Highlights from this issue

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Science marches on, opening up new approaches to diagnosis and treatment. It's always important to consider the potential downside of new developments—which may vary between settings. This month Giffard and colleagues report on an experiment with contamination which re-emphasises the need to get the basics of specimen collection right.[1] Eagle eyed readers will remember this team's editorial exploring the meaning of a positive nucleic acid test for *Chlamydia trachomatis* in the Australian context where—shockingly—trachoma remains endemic in indigenous areas where STI is often reported in young adolescents.[2] This is all fascinating stuff which takes us back to the basics of positive predictive value, negative predictive value and the importance of getting the testing environment clean, as has also been explored in the UK setting.[3]

Another theme of this month's issue is surprises. Surprises, of course, are relative—a surprise HIV diagnosis in a gastroenterology or haematology clinic may not be unexpected to an HIV physician. And, of course, *vice versa*. Extra-rectal *Lymphogranuloma venereum* is probably a surprise everywhere it pops up, and may well not present initially to sexual health physicians. Desclaux *et al*[4] report on the molecular and clinical aspects of this condition in France, a fascinating read. In a similar vein, Lee *et al*[5] report acute hepatitis A infection in an HIV positive individual previously confirmed as immune, in a report which has implications for clinical practice and for immunisation policy.

Antimicrobial resistance (AMR) is a regular and worrying topic for our readers. In the case of *M. genitalium* the current lack of routine testing complicates estimates of resistance, as reported by Pitt *et al*.[6] However even if surveillance data have their limitations, the systematic review by Horner *et al*[7] confirms high rates of treatment failure and development of macrolide resistance under standard single dose regimes. This is a real concern. On the topic of AMR, we also have a report on *N. gonorrhoeae* from surveillance sites in Zimbabwe, by Latif *et al*[8] and a letter from Affolabi and colleagues in Benin.[9]

The treatment of genital warts is an important, if unglamorous, topic - a condition that causes real, hidden and often stigmatised distress. While HPV vaccination offers some hope for the future, it is unlikely to eradicate a distressing and persistent condition. As a colleague observed , 'For some unlucky people, it really destroys their lives'. Although we cannot report a magic bullet, it is good to be able to report clearly on the state of the evidence, and this month Westfechtel and colleagues[10] publish a meta-analysis stating that there is no reliable evidence favouring systemic interferon over ablative treatment.

What is the role or importance of specialist sexual health services for higher risk groups? This may feel straightforward in major urban centres, but in many settings men who have sex with men (MSM) may have no choice but to go to the nearest service. It is therefore fascinating to ready Mebrahtu *et al*'s report on service provision and uptake within and outside specialist sexual health services.[11] MSM attending non-specialist clinics were younger, more likely to be of mixed ethnicity, more likely to have an STI diagnosis, but less likely to have an HIV test.

Where, when and who to test for STIs and HIV? These issues are addressed by several research reports by Datta *et al* on MSM perceptions of STI testing[12] and HIV testing in a mobile van.[13] The vexed relationship between migration and risk is addressed by Shang *et al*[14] while the co-infection relationships between shigellosis and HIV reported by Mohan and colleagues[15] and HPV/STI described by Giuliano *et al* are fascinating.[16] And it is always good to see an RCT of sexual risk reduction like the one reported by Eaton *et al*. [13]

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