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Highlights from this issue

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We start 2016 with an editorial that looks towards the future shape of sexually transmitted infection (STI) services and research. Chen *et al*¹ introduce the recent RECORD guidelines, and extension of the STROBE guidelines (<http://www.strobe-statement.org/>) which covers Reporting of studies Conducted using Observational Routinely collected Data. We have published a growing number of studies using electronic health record data, many from Australia where use of fully electronic records is widespread. Although the challenges of collecting and interpreting such data are considerable, as discussed in an interesting study by Brook *et al* and a BASHH column, the use of electronic health records is opening a new era in health research. At *STI* journal we strongly encourage the use of guidelines, such as those promoted by the Equator Network (<http://www.equator-network.org>). Large scale routine health dataset enables us to increase the scale, detail and coverage, while introducing new opportunities for error and ambiguity. Research has traditionally built on customized data collection tools, but now even Randomised Controlled Trials are now being conducted using routine records for outcome assessment. Our next generation of researchers will need to develop the skills to work with, link and enhance routine datasets, and to address openly and transparently the very real challenges and opportunities of the electronic data age.

Routine electronic health records also provide new opportunities to improve risk assessment and the targeting of services, and we need to look at ways to do this simply and efficiently, at scale. Lee *et al* report a simple risk assessment tool with good performance in identifying higher risk clients in the UK,² while in the USA Gaydos *et al* report the use of a “risk quiz” to explore the relationship between behaviour and online test positivity.³ Falasinnu *et al* similarly attempt a clinical prediction rule, reporting a sensitivity of 86% in a Canadian setting.⁴ With growing pressure on clinical services, and increasing demands to simplify, streamline

and reduce their cost, commissioners and insurers will expect us to understand and use opportunities to target complex services to those at greatest risk. We should however be cautious in our embrace of new technologies as solutions for patient care, as Nuñez-Forero *et al* remind us in a report on still weak performance of point of care tests, especially for *Chlamydia trachomatis*.⁵

Two studies address the still mysterious role of *Mycoplasma genitalium*, with a follow up from the POPI study⁶ reporting that it disappeared as a risk for pelvic inflammatory disease after adjustment for baseline *Chlamydia trachomatis*. Van de Veer *et al* estimate in the Netherlands that up to 6% of symptomatic STI in males could be due to *M. Genitalium*, where *Trichomonas vaginalis* remains uncommon among males. The epidemiology of *Trichomonas vaginalis* in Europe and most other developed countries is still in striking contrast to extremely high prevalence reported in the USA, this month by Alcaide *et al*.⁷

Our clinical readers will be interested in a report on the role of *Haemophilus influenzae* and *parainfluenzae* in male urethritis. How often is this missed through lack of testing, as we switch to nucleic acid testing? Widespread contamination of clinical services by HPV is also a concern.⁸

HIV testing, and its disclosure to partners in South Africa is interestingly explored by Doherty *et al*,⁹ while Ding *et al* report incident HSV in HIV discordant couple.¹⁰ HIV incidence in a community cohort of MSM in Spain is reported by Ferrer *et al*.¹¹

Other themes this month include medicated sex in the UK National Study of Sexual Attitudes and Lifestyles,¹² the interaction between drug use and location of risk in MSM,¹³ HPV in transsexuals and the need to interpret chlamydia surveillance trends in the light of laboratory related effects. Something for all of our readers, we hope. Happy New Year.

Competing interests None.