PostScript

LETTERS

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The practice of STI treatment among chemists and druggists in Pokhara, Nepal

Chemists and druggists working in “medical shops” play a significant part in the treatment of sexually transmitted infections (STIs) in resource poor countries.1 In some settings, chemists and druggists are consulted for first line treatment of STI symptoms more often than hospitals and clinics designed specifically to service such clients.1 Recent unpublished data from Pokhara, Nepal, suggest that in up to 80% of cases, treatment provided by chemists and druggists was inappropriate or incomplete.2 We report here on the quality of STI case management among a random sample of chemists and druggists from the 75 medical shops in Pokhara Municipality Area, Nepal.

Chemists and druggists working in all Pokhara medical shops, 65% of whom had received previous training in the national STD case management guidelines,3 based on WHO syndromic algorithms,4 were trained and motivated to initiate a register of all STI client visits and their treatment. Registry data from January to December 1999 were reviewed. Thirty seven registered medical shops were randomly selected for visits using the simulated client method (SCM) presenting 22 urethral discharge (UD) and 15 vaginal discharge (VD) scenarios.

Of the 6374 STI cases (68% female, 32% male), 22% presented with urethral discharge, 31% with vaginal discharge, 21% with genital ulcer disease, and 26% with pelvic inflammatory disease. Seventy per cent of clients visiting medical shops for STI treatment in Pokhara Municipality Area in 1999 were there for first line treatment—findings in agreement with a recent study conducted in Ghana, which found that 60% of STI clients came to pharmacies without a prescription.5 In 43% of cases, chemists and druggists in Pokhara Municipality Area correctly dispensed medication for the treatment of UD or VD. While over 95% of SCM clients were made to feel welcome, given a private consultation, and were asked about their health history, risk counselling was conducted only 57% of the time, partner notification occurred in only 43% of cases, and condom use was promoted in only 35% of cases.

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Acknowledgements

This study received funding from the University of Heidelberg STD/HIV Project, Kathmandu, Nepal, which is funded by the European Union (EU) (B76211.97/044).

There are no conflicts of interest.

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References

1 Zeeb DH. Provision of care for patients with sexually transmitted diseases in Pokhara, Nepal. A research report for the degree of Postgraduate Master of Science in Community Health and Health Management in Developing Countries offered by the University of Heidelberg, Germany, May-June, 1996.


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health is eager to perform surveillance for STIs, including viral hepatitis, resources for collection, storage, and testing of specimens are meagre. We evaluated the utility of a filter paper blood collection technique for determining rates of HIV, syphilis, and viral hepatitis B and C in this resource limited setting.*

*The study was approved by the institutional review boards at the University of Alabama at Birmingham and the Mongolian ministry of health. Volunteers including commercial sex workers, itinerant traders, homeless people, and attendees at the STI clinic were sampled in Ulaanbaatar, Mongolia. All subjects completed a questionnaire and provided blood via a finger stick.

Blood specimens collected as filter paper spots using Schleicher and Schuell (Keene, NH, USA) no 903 filter paper following the National Committee for Clinical Laboratory Standards protocol. Samples were dried, stored at room temperature for the duration of the 2 week visit to Mongolia, and then refrigerated upon arrival to the testing laboratory. For every blood spot, a 1/4 inch disc containing about 1µl of sample was punched out of the filter paper. Disc samples were eluted in 400µl of phosphate buffered saline for samples to be tested for HBsAg and HCVAb, 200µl of specimen diluent solution for samples to be tested for HIV, or 4µl of 0.9% saline solution for rapid plasmin reagin (RPR) and FTA-ABS tests.

