Letters to the Editor

HPV vaccines

I read with interest the article on human papillomavirus (HPV) vaccines published recently in this journal.1 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, MRCP GP, DFFP
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Reference

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 genotypes of HPV (other than anal HPV) 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.

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Reference

Confidentiality and patient care

Henrietta Hughes’ effort to seek the opinion of various professionals when faced with the sensitive scenario of ‘to tell or not to tell, and when to tell’ is thought provoking.

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 specialist clinic for expert counselling, but take the opportunity to also educate her about the female condom (and discuss the possibility that the partner may occasionally get wrongly positioned between the Femidom® sac and the vaginal wall). Forced sexual intercourse within marriage remains an occasional but often tolerated phenomenon.2

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Reference

Opportunistic screening for chlamydia

I read with great interest the article by Noone et al.1 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 tested each year. This study was 5.2%. Examination of the figures reveals that only half the study group were tested each year. This age group, as we know, has the highest incidence of chlamydial infection.2 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 above 5% or higher.3 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 be 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 gynaecological medicine (GUM) clinics there is a dedicated set-up to counsel, perform near-patient testing with a wide 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 are not attended, 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 Guideline4 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.

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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 clinic.

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, notably in FPC’s whose staff are being trained by health advisers in this role. Integrated clinics do seem to be helpful in facilitating attendance by partners.

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Letters to the Editor

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.1,2 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.

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References

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