as to whether HSV-2 serologic testing among asymptomatic persons results in persistent negative psychosocial consequences.

**Methods**
Eight electronic databases and unpublished data sources were searched to identify studies measuring the psychosocial impact of HSV-2 serologic testing in persons without a history of genital herpes. To be included, studies had to test for HSV-2 using an HSV type-specific serologic test and to perform at least one psychosocial assessment of participants after they received HSV serologic results. We compared psychosocial responses in HSV-2 positive persons over time and vs HSV-2 negative persons (when available).

**Results**
Nine studies satisfied the inclusion criteria. Studies were published from the years 2000–2008 and were conducted in the USA (N = 6), Australia (N = 2), and the UK (N = 1). In total, 1355 participants were included; 596 (44%) participants were HSV-2 positive, and of these 341 (57%) lacked prior history of genital herpes. Participants were recruited from a variety of settings (ie, STD clinics, HMO enrollees, college campuses). Follow-up ranged from immediately after diagnosis to 1 year afterwards. Seven studies reported that HSV-2 diagnosis by serologic test did not have a persistent negative impact on participants’ mental health (anxiety, depression, self-esteem) or sexual attitude and satisfaction. Two studies reported a negative impact of testing; one found that 5 HSV-2 seropositive college students had increased distress 3 months post-testing as compared to HSV-2 negatives, and the other found self-reports of sexual undesirability up to 1 year after diagnosis. A genital herpes diagnosis was perceived as moderately severe for participants prior to testing; however, after HSV-2 testing, the perceived severity of a herpes diagnosis was lower among those testing HSV-2 positive.

**Conclusions**
Diagnosis of HSV-2 by type-specific serologic testing did not result in long-term psychosocial harm in most asymptomatic persons. Concerns about sustained emotional impact should not deter clinicians from testing individuals without a history of genital herpes for HSV-2.

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**P2-S3.11 STI-RELATED RISK BEHAVIOURS AND STI DISPARITY BETWEEN RESIDENTS OF BALTIMORE CITY AND OTHER URBAN CITIES IN THE USA**


1M Villarroel, 2S Rogers, 3C Turner. 1Johns Hopkins University, Baltimore, USA; 2RTI International, Washington, District of Columbia, USA; 3City University of New York, Queens College and the Graduate Center, New York, USA

**Background**
Baltimore City, Maryland, has experienced rates of STDs that are consistently higher than the national average. National surveillance data indicate that in 2000 the rates of gonorrhea and Chlamydia in Baltimore City were 3.3 and 6.7 times higher than the overall US rate. Among US cities with greater than 200,000 people, Baltimore City ranked among the top four for Chlamydia and gonorrhea infection rates.

**Objective**
To compare reports of diagnoses of gonorrhea and Chlamydia among adults residing in Baltimore City to those in other central cities of the US and to assess whether a higher prevalence of sexual and substance use behaviours in Baltimore may account for infection disparity.

**Methods**
We utilised data collected from a cross-sectional probability telephone survey of the USA (N = 1,545) and Baltimore City (N = 744) adults aged 18–45 years old in 1999–2000. Respondents were asked about a wide range of STI-related risk behaviours and STI history. Bivariate analysis assessed differences in the prevalence of self-reported history of gonorrhea and chlamydia, substance use, and sexual risk behaviours among residents of Baltimore City and other central cities of the USA Multivariate logistic regression models measured heterogeneity in self-reported history of gonorrhea and chlamydia by location of residence, substance use and sexual history, adjusting for race and age.

**Results**
Lifetime prevalence of gonorrhea and chlamydia was 18.2% (95% CI 14.8% to 22.1%) among Baltimore residents and 9.8% (95% CI 7.3% to 13%) among residents of other central cities (p < 0.001). In bivariate analysis, Baltimore residents were more likely to report having six or more lifetime sexual partners (49.1% vs 40.7%, Prev. Ratio 1.21 (95% CI 1.2 to 1.24)), multiple partners in the past year (24.3% vs 16.9%, Prev. Ratio 1.4 (95% CI 1.4 to 1.5)), and a history of paid sex (17.8% vs 8.7%, Prev. Ratio 2.0 (95% CI 1.8 to 2.3)).

**Conclusion**
The higher prevalence of sexual risk behaviours among Baltimore adults is likely to accelerate STI transmission and contribute to the higher incidence of STIs in Baltimore.