A total of 393 volunteers were enrolled. The prevalence of infection using the filter paper technique was 9.0% for syphilis, 10.5% for hepatitis C, and 21.6% for chronic hepatitis B. The prevalence of hepatitis C was higher among homeless people compared to other risk groups (21.3% vs 5.2–9.7%) (table 1). For 128 volunteers with chronic hepatitis B, 86 of them (67.2%) occurred in STI clinics attended. Eleven individuals had reactive tests for syphilis. Three individuals had reactive tests for HIV in the absence of antibodies for hepatitis B in their sera.

We found the filter paper technique for blood collection to be a reliable and useful method for serological studies in resource poor areas where blood collection and/or specimen transport may be difficult. Specimens were easily collected, stored, and transported before testing. Rates of viral hepatitis were high but rates of syphilis and HIV unexpectedly low. Future prevalence testing using this method will be able to determine trends of these communicable diseases in Mongolia.

Acknowledgements

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Contributors

IT helped design the project, organised and participated in specimen collection, performed data entry and analysis, and drafted the manuscript; MA organised and facilitated the study in Mongolia and reviewed the manuscript; SV helped design the project and reviewed the manuscript; JWG processed laboratory specimens for HIV testing and mentored IT in same, reviewed manuscript; EHH processed laboratory specimens for syphilis testing and mentored IT in same, reviewed manuscript; JS helped design project, was the principal mentor for IT for all aspects of the project, and assisted in writing the manuscript.

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Congenital syphilis—missed opportunities for prenatal intervention

The changes in political, economic, and social life in the eastern European countries—that is, greater group mobility, substantial rise in travel activity, changes of the sexual behaviour are all related to the increased syphilis morbidity.† These changes have not been treated for syphilis morbidity in Bulgaria in 1999 compared with 1990—that is, 2628±378 diagnosed cases respectively,‡ in 2000 there were 1605 cases. An increased number of syphilis patients among adolescents, young, and adult women, reflected the growing incidence of congenital syphilis. The incidence of congenital syphilis in Bulgaria increased from one case in 1990 to 31 in 2000. This is observed as one of the present alarming trends in morbidity.

We report four infants with congenital syphilis—a 20 day old male infant, two male newborns, and a 2 month old female. The children were in quite a bad condition. They were infected with disseminated disease (case 4), erythromyasquamous and haemorrhagic (case 1), bullous and papulosquamous lesions, and prematurity (cases 2 and 3). The mothers of the children were in quite a bad condition. They were treated with penicillin successfully. The mothers of the children had positive syphilis serology; they have not been treated for syphilis.

Congenital syphilis is a serious disease, whose clinical spectrum ranges from asymptomatic infection to fulminate sepsis or death. But many cases could be prevented with early and adequate prenatal care. Pregnant mothers have to be examined twice during pregnancy in the first and early third trimester as well as immediately after delivery (umbilical blood sample). Unfortunately, these rules are often not followed. The reduced or absent serological screening in pregnant mothers (as in our cases) is common. The mothers of cases 1 and 3 have not been tested at delivery. A general Lues serodiagnostic test is recommended in all newborns before they leave the obstetric departments.

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Some authors found that the longest delay was the time at the laboratory as in case 1. The mother was negative in the first trimester of pregnancy, became positive in the late third trimester, but the results came too late—after delivery.) Improved laboratory services will solve this problem.

Patients have often been treated by non-venerologists without contact tracing, like the father of case 1, and his diagnosis and therapy were not adequate. With regard to confidentiality patients often receive non-professional treatment or undergo self-treatment.

Unfortunately, the difficulty in dealing with patients having a poor educational background and insufficient sexual knowledge results in the impossibility to find all the sources of infection. The parents of patient 2 did not seek medical help, although the father had penis lesion. The mother did not visit a doctor after she was pregnant. Even her labour was at home, as it was in the mother of case 4.

Another big problem is prostitution, which is not legal and cannot be controlled in our country. The mothers of patients 3 and 4 were prostitutes, who did not seek medical assistance at all.

More than half of our patients are unable to indicate the name or address of the contacts (the fathers in case 1 and the mothers of cases 2, 3, 4), thus demonstrating the high frequency of occasional sexual contacts and the lack of protective measures.

