resuming pill taking and/or starting the next pack without a break and to avoid risk of pregnancy (by advising condoms/abstinence for 7 days). EC is not indicated when this advice is followed.

Susan Brechin, MRCP, MFFP and Gillian Penney, FRCOG, MFFP
Co-ordinator and Director, respectively, of the FFPRHC Clinical Effectiveness Unit, Aberdeen Maternity Hospital, Aberdeen, UK. E-mail: sue.brechin@abdn.ac.uk

REFERENCES

Stephen R Killick, FRCP, MFFP
Professor of Reproductive Medicine and Surgery, University of Hull and Hull York Medical School, Hull, UK. E-mail: S.R.Killick@hull.ac.uk

REFERENCES

Chlamydia screening in general practice: a missed opportunity?

Chlamydia screening Programme (NCSIP) is currently underway in a quarter of primary care trusts in England, covering settings such as family planning, antenatal, colposcopy and termination of pregnancy services as well as general practice.

There is not much literature that relates to implementing chlamydia screening in general practice, the paper by Harris in the April 2005 issue of the Journal is very timely. However, I feel he hasn’t considered the full potential of ‘opportunistic’ screening to make the screening more effective.

Harris observed there are opportunities to discuss chlamydia screening in primary care practice. Chlamydia screening was offered to women aged between 16 and 25 attending for smears or consulting about contraception, and men aged between 16 and 34 at a new patient health check appointment. I have several concerns with this approach.

First, the cervical cytology screening schedule in the UK no longer invites women under the age of 25 years. In the paper, three out of the five positive cases were screened during cervical cytology; hence relying on this consultation would potentially miss the group of young women in whom the infection is most prevalent.

Second, although it was good practice to offer chlamydia screening as part of sexual health promotion, offering screening to those who attend only for cytology and contraception would worsen health inequalities by denying screening to those who are least educated and informed to use preventative services and consequently increasing the risk of infection.

The third concern is the men. The author rightly pointed out that men have responsibility for their sexual health but the only opportunity to screen men aged over 40 years was a patient health check. If men are traditionally perceived to be low users of health services, then every opportunity must be taken to make them aware.

In addition, I fail to see why only clinicians should recruit the target groups opportunistically.