Meena Gupta, *Clinical Research Fellow, Department of Genitourinary Medicine, Arrowe Park Hospital, Wirral, UK*

Asha Kasliwal, *Specialist Registrar, Department of Obstetrics and Gynaecology, Arrowe Park Hospital, Wirral, UK*

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Author's reply

Madam

We read with interest the letter referring to our recent paper.[1] The authors raise important testing issues that have significant training implications. The accuracy of tests for chlamydia and gonorrhoea depend upon the quality of the clinical specimen. In addition to accurate technique and correct choice of swab, the authors highlight the important need for information on specimen storage and transport. Evidently, from their audit, the results of our survey and other studies, there is a clear need for comprehensive guidelines and training to optimise testing. Furthermore, training is required not only on accurate specimen collection and storage but also in identifying clinical symptoms, history taking, information giving, treatment and follow-up care. The latter may involve contact tracing and counselling, or clear information on the need to refer to genitourinary medicine (GUM) for these aspects of infection management and co-morbidity screening. An emphasis on the need to test at the time of intrauterine device (IUD) insertion and on emergency contraception is also required. As data from the UK pilot studies inform an imminent screening programme that will opportunistically test in primary care, these training issues become essential. Failing to optimise clinical practice may mean that screening will in fact do more harm than good. Finally, with the increased use of nucleic acid amplification tests (NAAT), and non-invasive samples such as urine, the need for clear guidelines and local agreement on how to organise testing is required to ensure effective use of resources.

Catherine Griffiths, *London School of Hygiene and Tropical Medicine, London, UK*

BULLETIN BOARD

Football helps the fight against HIV

During the course of a 90-minute football match, 400 young people aged 15 to 24 years will have contracted human immunodeficiency virus (HIV) worldwide. Around 100 children under the age of 15 will die from acquired immunodeficiency syndrome (AIDS) and another 400 will lose parents through AIDS. The United Nations Children's Fund (UNICEF) has joined forces with the International Federation of Association Football (FIFA) to use the power of football to educate young people around the world about HIV/AIDS. In Ethiopia and Kenya there are projects that involve a variety of football programmes. At half time players, coaches and health workers distribute brochures and information to supporters and opponents about preventing the disease. Young people are being encouraged in these programmes to play a role in the fight against the spread of HIV.

Source: www.durexhealthcare.com

Proposal for health services in UK schools welcomed by fpa

Anne Weyman, the Chief Executive of fpa (previously the Family Planning Association), said: 'We welcome the Government's acceptance of the recommendation that health services should be available on site in schools. The rate of teenage pregnancy in this country is too high and action to bring it down is essential. Measures such as this are eminently sensible'. Ms Weyman went on to state: 'Young people need easy access to confidential and holistic health services that meet their needs and cover a range of issues, such as relationships with family and friends, emotional problems and general health as well as sexual health. Provision of such services is up to the school community of parents, teachers, pupils and governors but ideally we'd like to see them available in schools throughout the country'.

Source: fpa press office June 2002

Perpetuating the negative attitude toward the intrauterine contraceptive device

The intrauterine device (IUD) has received a plethora of bad publicity since the 1970s and has been blamed for everything from pelvic infection to infertility and ectopic pregnancy. Studies since the 1970s, however, have shown that the risk of infection is largely confined to the immediate time following insertion and that the ectopic risk overall is reduced. A recent study by Espey and Ogburn published in *Contraception* examined the information regarding the IUD in medical textbooks published between 1996 and 2001 in both Britain and the US. It was disappointing that over half of the textbooks published still mentioned these factors as risks associated with the IUD and suggested that the IUD should only be used as a last resort. The authors state that many of the teachers in medical schools also appear to be continuing to pass on these myths. It is clear that new evidence needs to be in the public and professional domain so that these myths can be dispelled.

Source: Espey E, Ogburn T, Perpetuating the negative attitudes about the intrauterine device: textbooks lag behind the evidence, Contraception *2002;* **65***: 389–395*

New website for health care professionals caring for asylum seekers in the UK

A national website has been launched for health professionals and volunteers working with asylum seekers and refugees. This website can be found at **www.harpweb.org.uk** and provides a huge amount of useful information for all health care personnel involved in the management of the many health issues faced by asylum seekers. It covers issues related to men and women including emotional problems, genital mutilation and cultural issues. It has very useful link called 'communicate' that provides access to a multilingual appointment card. Name, address, consultant, place of appointment is typed in English and it is automatically translated into one of many languages. It can be used and printed online. This site will prove useful to anyone with an interest in issues facing asylum seekers.

