Highlights from this issue

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As testing technologies evolve, they change clinical practice. Once upon a time, nearly all tests in the venereology clinic were 'near patient' or 'point of care' (POC) tests, though we didn't yet think of them in this way. Microscopy whether dark ground, wet preparation or Gram stained; the Wassermann reaction; the complex clinical phenomena of syphilis on which so much of the art of clinical examination was founded—all these were POC tests. With the advent of nucleic acid amplification tests, and the decline of morbidity due to syphilis, the time from test to diagnosis extended. It became less clear what an STI clinic had to offer a patient. In theory at least, most tests could be accessed through a GP or any other provider by a patient willing to wait a few days for the lab report. Chlamydia testing or screening programmes of several developed countries[1] take it for granted that a week's wait for a diagnosis is of negligible public health impact, when measured against the benefits of testing the wider population. For the majority of individuals, this is probably correct.

Demand for POC tests has grown, driven by the needs of low resource settings as well as the age-old desire of patients to know what is wrong with them, today and not next week. POC testing for HIV is now widely available for higher risk individuals in most clinics, and in a few years we may have regained a golden age in which most tests are done on the spot, in clinic. This creates its own challenges. Herbert *et al*[2] report their evaluation of a CD4 POC test, which was found to be highly correlated with laboratory CD4 testing in the HIV clinic setting. The extent to which this will change, or reduce the costs of, HIV care is of course far from clear. Treatment decisions are made in the light of viral load and resistance tests as well as CD4 count—clearly both economic and clinical evaluations of the resulting care pathways are needed. For many conditions, staff costs outweigh treatment costs and underpin the argument for a POC test. In HIV, by contrast, the high and ongoing costs of medication are a more important consideration in optimising the care pathway. We look forward to seeing evaluations of such tests in a wider context.

Can contamination of clinic surfaces create false-positive nucleic acid amplification tests? Anxiety about cross-contamination has grown in recent years, as patients increasingly swab themselves unsupervised, in communal toilets at the clinic. Lewis *et al*[3] report higher rates of contamination within patient toilets than clinical areas—while the small quantities of nucleic acid detected a low risk of cross contamination, the potential for false-positives remains.

The potential of testing to improve care is the focus of Korhonen's study of genotyping rectal and pharyngeal chlamydia specimens[4]. They suggest that subtyping can be used to achieve prompt diagnosis of LGV within diagnostic laboratories. A surveillance study exploring syphilis subtypes and resistance in South Africa[5] by Müller *et al* reassuringly shows low levels of macrolide resistance in South Africa. Such studies are essential for development of evidence based diagnostic and treatment practices.

As the availability of sexual health services develops beyond the traditional specialist providers in many countries, new questions arise about who can provide, and the role of specialists. General practice is an acceptable place for STI testing for the majority of young men—contrary to much popular and professional mythology. Saunders *et al*[6] report that four-fifths of young men would be willing to have an STI test in primary care—and three quarters have seen their GP in the past year. These findings, consistent with other data on young men's use of general practice, present a challenge to those wishing to develop innovative, non-clinical service models for young men. Primary care presents an opportunity to meet their wider health needs, including smoking and drinking. The challenge is not to create new settings to find men, but to use better what we have—for example, to use STI clinics to address their wider health risks, while training general practitioners in basic sexual health care. Worryingly, Kepka *et al*[7] report from the USA that half of practitioners admit to making guideline-inconsistent recommendations for the HPV vaccine. Specialists need to continue a supportive and productive dialogue with primary care practitioners, opinion leaders, commissioners and policymakers.

Other highlights of this issue include a report of lower sperm counts and higher rates of sperm abnormality in genitourinary (GUM) medicine attenders, by Carne *et al*[8]—go to our website for a podcast discussing the implications of this study. Nadarzynski *et al*[9] report an interesting study on the impact of risk factor and aetiological information about HPV and cervical cancer for women. Finally, two behavioural studies emphasise ongoing risk for MSM, which remains a major public health failure: Zhang *et al*[10] report growing HIV prevalence in Chonqing, China, while Marongiu *et al*[11] demonstrate higher risk of HIV and HCV in intravenous drug users in Scotland.

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