

## Letters to the Editor

### HPV vaccines

I read with interest the article on human papillomavirus (HPV) vaccines published recently in this journal.<sup>1</sup> I understand the reason for vaccinating girls, but why would it not be relevant to vaccinate boys as well since they are involved in the sexual transmission of the virus?

**Katherine Greenwood, MRCGP, DFFP**  
General Practitioner, St James Medical Practice,  
County Court Road, Kings Lynn, Norfolk PE30  
5SY, UK

#### Reference

- 1 Stanley M. Human papillomavirus (HPV) vaccines: prospects for eradicating cervical cancer. *J Fam Plann Reprod Health Care* 2004; **30**: 213–215.

### Reply

Dr Greenwood is quite correct in her comment that vaccinating boys as well as girls is relevant. Herd immunity would require that the total population at risk for infection be vaccinated rather than a particular target group. However, apart from sociocultural issues there are some scientific ones. There are very few epidemiological data on either the incidence or prevalence of infection with the high-risk genital HPVs in men (other than anal infection) and virtually none on the natural history of these infections in sexually active men. Furthermore, as far as I am aware, there are no published data on the safety and immunogenicity of the HPV VLP vaccines in men and certainly no efficacy data. All the trials to date have tested the vaccines exclusively in women. It is likely that the regulators would require this baseline data before the vaccines could be administered to boys as well as girls. However, Dr Greenwood's point is highly relevant and one that is important if the vaccines are to be optimally effective.

**Margaret A Stanley, MB, PhD**  
Professor of Epithelial Biology, University of  
Cambridge, Department of Pathology, Tennis  
Court Road, Cambridge CB2 1QP, UK. E-mail:  
mas@mole.bio.cam.ac.uk

### Confidentiality and patient care

Henrietta Hughes' effort to seek the opinion of various health professionals when faced with the sensitive scenario of 'to tell or not to tell, and what to tell' is thought-provoking.<sup>1</sup>

As to what the reader would do when faced with such a situation, besides being in agreement that to maintain confidentiality one cannot knowingly allow a partner to get infected, I would not only organise an appointment for her to attend a special clinic for expert counselling, but take the opportunity to also educate her about the female condom (and discuss the possibility that the penis may occasionally get wrongly positioned between the Femidom<sup>®</sup> sac and the vaginal wall). Forced sexual intercourse within marriage remains an occasional but often tolerated phenomenon.<sup>2</sup>

**R K Bhatena, MD, FRCOG**  
Consultant Obstetrician and Gynaecologist, Petit  
Parsee General and Masina Hospitals, B. Petit  
Road, Cumballa Hill, Bombay 36, India. E-mail:  
rkbhatena@hotmail.com

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- 1 Hughes H. Confidentiality and patient care: different perspectives of professionals in reproductive health care. *J Fam Plann Reprod Health Care* 2004; **30**: 179–180.
- 2 Keeling J, Birch L, Green P. Pregnancy counselling clinic: a questionnaire survey of intimate partner abuse. *J Fam Plann Reprod Health Care* 2004; **30**: 165–168.

### Drospirenone and PCOS

The pilot study to determine the influence of the recently introduced combined oral contraceptive containing drospirenone and ethinylestradiol in women with polycystic ovary syndrome (PCOS) is indeed welcome as this condition affects a significant number of women. A key message point was that this formulation failed to change significantly the Ferriman and Gallwey score in 12 hirsute women at the end of six cycles.

As regards amelioration of hirsutism, because of the duration of the average hair cycle, a response is unlikely to be visible within 6 months. Twelve months or more of treatment should generally be allowed for an optimal effect.<sup>1–4</sup> Further publications from the Leeds study group after 12–18 months of treatment in a larger cohort of women would offer a more realistic assessment of the effect of drospirenone on hair growth.

**R K Bhatena, MD, FRCOG**  
Consultant Obstetrician and Gynaecologist, Petit  
Parsee General and Masina Hospitals, B. Petit  
Road, Cumballa Hill, Bombay 36, India. E-mail:  
rkbhatena@hotmail.com

#### References

- 1 Conn JJ, Jacobs HS. Managing hirsutism in gynaecological practice. *Br J Obstet Gynaecol* 1998; **105**: 687–696.
- 2 Balen A. The current understanding of polycystic ovary syndrome. *The Obstetrician and Gynaecologist* 2004; **6**: 66–74.
- 3 Azziz R. The evaluation and management of hirsutism. *Obstet Gynecol* 2003; **101**: 995–1007.
- 4 Falsetti L, Gambera A, Platto C, Legrenzi L. Management of hirsutism. *Am J Clin Dermatol* 2000; **1**: 89–99.

