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?

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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 genital HPV types in men (other than anal and oral) 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.

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Confidentiality and patient care

Henrietta Hughes’ effort to seek the opinion of her patients on whether they would be willing to discuss the possibility of chlamydia but take the opportunity to also educate them about knowing to allow a partner to get infected, I think is a very valuable phenomenon.2

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

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2 Balan A. The current understanding of polycystic ovary syndrome. The Obstetrician and Gynaecologist 2004; 6: 16–71.

Opportunist screening for chlamydia

I read with great interest the article by Noone et al. 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.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 about 5% or higher.2 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 relucance 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, in some cases, 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 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 were not in attendance, and test the majority of those who are chlamydia-positive for other STIs.

It is only this capability has major health implications in that it breaks the cycle of infection and re-infection. Indeed the SGN Guideline3 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 cervical 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 are the first point of contact in this regard. However, partner notification is now increasingly being undertaken in other settings, 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.

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References