Highlights from this issue

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Once upon a time, it all seemed so simple. Early trials of chlamydia screening looked promising in reducing the incidence of pelvic inflammatory disease, so attention quickly turned to evaluating means of delivery, and it was widely assumed that prevalence would rapidly fall. As the optimism of a new millennium faded, chlamydia prevalence was shown in a range of studies to remain stubbornly resistant to control activities or to decline regardless of testing patterns. A number of population based studies suggest that pelvic inflammatory disease (PID) is also in decline in many settings, for reasons which remain unclear. So what is the impact of chlamydia screening or other control activities? Are we selecting for less symptomatic strains (and if so, are they less damaging to fertility?) Have approaches to the diagnosis of PID changed? Are health-seeking behaviours—or health professional practices—changing in ways that challenge our ability to measure the outcomes of chlamydia testing or screening? How could we tell? In this month's issue, Heijers *et al*[1] offer an overview of chlamydia testing in a region of the Netherlands, showing very different distribution of test setting by gender, with little extragenital testing outside STI clinics. In an accompanying editorial, Woodhall and Saunders[2] remind us of the basic principles of assessing chlamydia control, recognising the wide variety of relevant metrics that need to be taken into account. A related UK paper explores chlamydia testing in a population based sample of young adults, emphasizing untapped potential for testing in more deprived areas where prevalence is higher.[3]

Clinically oriented readers will be interested to see a case series of men with adenovirus urethritis, in which the median duration of symptoms was surprisingly long at 7 days.[4] Dysuria was very common, as was visible meatitis. Cervicitis is another diagnostic conundrum in the sexual health clinic setting. In a careful study, Lusk *et al*[5] show that only 18% of confirmed cervicitis cases could be attributed to four common pathogens, suggesting that there is much still to be discovered about its aetiology. The role of genital inflammation more broadly is an emerging field. Masson *et al*[6] demonstrate very high levels of inflammatory cytokines in cervico-vaginal lavage among women with a variety of bacterial STI—not, however, reflected in plasma cytokines.

Sexual behaviour research is more easily undertaken, and more socially acceptable, in some settings than others. This often leads to the mistaken belief that it is impossible, and that little or nothing is known about the behaviour of their at risk groups. If you look through our archive, you will find many examples of research from "difficult" settings—such as our blockbuster special issue on Middle East and North African research in 2013.[7] We are delighted this month to publish a population based survey on STI related symptoms from Iran,[8] a report on STI and HIV in MSM from Uganda,[9] and an exploration of rectal microbicide preferences in Peruvian MSM.[10]

Turning our attention to the developed world, an interesting substudy from the "Safe in the City" trial has implications for partner notification practices.[11] Abstinence before adequate treatment is more likely where an index male patient has communicated an STI diagnosis to a partner. This suggests that we could consider evaluating time to communication of STI diagnosis to partner as an outcome measure within the care pathway. This could be facilitated by new communication technologies such as Suggest a Test.[12]

Finally, we draw your attention to interesting reports on condom "deserts" and their implications,[13] a field test of novel syphilis and HIV diagnostic,[14] and an exploration of differing HPV epidemiology by gender and sexual orientation in the wake of vaccination.[15] We hope you enjoy this month's issue.

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