News Roundup

Self-testing kits for chlamydia screening

A pilot study developed by the Men's Health Forum in conjunction with Telford and Wrekin Primary Care Trust (PCT) distributed health promotion information about chlamydia together with supplies of self-testing kits. The information and kits went to locker rooms and toilets in factories, colleges, a drop-in sexual health clinic and a military police training centre. In total, 2892 kits were picked up and 401 specimens sent in, of which 80% were submitted by men. Ten people (seven men and three women) had positive tests and a further five were found by contact tracing. The positive contacts were informed by telephone. Five opted to be treated by a pharmacy, four by the genitourinary medicine (GUM) clinic and one by a general practitioner (GP).

The Men's Health Forum published some recommendations following this pilot study. They concluded that success depends on a partnership between a PCT and various local non-National Health Service (NHS) organisations, well-designed 'male-friendly' materials, self-testing and availability of treatment at pharmacies. The materials for self-testing should discourage people from taking the kit, or submitting samples, when the risk is negligible, and they felt that further work on identifying and targeting high-risk young men was needed. Alternative ways of contact tracing, such as involving the pharmacist or providing an opportunity to meet a sexual health advisor in a non-health care setting, should be explored. Other recommendations and the complete report can be downloaded from the website. You might want to use this report to help you to extend chlamydia testing to those, typically young males, who do not attend traditional NHS provision and help people to identify for themselves when they might be at risk. Website: **http://www.menshealthforum.org.uk.**

Reported by **Gill Wakley**, MD, MFFP
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New recommendations for sexual health providers

The Medical Foundation for AIDS and Sexual Health (MedFASH) has published new recommendations for the provision of sexual health services in the NHS. *Recommended Standards for Sexual Health Services* are designed to be complementary to the *Recommended Standards for NHS HIV Services,* published by MedFASH in 2003. Some aspects of service provision, such as sexual health promotion and HIV testing, are addressed in both documents, but most are distinct to one or the other. However, the key common feature of both sets of recommended standards is delivery through service networks, which help clinicians and other providers to meet shared standards of care.

The standards include advice on sexual health service networks, promoting sexual health, empowering and involving people who use services, identifying sexual health needs, access to services, detecting and managing sexually transmitted infections (STIs), contraceptive advice and provision, pregnancy testing and support, abortion service provision and protection and use of sexual health information.

The standards have been left deliberately open to local interpretation. They are not specific for any health sector as some services (e.g. contraception) may be provided in different settings including general practices, community clinics and secondary care. The standards encourage closer working between the different providers and seek to raise standards across the whole range.

Improving access is one of the standards where the recommendations include suggestions to provide prompt access to a full range of sexual health services and to comprehensive information on local sexual health service provision. Adequate capacity is needed to ensure services can respond to local need and demand. This standard specifies time limits for access to each type of service. Other measures to facilitate access include maintaining open access and self-referral for GUM and community contraceptive services, agreeing integrated care pathways within a sexual health network, and ensuring adequate STI and contraceptive services are provided on each working day within a network area.

Calls are being made to increase further the investment into sexual health services following the £300 million announced by the government in the autumn of 2004. The Quality and Outcomes Framework (QOF) for general practices only includes two points for contraception at present. Standards from this document could readily be adapted for use in revisions of the QOF and for local commissioning to raise standards and reward good quality care. The document is available to download as a pdf document from: **http://www.medfash.org.uk.**

In Scotland, the publication of *Respect and Responsibility: Strategy and Access Plan for Improving Sexual Health* requires the 15 NHS boards to identify a lead clinician and senior manager to take the strategy forward. The recommendations include plans to bring GUM and contraceptive services closer together and that the NHS boards should spend £15 million more in the next 3 years to implement the strategy. Website: **http://www.scotland.gov.uk.**

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HRT and endometrial cancer: more dilemmas from the MWS

The Million Women Study's (MWS) latest results create more dilemmas for those prescribing and for women taking hormone replacement therapy (HRT). We are all aware now of the increased risk of breast cancer from combined HRT, as opposed to oestrogen-only HRT or tibolone. However, both tibolone and oestrogen-only HRT increase the risk of endometrial cancer.

Breast cancer is the most common cancer of the two, and when rates for both breast and endometrial cancer are combined the biggest risk is for those women taking combined HRT. The study published in *The Lancet* shows that 3 women in every 100 on combined HRT will develop either breast or endometrial cancer whilst only 2.5 women in every 100 on tibolone or oestrogen-only HRT will develop breast or endometrial cancer over a 5-year period.[1]

The study goes on to report that obesity plays a role in an individual's relative risk. Those women with a higher body mass index are more at risk of endometrial cancer. The study showed that combined HRT was associated with substantially reduced risk of endometrial cancer in obese women. Tibolone showed increase risk of endometrial cancer in normal or overweight women.

This reinforces current medical opinion that HRT should be taken at the lowest dose for the shortest possible time for relief of symptoms.

Reference
1 HRT and endometrial cancer – the results from the Million Women Study. *Lancet* 2005; **365**: 1543–1551.

Reported by **Laura Patterson**, MRCGP, DFFP
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The contraceptive sponge

Originally introduced in 1983, the contraceptive sponge has been re-approved by the US Federal and Drug Administration (FDA). This disposable polyurethane foam contraceptive will be available for purchase without prescription in the US in the summer this year. It is marketed as being easy to use, convenient and safe and has enjoyed a great deal of popularity in the past. The sponge provides pregnancy protection by its regular release of low-dose spermicide over a 24-hour period. It creates a physical barrier and the polyurethane absorbs semen. Although this sounds great, the method effectiveness is reported as 89–91%. The effectiveness that can be expected when the product is used by a large group of women (some of whom fail to use it correctly) is much lower at 84.5–87%. It adds to the number of methods available without prescription and is better than no contraception – but with so many more effective methods available, I hope that women are not encouraged by marketing hype to use a less effective method.

Reported by **Laura Patterson**, MRCGP, DFFP
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Pharmacists' moral objection to emergency contraception

Conscientious objection to performing terminations of pregnancy has been taken to a new level in the USA where a growing number of pharmacists have refused to dispense emergency contraception (EC).[1] This has been reported as pharmacists tearing up prescriptions, stalling the patient beyond the point where EC would be effective, and giving patients speeches on morality. Some states require pharmacists to fill prescriptions for EC but other states allow them to decline. The American Pharmaceutical Association has recommended that patients should be directed to pharmacists who do not have a moral objection to EC. Unfortunately patients' insurance plans may restrict their choice to particular chains of pharmacies.

Reference
1 Tanne JH. Emergency contraception is under attack by US pharmacists. *BMJ* 2005; **330**: 983.

Reported by **Henrietta Hughes**, MRGCP, DFFP
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Can the pill dull desire forever?

Researchers in Boston have studied women in a sexual dysfunction clinic by measuring steroid hormone binding globulin (SHBG) levels.[1] Women taking combined oral contraceptives (COC) had a higher level of SHBG, which can lead to lower serum testosterone. Women who had stopped COC previously had slightly reduced SHBG levels but still seven times higher than women who had never taken COC. Reduced libido is a recognised symptom in women taking COC but in a recent presentation this team has suggested that the effect may last beyond the actual pill use.

Reference
1 Can taking the pill dull a woman's desire forever? *New Scientist* 27 May 2005; **2501**: 17.

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