LETTERS

Chlamydia testing

Madam

May I congratulate Lesley Bacon on the thought-provoking editorial,[1] which explained how we – the medical professional – can co-operate together in tackling a major public health issue such as the chlamydia epidemic.

I wish to add one further point. One of the highest prevalence rates of *Chlamydia trachomatis* is among women attending for termination of pregnancy (i.e. 12.7%).[2] If untreated, *C. trachomatis* can lead to infertility, chronic pelvic pain and ectopic pregnancy, with an estimated cost to the National Health Service of at least £100 million annually.[3]

The Royal College of Obstetricians and Gynaecologists recommended that abortion care should encompass strategies for minimising the risk of post-abortion infective morbidity. These strategies should include prophylactic antibiotic or screening for lower genital tract organisms with treatment of positive women.[4]

After leaving the abortion clinic, many of the women will be difficult to contact with their results or may not want to be contacted. This led many of the abortion clinics to adopt a policy of prophylactic antibiotics.[5]

However, the policy of prophylactic antibiotic dose not address the problem of partners, so for those with the infection re-infection is likely; and from the public health aspect, the prevalence of *C. trachomatis* is not likely to be effectively reduced in the community.

The majority of these women are seen and referred by primary care, primarily general practitioners and family planning doctors. If screened for *C. trachomatis* at the time of referral, the results of the screening will be available at the pre-abortion assessment appointment so proper antibiotic treatment and genitourinary medicine referral can be initiated for them and their partners early before leaving the abortion clinics. This kind of co-operation between primary and secondary care might be effective in tackling this public health crisis.

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References
1 Bacon L. Chlamydia testing in contraception clinics: who, where, how and why? (Editorial). *J Fam Plann Reprod Health* Care 2004; **30**(2): 82–83.
2 Underhill G, Hewitt G, Mclean L, et al. Who has chlamydia? The prevalence of genital tract Chlamydia trachomatis within Portsmouth and South East Hampshire, UK. *J Fam Plann and Repod Health Care* 2003; **29**(1): 17–20.
3 Department of Health. *Effective Commissioning of Sexual Health and HIV Services. A Sexual Health and HIV Commissioning Toolkit for Primary Care Trust and Local Authorities*. London, UK: Department of Health, 2003.
4 Royal College of Obstetricians and Gynaecologists (RCOG). *Guidelines for Induced Abortion*. London, UK: RCOG, 2000.
5 Hopwood J, Mallinson H, Gleave T. Evaluation of near-patient testing for *Chlamydia trachomatis* in pregnancy termination service. *J Fam Plann Repod Health Care* 2001; **27**(3): 127–130.

'Taking the strain' from chlamydia screening

Madam

The editorial and interesting papers about chlamydia screening in the April 2004 issue of the Journal raise many positive aspects but highlight the need for appropriate funding and staffing in order to ensure consistent and effective management of screened-positive people and their partners.[1–3]

I think that our 1990 paper entitled 'Chlamydia screening – should it be offered as a routine?'[4] was the first in the UK to suggest that chlamydia screening could be carried out in family planning clinics (FPCs). Offered at the time of cervical smear in four Wirral clinics, even with the suboptimal enzyme-linked immunosorbent assay (ELISA) test, we found a prevalence of 9.1% in women aged under 30 years.

Our continuing work in Liverpool clinics identified the difficulty and time involved in tracing results and notifying and referring people who tested positive. At that time we referred all those testing positive to the department of genitourinary medicine (GUM) and found that many did not attend or delayed attendance (range, 10–210 days after sample collection).[5]

These issues were further highlighted by our work in a hospital setting, where we identified that people testing positive were often not given their results, many were not treated appropriately, and rarely was advice given about partners.[6] Similarly, we demonstrated the time and commitment required in a termination of pregnancy service in carrying out chlamydia testing.[7]

It is not enough simply to find chlamydia; timely treatment of the index patient and partner are important issues. There are settled claims already where services have not achieved this, with resultant infertility.

So, when asked by the Department of Health to set up a community-wide pilot screening programme on Wirral, involving general practice, FPCs, gynaecology, walk-in services, and so on, we devised a central office with overall responsibility, not only for administration of the programme but also for all screened-positive people. All results are sent to this chlamydia office, in addition to the test initiator, whose printed positive reports clearly state that they will be managed by the office. From there results are sent by letter to the client/patient and those testing positive are asked to contact the office to arrange treatment for themselves and partner(s). After discussion, some clients opt to attend a GUM department but otherwise they are treated by our community health advisors at the office or by arrangement at another venue, e.g. their family planning service. Non-attenders are sent further reminders. For patients given treatment at the time the sample was collected, e.g. if their symptoms are suggestive of pelvic inflammatory disease, the system acts as a failsafe and enables partners to be dealt with.