### Opportunistic screening for chlamydia

I read with great interest the article by Noone *et al.*<sup>1</sup> on opportunistic screening for genital *Chlamydia trachomatis* infection and partner follow-up. It was quite informative. I do, however, have a few comments I would like to raise about this article.

The prevalence rate for chlamydia seen in this study was 5.2%. Examination of the figures reveals that only half the study group were women up to 24 years of age. This age group, as we know, has the highest incidence of chlamydial infection.<sup>2</sup> In fact, the average prevalence of chlamydia in this group was 8%, which compares well with what is expected. Conversely, the average prevalence in those over 24 years of age was 2%. This bears out the fact that screening tests should be targeted at that population group in which we expect to find a high prevalence to make it worthwhile. Indeed, screening is cost-effective when the population prevalence is about 5% or higher.<sup>3</sup> Such findings may prompt a debate on defining criteria for testing women in different age groups for best utilisation of resources.

Only 83/159 (52%) chlamydia-positive women got a sexual screen. It would have been interesting to know what tests were involved in a sexual screen.

The study shows the reluctance of women to inform previous sexual partners and only 33/159 (20%) first-mentioned partners were seen and presumably treated by the clinics. The majority were reported to have been treated and, one presumes, not seen by any of the participating clinics.

Also, what was the outcome in the 344 women who had symptoms/signs of genital infection and were chlamydia-negative?

In genitourinary medicine (GUM) clinics there is a dedicated set-up to counsel, perform near-patient testing with a whole range of tests, and promptly treat patients for all sexually transmitted infections (STIs). Dedicated, trained health advisers perform not only patient

referral but also provide unconditional referral. This makes it possible for GUM clinics to get in touch with those contacts an index case is reluctant to inform personally, follow up those who do not attend, and test the majority of those who are chlamydia-positive for other STIs.

Certainly this capability has major health implications in that it breaks the cycle of infection and re-infection. Indeed the SIGN Guideline<sup>4</sup> states that: "patients should be referred to trained health advisers for support with partner notification. At present the only NHS staffs trained to carry out partner notification are health advisers in GUM departments".

In the light of this statement, I would agree with the authors that an integrated or networked GUM/family planning service is the way forward in order to provide patient-focused, holistic sexual health care.

**Indranil Banerjee, DTM&H, MRCPI, DFFP, Dip. GUM**  
Consultant, Department of Genitourinary  
Medicine, Victoria Hospital, Kirkcaldy, Fife KY2  
5AH, UK

#### References

- 1 Noone A, Spiers A, Allardice G, Carr S, Flett G, Brown A, *et al.* Opportunistic screening for genital *Chlamydia trachomatis* infection and partner follow-up in family planning clinics in three Scottish cities. *J Fam Plann Reprod Health Care* 2004; **30**: 84–85.
- 2 Sudlow E, Court S, Smith C. Prevalence of *Chlamydia trachomatis* infection in small rural town family planning clinics in the central belt of Scotland. *Health Bull* 2001; **59**: 332–334.
- 3 Screening to prevent pelvic inflammatory disease from *Chlamydia trachomatis* genital infection (Editorial). *J Med Screen* 2000; **7**: 55.
- 4 Scottish Intercollegiate Guidelines Network (SIGN). *Management of Genital Chlamydia trachomatis Infection*. SIGN Publication No. 42. Edinburgh, UK: SIGN, March 2000.

### Reply

We are happy that Dr Banerjee has found our paper of interest and informative.

Arrangements for full sexual screening varied between clinics. Chlamydia-positive women were either screened in the family planning clinic (FPC) or referred to GUM clinics. Where screening took place in the clinic the patient would have been tested for gonorrhoea (i.e. a high vaginal swab and endocervical swab taken). Screening for blood-borne viruses and syphilis would only have been done on request and dependent on sexual health risk history. The latter practice has now been changed and blood testing is routinely offered in the clinics.

No genital pathology was found in the women who were symptomatic. They were treated symptomatically and further investigations (gynaecological) were undertaken where appropriate.

Partner notification is of course a difficult problem and every effort needs to be made to ensure that partners are notified and managed properly in a setting that is acceptable to them. We agree that GUM clinics provide an excellent service in this regard. However, partner notification is now increasingly being undertaken in other settings, most notably in FPCs whose staff are being trained by health advisers in this role. Integrated clinics do seem to be helpful in facilitating attendance by partners.

**Ahilya Noone, MSc, FFFPHM**  
Consultant Epidemiologist, Scottish Centre for  
Infection and Environmental Health, Clifton  
House, Clifton Place, Glasgow G3 7LN, UK. E-mail:  
ahilya\_noone@yahoo.co.uk