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BIG BROTHER SHOULD BE WATCHING

With the steeply rising STI prevalence seen today in many countries should we not be directing resources to finding out which sexual behaviours are bad for our health? That is, who is indulging in such unhealthy behaviour, how are these changing over time, and what key behaviours we are failing to collect and why?
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WHO PAYS FOR FORESIGHT?

Screening for chlamydia, rather than testing symptomatic women, is cost saving even when prevalence falls to 1.1% if the appropriate age and tests are chosen. However, such interpretations depends on unvalidated assumptions. And of course costs saved by a later generation are incurred by earlier ones. Also, offering chlamydia testing to women undergoing termination of pregnancy has, unsurprisingly, a high pickup rate. Asking the women to pay a £20 fee would, however, self exclude two thirds of women. Clearly society needs to see itself longitudinally and not in cross section.
See p 406 and 416

WHO PAYS FOR THE INFANTS?

Current US guidelines in preventing neonatal herpes are cost effective but have little impact on transmission—missing 82% of infections. To prevent the rest—with a screen and suppress policy—would cost over one third of a million dollars per child saved. Can life be turned into cash?
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REMEMBER MEN

Men are getting a raw deal when it comes to chlamydia screening, even though no one doubts that it is sexually transmitted. Hart *et al* suggest we should screen all men attending GUM clinics. But most already do. If, however, 71% of young men access their GP at some time—here is an opportunity lost.
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NUGENT SIMPLIFIED

A simple diagnostic test for bacterial vaginosis which did not depend on a wine-taster's nose or a microscopist with elephantine patience was sorely needed. Cathy Ison has validated a greatly simplified way to diagnose bacterial vaginosis (BV) on Gram stained slides. The way is open for large scale field studies of BV and in particular its relation to HIV transmission.
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TARGET THE INFECTED

Since only HIV infected individuals can transmit the infection, DiClemente argues, it makes sense to target this group for preventative health education, particularly as this group are increasingly engaging in unsafe behaviour. Unfortunately, most behaviour intervention studies show little evidence of long term persistence.
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BREAK THE CODE

Contact tracing with the standard contact slip containing a diagnostic code is notoriously unrewarding. Wright *et al* show that if you spell out to the contact that they have been exposed to chlamydia, and give them some information to scare them out of their complacency they are more likely to attend for treatment. Confidentiality? This strategy probably makes it easier for partners to talk about the infection. Will it apply to other STIs?
See page 422

TONGUE TWISTING ULCER

Bacteriologists must have a sadistic streak. Consider *Calymmatobacterium granulomatis*, the organism of donovanosis. The tropical medicine series visits this unusual condition which has such patchy epidemiology, uncertain sexual transmission but probable importance in HIV transmission. O'Farrell gives us good pictures and the good news that it is a *Klebsiella* after all, just as it appears to be vanishing.
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PATCHY PREDICTABILITY

A simple scoring system based on age, gender, and number of lifetime partners was able to predict prevalence of HSV-2 antibody in London blood donors. But the same criteria were not reproducible in other settings hence limiting its usefulness.
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ABORT THE LESION

Episodic treatment of recurrent genital herpes with valaclovir can abort lesions, particularly if started within six hours of signs or symptoms. Three days treatment was as effective as five days. In the USA, three day therapy with acyclovir is licensed. Why not in Europe?
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AUTUMNAL FLUSH

Chlamydia is not the sole cause of simultaneous conjunctivitis and urethritis. Think adenovirus especially if they admit to receptive oral sex in the autumn or winter months
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