Source: www.harpweb.org.uk

New international society for sexuality and cancer

One of the hidden areas in relation to cancer, particularly gynaecological cancer, is sexuality and associated sexual problems. Patients often feel unable to talk to their doctor for a variety of reasons, and even when they do there is a lack of availability of trained professionals to work with them. This can have a negative impact on their quality of life even when the cancer has been treated successfully. As a response to clinical observations and calls from service user groups, backed up by a recent peer-reviewed publication, a new international society is being formed which aims to focus on this area of clinical care. A core 'start-up' group formed by the UK, The Netherlands, Belgium, Israel and Australia is in the process of compiling a mailing list, preferably by e-mail. If readers require further information, or wish their names to be added to the list of interested professionals, they should contact Dr Susan Carr, Consultant in Family Planning and Reproductive Healthcare, The Sandyford Initiative, 6 Sandyford Place, Glasgow G3 7NB, UK, or e-mail the Journal at **www.ffprhc.org.uk** and their e-mail will be forwarded on to the relevant parties.

Source: Susan Carr, Consultant in Family Planning and Reproductive Healthcare, The Sandyford Initiative, Glasgow, UK

First phase of chlamydia screening programme announced in the UK

Thousands of women across the country will shortly be offered testing for chlamydia – the most common sexually transmitted infection (STI) according to new statistics published recently. The Department of Health has identified ten locations to take forward the first phase of a national chlamydia screening programme.

The screening programme, outlined in the National Strategy for Sexual Health and HIV, will tackle this bacterial infection which, because it often has no obvious symptoms, frequently remains undiagnosed. Although easily cured with antibiotics, if untreated chlamydia in women can lead to pelvic inflammatory disease (PID), ectopic pregnancy and infertility.

The ten sites will share £1.5 million additional funding to set up the screening programme which will take place in clinics where young people access sexual health services such as family planning and genitourinary medicine (GUM) clinics. Locations have been chosen to give an even spread geographically, to provide an urban/rural balance and reach minority ethnic groups. The ten sites will build upon earlier work carried out at two pilot schemes in Portsmouth and the Wirral and further inform the gradual roll-out of a nationwide programme.

Evaluation results from the Portsmouth and Wirral pilots found that testing was a success with both patients and health care professionals and reached a high proportion of the target group. A total of 75% of those offered screening accepted and approximately 1 in 10 were found to be infected; 95% of those diagnosed with chlamydia returned for treatment. The two centres are currently investigating reinfection rates for chlamydia, in order to ascertain the frequency required for an effective national programme.

Public Health Minister, Hazel Blears said: 'We are committed to tackling the rising rates of all sexually transmitted infections and today's announcement is an important step in the right direction. As we continue to implement the first ever National Strategy for Sexual Health and HIV we will deliver a range of measures to increase public awareness, improve access to GUM services and offer better treatment and care to those who need it.'

The first ten sites will primarily target women aged 16–24 years who access sexual health services. Young women, particularly those under 21 years, are at greatest risk of infection and the long-term complications of untreated chlamydia are more serious for women. However testing will be offered to both men and women presenting with symptoms, and greater uptake of testing among men will be promoted. Efforts will also be made to trace partners or ex-partners of those found to be infected to offer treatment.

The increase in diagnosis of chlamydia over recent years is, in some part, due to improved awareness of the infection amongst both public and professionals and increased testing. However, continued efforts to increase awareness are needed – ongoing work will be supported by the Department of Health's public information campaign to be launched in Autumn 2002. It will highlight the risk of contracting all STIs, including human immunodeficiency virus (HIV), and the importance of practising safe sex.

Source: Department of Health

Legal action against the manufacturers of third-generation pills fails in the UK

An action against the manufacturers of combined oral contraceptives (COCs) containing third-generation progestogens began in 1997 and was heard in court between March and July 2002. The lawyers representing the former users of these contraceptive pills had to show beyond reasonable doubt that the third-generation pills were defective (i.e. not as safe as the women were entitled to expect) and that they caused the injuries sustained by the women. On 29 July 2002, the judge gave his judgement that he accepted the defence case that the evidence did not establish reliably that there was an excess risk from third-generation pills compared to second-generation pills. The judge also concluded that none of the claimants were able to demonstrate that their venous thromboembolism (VTE) was 'more likely than not to have been caused by the third-generation contraceptive pill'. The claimants had to show that the third-generation pills were twice as likely to have caused the VTE than a second-generation pill containing levonorgestrel and this they had failed to do.

Although the judge expressed the view that this trial was 'the most exhaustive examination this question has ever received', this can only be said to be true in the legal sense.

Most readers of this journal will remember the intense and sometimes acrimonious public and private discussions following the publication of the four epidemiological studies in 1995 and 1996 showing a difference in the incidence of venous thrombosis between second- and third-generation pills. Numerically the number of events was small compared to the number of users. However, the conclusion from these studies that third-generation pills carried twice the risk of the second-generation pills led to the Committee for Safety of Medicines (CSM) in the UK issuing a warning to prescribers. The advice was to only use third-generation pills if the user was intolerant of second-generation pills. Following reanalysis of the original data obtained in the epidemiological studies, the estimates of harm were revised downwards, while controversy continued about bias and statistical manipulation.

