>X Blood was stored and retrospectively tested</td>
<td>Y Index antenatal test (serum not available for repeat retrospective testing) Clear negative</td>
<td>Y Blood was stored and retrospectively tested</td>
<td>St Mary's Postnatal test. Blood stored</td>
</tr>
<tr>
<td>HIV antibody screening tests</td>
<td>Clear negative Detect-HIV&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Clear negative</td>
<td>Weak positive</td>
<td>Strong positive</td>
</tr>
<tr>
<td>HIV specific antibodies (CPHL in-house EIAs)</td>
<td>Clear negatives, (OD/CO) HIV IgG=0.49, IgM=0.36, IgA=0.44</td>
<td>—</td>
<td>Strong positives, (OD/CO) HIV IgG=12.34, IgM=10.94, IgA=5.28</td>
<td>Strong positives for IgG and IgA: weak positive IgM (OD/CO) HIV IgG=15.41, IgM=3.14, IgA=4.18. *Note decreasing values for IgM and IgA compared to previous</td>
</tr>
</tbody>
</table>

*Enzyme immunoassay (EIA) for detection of antibody to HIV-1 and 2. Biochem Immunosystems Inc, Montreal, Quebec, Canada.
*EIA for detection of antibody to HIV-1 (Abbott Murex). Murex Biotech Ltd, Dartford, UK.
*EIA for detection of antibodies to HIV-1 and 2. Abbott Laboratories, IL, USA.
*EIA for detection of antibodies to HIV-1 and 2 (Abbott Murex). Murex Biotech Ltd, Dartford, UK.
*Passive particle agglutination test for detection of antibodies to HIV-1 and 2 Fujirebio Inc, Tokyo, Japan.
*Western blot for detection of antibodies to HIV antigens. Genelabs Diagnostics, Singapore.
*Polymerase chain reaction (PCR) for quantitative detection of HIV-1 RNA. Roche Diagnostics, Branchburg, NJ, USA.
*Signal amplification nucleic acid probe assay for quantitative detection of HIV-1 RNA. Chiron Corp Emeryville, CA, USA.

Economic advantages of ligase chain reaction for diagnosis of genital Chlamydia trachomatis infection in GUM clinic attenders

Editor,—Genital infection with Chlamydia trachomatis is highly prevalent and recognised as a major threat to public health. There is now a wealth of evidence to demonstrate the superiority of DNA amplification techniques over antigen detection and culture. Only one large study has directly compared ligase chain reaction (LCR) with enzyme immunoassay (EIA) on identical clinical material and no studies have analysed the health economic impact of LCR in a genitourinary medicine (GUM) clinic population.

We studied the diagnostic effectiveness and cost of LCR compared with EIA.

All GUM attendees undergoing sexual health screening were offered the opportunity to participate. Men presenting with dysuria or urethral discharge were defined as symptomatic. Swabs were collected in a pre-randomised order from the cervix in female patients and 4–5 cm proximal to the urethral meatus in male patients. Urethral specimens in male patients were evaluated for evidence of urethritis (defined by >3 polymorphs per high powered field).

EIA was performed using a standard immunoassay technique (Organon Chlamydia-Tek), with confirmation of reactive tests by microdot DIF. LCR (LCX system, Abbott Laboratories) was also performed on every specimen. Specimens
testing positive by LCR alone were retested by an alternative PCR assay for DNA sequences coding for the major outer membrane protein (MOMP) of Chlamydia trachomatis.

A total of 148 male and 153 female patients were tested; 23/148 (16%) swabs from male patients and 10/153 (7%) from female patients were positive for Chlamydia trachomatis by LCR (see fig 1).

The sensitivity, specificity, and positive predictive values, and cost/test of LCR and EIA, respectively, were 100%, 100%, 100%, 100%, £27.64 and 58%, 100%, 95%, 100%, £4.05.

Of 33 cases of chlamydial infection, 15 cases (12% (9.2%) in men and two (20.0%) in women) would have remained undetected if EIA had been used alone.

Although EIA tests cost less than LCR, the inferior detection rate for EIA (17 patients need to be screened per case detected) compared with LCR (nine patients screened per case detected) was also included in analysis of the results. The cost per case of chlamydial infection detected using EIA in this population was £165, compared with £350 for LCR.

In a hypothetical cohort of 100 GUM attendees, with an 11% prevalence of chlamydial infection (as in the present study), testing with EIA would cost £405 and would detect 6.4 of the 11 cases. Testing the cohort with LCR would cost £564 and detect all 11 cases.

The clinic in which the study was conducted sees 6000 new attendees annually. Had EIA been used alone, 276 cases of chlamydial infection would have been missed in a one year period, at an estimated cost of over £82 000. A full economic evaluation would require that these long term health and resource costs be more thoroughly quantified and compared with other uses of NHS resources.

In summary, this study demonstrates that the overall sensitivity of LCR was double that of EIA, the previous standard diagnostic test for Chlamydia infection was £65, compared with £50 for LCR.

In a one year period, at an estimated cost of 6.4 of the 11 cases. Testing the cohort with LCR would cost £564 and detect all 11 cases. Additional case detected is £34.


Further details: ECEAR 2001 Conference Secretary, Division of Microbiology, NIBSC, Blanch Lane, South Mimms, Potters Bar, Herts, EN6 3QG, UK.

International Congress of Sexually Transmitted Infections, 24-27 June 2001, Berlin, Germany

Further details: Congress Partner GmbH, Krausenstrasse 63, D-10117, Berlin, Germany (tel: +49-30-204 500 41; fax: +49-30-204 500 42; email: berlin@cpb.de).

1st Asia Pacific Forum on Quality Improvement in Health Care

The 1st Asia Pacific Forum on Quality Improvement in Health Care will be held from 19-23 September 2001 in Sydney, Australia. Presented by the BMJ Publishing Group (London, UK) and Institute for Healthcare Improvement (Boston, USA), with the support of the Commonwealth Department of Health and Aged Care (Australia), Safety and Quality Council (Australia), NSW Health (Australia) and Ministry of Health (New Zealand). Further details: quality@bma.org.uk; fax +44 (0) 7383 8696.

10th International Symposium on Behcet's Disease will be held in Berlin 27-29 June 2002

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

Second International Conference on Sexual Health, to be held in Bangkok, Thailand on 23-28 February 2002. Calls for abstracts deadline 1 September 2001

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

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: 413770 (Direct); 4132111-2-6-7; fax: 091-022-4964853 or 091-022-4139412; e-mail: vicchin@bom4.vsnl.net.in OR dirirr@vsnl.com).

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; e-mail: ISHCIX@itsa.ucsf.edu).

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 (ref: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: p.fournier@colloquium.com website: www.derm-wcd-2002.com).