The government health system has existed in Bulgaria for more than 50 years but social responsibilities are not legal and cannot be controlled in our country. The mothers of patients 3 and 4 were prostitutes, who did not seek medical assistance at all.

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Condom access does not ensure condom use: you’ve got to be putting me on

Approximately 15 million incident cases of sexually transmitted infections (STIs) occur in the United States each year. These figures are troubling, given the availability of primary prevention measures that sexually active people can use to avoid unprotected intercourse, including latex condoms. Although considerable attention has focused on making condoms widely available, surprisingly little research has examined whether condom availability is sufficient to ensure condom use. We recruited a convenience sample of 98 male students through advertisements posted on two Georgia university campuses to evaluate sexual risk taking behaviour. Men were required to be aged 18–29 years, full time students, and to have used condoms for ≥3 episodes of vaginal intercourse. After providing consent “within the same room” (median lifetime number of times without condom; range 1–450). Among men acknowledging unsafe sex, 42% (58%) admitted ever having unprotected intercourse despite ready access to condoms. Eighty-five men (87%) used condoms because of concern about acquiring STIs; of these, most men were also concerned about acquiring pregnancy. However, 73 men (74%) reported having vaginal sex without a condom when they “felt one should have been used” to protect against pregnancy and infection (median lifetime number of times without condom; range 1–300). Overall, condoms, although readily available, were not used in more than one third (37%) of lifetime acts of intercourse where risk of pregnancy or infection was perceived (fear or loss of sensation or erection, 17%). Among all 98 participants, 58 men (59%) also reported occasions in which they intended to use a condom, only to find that they did not have a condom with them. At the most recent occasion when condoms were not available, 34 men (38%) chose to have unprotected intercourse. The remaining 24 men (42%) elected to abstain from intercourse and instead participated in non-penetrative sexual activities posing less risk for STI acquisition, or waited until a condom could be obtained.

Despite the small size and self-selected nature of our population, these findings point to formidable barriers to condom use, at least in this heterosexual setting. Condom availability did not ensure condom use, even when condoms were needed. Similarly, the lack of availability of condoms did not deter most men from having intercourse. Avoiding sexual intercourse with an infected partner is the most effective way to prevent STIs. However, for sexually active people, condoms can only reduce the risk of infection when they are both readily available and actually put on.

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Conflict of interest: Neither author has a conflict of opinion on the topic. This letter to the editor responds to a conflict of interest raised by an author from another country.

Contributors

Both authors have made substantial contributions to the intellectual content of the paper. Their financial involvements or specific affiliations. All financial and material support for this research and work are clearly identified in the manuscript.

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References


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Resolution of the recent performance problem of Abbott LCx Chlamydia trachomatis assay. Issues of repeat testing for confirmation of chlamydial infection

In February 2001, Abbott Laboratories issued a device correction notice to users of their LCx Chlamydia trachomatis assay suggesting that initially reactive ligase chain reaction (LCR) tests should be repeated on the same sample to validate the test result. A recent alert (December 2001) from the Medical Devices Agency (MDA, DA2001(09)) indicates that the device correction is still in force and points out the resource implications where retesting is required. We offer some data on LCR performance characteristics during this period and before.
The Department of Health pilot study on “Opportunistic screening for genital chlamydial infection in Portsmouth and Wirral” ran for a year up to October 2000. During that study, the standard adopted for reporting chlamydial infection included a repeat LCR test on all first catch urine samples that were initially LCR positive. Samples giving discrepant LCR results were further tested by Roche Cobas (PCR) polymerase chain reaction. Chlamydia LCR urine screening, with repeat testing of initially positive LCR urines, has continued in the Wirral pilot area and is also being used in other research projects locally.