By 2001, the regulatory authorities in the UK and in Europe had concluded that degree of difference in risk between second- and third-generation pills was of the order of 1.5 to 2. The information that is given to patients quantifies the risk of VTE as:

- about five cases per 100 000 women per year when not taking any hormonal contraception
- about 15 cases per 100 000 women per year when taking second-generation COCs
- about 25 cases per 100 000 women per year taking third-generation COCs.

The legal decision does not affect this advice which should be put into proportion by considering the risk of VTE in pregnancy (about 60 per 100 000 women per year).

While welcoming the news that the class action against the manufacturers of the third-generation COCs has failed, the legal decision does little to help practising clinicians in their everyday work with patients. Scientific evidence, argued over by many experts in journals, seems a better guide than a decision based on a single legal judgement. For the majority of patients with no added personal risk factors, the differences between the small risks of VTE associated with the use of a second- or third-generation progestogen will matter less than the acceptability of their chosen pill. Discussion of the risks and benefits with patients, in language that they can understand, will be the best protection against further legal actions.

Source: Report and comment by Dr Gill Wakley, Writer and Lecturer, General Practitioner Non-principal, Abergavenny, UK

JOURNAL CLUB

Risks and benefits of estrogen plus progestin in healthy postmenopausal women. Principal results from the Women's Health Initiative Randomized Controlled Trial. Writing Group for the Women's Health Initiative Investigators. *JAMA* 2002; **288**(3): 321–333

The results of this large study shows that for every 10 000 women using combined continuous hormone replacement therapy (HRT) compared to those women not using HRT there would be an additional eight cases of invasive breast cancer, seven myocardial infarctions (MI), eight cerebrovascular accidents (CVA) and eight pulmonary emboli (PE). However, there would be six fewer bowel cancers and five fewer hip fractures.

The Women's Health Initiative (WHI) clinical trials were designed in 1991–1992 in part to study the possible long-term health benefits of HRT. A total of 161 809 women were recruited into a set of clinical trials that included calcium and vitamin D supplementation, a low-fat diet, in addition to two HRT trials. The primary outcome of the HRT arm was coronary heart disease (CHD) and it was widely anticipated at that time that HRT would demonstrate a beneficial effect in keeping with the available observational and experimental data. Additional clinical secondary outcomes to be studied were incidence of osteoporotic fracture, invasive breast cancer, endometrial cancer, colorectal cancer and other cardiovascular disease. More than 16 000 women with an intact uterus aged 50–79 years were recruited into a randomised primary prevention trial comparing estrogen plus progestin (Premarin 0.625 mg plus Provera 2.5 mg both daily) versus placebo.

In May 2002, the US Data and Safety Monitoring Board recommended the termination of the oestrogen plus progestin component of the WHI study on the basis that the 'stopping boundary' for invasive breast cancer had been exceeded and the global index statistics supported risks exceeding benefits. The data was released to the public in July 2002 and the world media became whipped up into a frenzy over the results. Most UK daily newspapers carried variations on the 'killer HRT' headline predicting massive discontinuation of HRT.

The risk–benefit profile of HRT was not found to be consistent with primary prevention of chronic disease. The effects of HRT on venous thromboembolism (two-fold increase) and breast cancer (26% increase) were entirely in keeping with earlier data. The fracture data for HRT was surprisingly robust with a 33% reduction in hip fractures and 24% reduction in total fractures. HRT was also found to decrease colorectal cancer by 37%. However, it was the finding that women on HRT had 29% more CHD events and 41% more strokes over 5 years that caused particular concern. The investigators emphasised that the overall absolute risks were small and all-cause mortality was not increased with HRT.

It is very difficult to predict the impact of this study on prescribing patterns and how women will view HRT in the future. The data are likely to have serious repercussions for the pharmaceutical industry for which long-term HRT prescribing for women worldwide was a major goal. The majority of HRT users in the UK who take HRT in the short term primarily for beneficial effects on menopausal symptoms are unlikely to be perturbed by the results of this study. It is simply not known whether these results relate particularly to the combination of Premarin and Provera or whether it can be assumed that all HRT would exhibit similar effects. Women in the parallel arm of the WHI study taking oestrogen alone have not been found to have increased breast cancer risk and this arm will continue as planned until 2005. However, the clear message from this study is that combined HRT should not be initiated or continued for the indication of primary prevention of CHD at the present time. The medical establishment should welcome high-quality data on this subject even though it may not be the answer we anticipated or wanted to hear.

Reviewed by **Dr Ailsa Gebbie,** MRCOG, MFFP
Consultant in Community Gynaecology, Family Planning Services, Edinburgh, UK