Highlights from this issue

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Jackie A Cassell, *Editor*

This month, we publish two reports[1 2] on the effect of viral sexually transmitted infections on quality of life. These are particularly timely for British readers, with the recent reporting of a survey of UK doctors by the British Association of Sexual Health and HIV research (BASHH) (REF http://www.bashh.org/news/576_hpv-vaccine-press-release)—the bivalent vaccine, protecting against oncogenic viruses but not the subtypes most commonly causing genital warts, has been chosen for the national vaccination campaign. According to reports of BASHH's survey, 93% of sexual health clinicians would advise the quadrivalent vaccine, and 61% had obtained this for their daughters either instead of, or in addition to, the vaccine available through the National Health Service (NHS). Sénécal *et al*,[1] in a study funded by Merck Frosst, show detriment in anxiety/depression, pain/discomfort and usual activities scores for genital warts. In a broader-ranging Indian study, Raj *et al*[2] also show physical and psychological impairment for HPV, though this was not as great as for HSV, HIV or mixed infections.

We are also publishing two 'big picture' surveillance studies, focussing on the remarkable inequalities in STIs that persist between populations, by comparison with rates of chronic diseases. Gorgos *et al*[3] report trends in the distribution of gonorrhoea diagnoses in the USA, reporting a concentration such that over 50% of all cases are seen in only 57 of 573 counties, with a predominance in young, non-white women. A more complex picture can be told for syphilis, with its stages and gradations, and Jebbari *et al*[4] report a story of partial success in control. By contrast with the early days of syphilis re-emergence, primary cases now exceed secondary cases. Nevertheless, latent cases form a higher proportion where contacts were casual, and a very high proportion of all cases remain oral sex associated, and/or in men who have sex with men (MSM).

This takes us into the question addressed by this month's open access Editor's Choice.[5] Kalichman *et al* have reviewed the literature on HIV co-infection with STIs, and conclude that the high prevalence of STI in this population may well impact on the potential for HIV treatments to catalyse prevention. This work is put nicely in context by Hao *et al*'s study from China,[6] which reports an incidence of 4.17 per 100 person years for HIV, and 7.58 for syphilis. Testing has a role in prevention, as attested in a South African study of HIV testing in relation to sexual health communication,[7] and a Scottish study of HIV testing in relation to undiagnosed HIV.[8] However, it is clearly not a panacea.

Niccolai *et al*[9] report an interesting study which attempts to estimate the proportion of repeat chlamydial infections that were attributable to new partners, rather than untreated partners. The largest attributable fraction was due to new partners, and the authors conclude that while expedited partner treatment is important, condom use and reduction in partner numbers remain important targets for health promotion.

The complexity of our field is attested in a study by Bórquez *et al*,[10] in a Mexican study of condom use by female sex workers. They conclude that, in assessing the transmission potential of commercial sex work, the devil is in the details of which client groups use condoms consistently.

We publish this month a number of letters on topics as diverse as the use of urethral probes for pleasure and the associated risk of infection, and quinolone resistance in Kenya. Don't forget to look at the STI blog for fortnightly updates of sexual health news, and our ever growing library of podcasts.

Provenance and peer review Not commissioned; internally peer reviewed.

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