

SCREENING

Screening asymptomatic men for non-specific urethritis

J C D Ross

For a clinical guideline to be of use, it needs to make clear recommendations for practice based on the available evidence. But what should be recommended when the evidence is finely balanced, limited and/or contradictory? An example of this is whether or not men without symptoms should be screened for non-specific urethritis (NSU)—a decision faced by virtually all clinicians working in sexually transmitted infection (STI) clinics every day. In many countries this practice was abandoned many years ago, but in others, particularly in the UK, it remains common.

If robust clinical trials are not available, then expert opinion forms the next level in the evidence hierarchy. The papers presented here provide an analysis of the

data on screening asymptomatic men for NSU, interpreted by experts who are familiar with the data and have considerable clinical experience. As you will see, they reach different conclusions. The purpose of presenting the arguments for and against in this forum are threefold. First, it draws together the available evidence and allows individual clinicians to make an informed choice about their own practice. Second, it clarifies the process that informed the decision not to recommend screening asymptomatic men for NSU in the recently published *UK national screening and testing guidelines for STIs*.¹ In this case the group commissioning the guidelines (clinical effectiveness group of the British Association for Sexual Health and HIV (BASHH))

reviewed the expert opinions and made a recommendation based on them. Third, it highlights the obvious gaps in our knowledge and indicates the need for further research. The main focus here needs to be on further defining the aetiology and pathogenesis of NSU, and on determining its long-term morbidity, especially regarding any effect on fertility in women.

The arguments for and against screening asymptomatic men for NSU are not clear-cut, but when an asymptomatic man walks into a clinic, clinicians have to make a decision, and not changing current practice is as active a choice as altering practice. The national guidelines and the information below should allow you to make the best choice for your patients based on what is currently known.

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REFERENCE

- 1 Ross JD, Ison CA. UK national screening and testing guidelines for STIs. *Sex Transm Infect* 2006;**82**(Suppl IV):iv1–iv5.

Chlamydia trachomatis, is it still useful to perform urethral microscopy in all men attending STI clinics even when symptoms are absent? We believe not and present our argument below in the form of answers to the questions that reflective clinicians will ask themselves when confronted with this issue.

WILL IMPORTANT PATHOLOGY BE MISSED IN THE MEN?

There is no evidence that cases of *C trachomatis* infection would be missed. Although the sensitivity of chlamydia assays is not 100%, more modern NAATs such as the Aptima assay from Gen-Probe Inc (San Diego, California, USA) shows very high sensitivities for detecting chlamydia in men via either urethral swabs or urine specimens (97.5% and 96.2%, respectively).¹⁴ So the question becomes that of whether there are any serious causes of NGU once infection with *C trachomatis* has been excluded. Currently the only microorganism that is a candidate for this role is *Mycoplasma genitalium*. The evidence that this causes NGU in men is extremely strong,¹⁵ but NGU itself in men is a nuisance condition, not a serious disease. By analogy with chlamydia, the important question is

Urethral smear in asymptomatic men

Is the urethral smear necessary in asymptomatic men attending a genitourinary medicine clinic?

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Available evidence does not support the performance of urethral smears in asymptomatic men

Urethral microscopy has long been an integral part of screening for non-gonococcal urethritis (NGU) in men.¹ This made sense when reliable tests were not available for chlamydia, although it has long been recognised that the urethral smear is a poor investigation, having high rates of both inter-observer² and intra-observer^{2,3} error (hardly surprising when one pauses to consider how the test is carried out). Another important observation, made by Swartz and Kraus,¹ is that more than one half of cases of asymptomatic urethritis resolve after 1

week without any treatment. Although a number of microorganisms are associated with NGU, no pathogen is isolated in the majority of patients (table 1), particularly in asymptomatic men.^{4–12} Moreover, there is no evidence that pathogen-negative NGU is a sexually transmitted infection (STI).¹³ Hence many patients are unnecessarily labelled as having an STI with all the associated implications for themselves and their partners. Now that accurate tests (nucleic acid amplification tests (NAATs)) are routinely available for the important pathogenic agent known to cause NGU,