The office has a part-time doctor, health advisors, an administrator and clerical support. There is close collaboration with the local GUM departments and all other services. The office provides continuity and enables monitoring of standards. It is a resource for information and training.

So – yes I endorse wholeheartedly screening in FPCs for both men and women. This takes little time if done against a backdrop of publicity and well-informed clients. We can discuss risk taking, use of condoms, the availability of examination and tests for other conditions if appropriate. With TMA [one of the nucleic acid amplification tests (NAATs)] we can offer gonorrhoea testing on the same sample.

This chlamydia office model is an accessible, effective, evidence-based service that can readily be adopted in any area. Please continue testing, but in the interests of efficiency and effectiveness let someone else 'take the strain'!

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References
1 Bacon L. Chlamydia testing in contraceptive clinics: who, where, how and why? *J Fam Plann Reprod Health Care* 2004; **30**(2): 82–84.
2 Noone A, Spiers A, Allardice G, 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**(2): 84–86.
3 Siddiqui F, Kirkman R, Chandiok S. Re-audit of referral compliance of chlamydia-positive women from a family planning clinic. *J Fam Plann Reprod Health Care* 2004; **30**(2): 86–88.
4 Hopwood J, Mallinson H, Agnew E. Chlamydia screening – should it be offered as a routine. A feasibility study in family planning clinics. *Br J Fam Plann* 1990; **16:** 59–67.
5 Hopwood J, Mallinson H. Chlamydia testing in community clinics – a focus for accurate sexual health care. *Br J Fam Plann* 1995; **21:** 87–90.
6 Gleave T, Hopwood J, Mallinson H. Management of *Chlamydia trachomatis* in a women's hospital: a review of current practice. *J Fam Plann Reprod Health Care* 2001; **27:** 161–162.
7 Hopwood J, Mallinson H, Jones I. There is more to a test than technology – evaluation of testing for chlamydia in a charitable sector termination service. *Br J Fam Plann* 1998; **23:** 116–119.

Laboratory diagnosis of HSV

Madam

We wish to share the experience of using polymerase chain reaction (PCR) to routinely diagnose and type herpes simplex virus (HSV) in the West of Scotland.

As Chan et al.[1] report, for many the current standard diagnostic test for HSV is viral culture. This is used by the majority of the family planning and reproductive health care and genitourinary medicine clinics in the UK. However, viral culture is a slow and labour-intensive technique. Using the PCR offers a rapid and highly sensitive test with favourable cost effectiveness.[2] It also allows the identification of the type of HSV involved. The use of PCR can increase the overall detection rate of HSV by 24% and yet it is currently under-utilised as a diagnostic test.[3]

The West of Scotland Regional Virus Laboratory based at Garnaval General Hospital in Glasgow currently uses the LightCycler™ (biogene) (Roche Diagnostics, Lewes, UK) technique. Its real-time PCR protocols employ the incorporation of dyes and the binding of probes during each cycle of the PCR so that the accumulation of product can be measured.

The transport medium does not require refrigeration and should not be allowed at any time to have contact with the skin (so moistening the swab with transport medium prior to sampling is not applicable as suggested by Chan et al.[1] for culture media).

In the West of Scotland we routinely have access to HSV typing. This allows improved patient care as the natural history of genital herpes is different for type 1 and type 2. The clinical course of HSV-1 (this has become an important cause of genital herpes) is more favourable than that of HSV-2. Those individuals with HSV-2 are more likely to have recurrences, which are more frequent and more painful than type 1. They are also likely to have a higher frequency of asymptomatic viral shedding. This aids with counselling the patient as regards to their chances of recurrences and how likely they are to pass on the virus to partners in the future.

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References
1 Chan E, Kingston M, Carlin E. The laboratory diagnosis of common genital viral infections. *J Fam Plann Reprod Health Care* 2004; **30**(1): 24–25.
2 Scoular A, Gillespie G, Carmen W. Polymerase chain reaction for diagnosis of genital herpes in a genitourinary medicine clinic. *Sex Transm Infect* 2002; **78**: 21–25.
3 Scoular A. Using the evidence base on genital herpes: optimising the use of diagnostic tests and information provision. *Sex Transm Infect* 2002; **78**: 160–165.