Following the original device correction, we continued to carry out a repeat LCR but additionally included a PCR test on all initially positive LCR urine samples. Analysis of our data (Table 1) suggests that compared to the baseline (satisfactory) performance during the Wirral pilot there was indeed a noticeable LCR reproducibility problem when the device correction notice was issued. Since then, however, the LCR performance has improved gradually to be at least as good as in the pilot period.

The MDA alert properly deals with kit expiration dates, but requires no further action if a test is 100% accurate. Problems of reproducibility have been reported for both LCR and PCR.

We recognise the dilemma in repeat testing of samples that give positive reactions in chlamydia NAATs; on the one hand, a low organism load in the specimen makes repeat positivity a matter of statistical chance of retesting a portion with detectable numbers—so cases will be missed. On the other hand, repeat confirmation ensures a more robust diagnosis is made which is so important in the light of the major implications of a chlamydia diagnosis for those who consider themselves well but decide to take a screening test. We would welcome debate on the need for retesting or independent confirmation of positive chlamydia NAATs and support the need for continuous monitoring of all tests to ensure their consistent optimal performance.

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# Table 1
Repeat LCR testing and PCR testing of initially positive LCR urines during the Wirral Chlamydia Pilot (Sept 1999 to Oct 2000, baseline) and for 3 month periods since the issue of the device correction (February 2001)

<table>
<thead>
<tr>
<th>No of urines</th>
<th>Negative</th>
<th>equivocal (0.5–0.99)</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial LCR positive (Sep–Nov 01)</td>
<td>960</td>
<td>65 (6.8%)</td>
<td>12 (1.3%)</td>
</tr>
<tr>
<td>Repeat LCR:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>65 (6.8%)</td>
<td></td>
<td>12 (1.3%)</td>
</tr>
<tr>
<td>equivocal (0.5–0.99)</td>
<td>12 (1.3%)</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Negative</td>
<td>13</td>
<td>50</td>
<td>2</td>
</tr>
<tr>
<td>Initial LCR positive (Jun–Aug 01)</td>
<td>134</td>
<td>42 (31%)</td>
<td>18</td>
</tr>
<tr>
<td>Repeat LCR:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>42 (31%)</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>equivocal (0.5–0.99)</td>
<td>18</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Negative</td>
<td>36</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Initial LCR positive (Mar–May 01)</td>
<td>121</td>
<td>24 (19.8%)</td>
<td>2</td>
</tr>
<tr>
<td>Repeat LCR:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Positive</td>
<td>24 (19.8%)</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>equivocal (0.5–0.99)</td>
<td>2</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Negative</td>
<td>19</td>
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<td>1</td>
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<tr>
<td>Initial LCR positive (Sep 99–Oct 00)</td>
<td>960</td>
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<tr>
<td>Repeat LCR:</td>
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<tr>
<td>Positive</td>
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</tr>
<tr>
<td>equivocal (0.5–0.99)</td>
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</tr>
<tr>
<td>Negative</td>
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</tbody>
</table>

(a) inhibitory, (b) insufficient.

We have recently also examined the reproducibility of our Roche Cobas chlamydia PCR results and are concerned to have found that of 282 initially PCR positive urine samples only 273 gave repeat PCR positive results.

We sense that there may be a mistaken view that patients should be made aware (as we did during the screening pilot) that no test is 100% accurate. Problems of reproducibility have been reported for both LCR and PCR. We recognise the dilemma in repeat testing of samples that give positive reactions in chlamydia NAATs; on the one hand, a low organism load in the specimen makes repeat positivity a matter of statistical chance of retesting a portion with detectable numbers—so cases will be missed. On the other hand, repeat confirmation ensures a more robust diagnosis is made which is so important in the light of the major implications of a chlamydia diagnosis for those who consider themselves well but decide to take a screening test. We would welcome debate on the need for retesting or independent confirmation of positive chlamydia NAATs and support the need for continuous monitoring of all tests to ensure their consistent optimal performance.

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