

# Brief Encounters

Budding

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## RAPID PUBLICATION

In this issue we have taken the unusual step of “fast tracking” two papers (*see p 330 and p 335*), which will have a time from acceptance to publication of under two months as opposed to our average of eight months. We hope that the reasons are obvious. One aims to influence management and thereby improve the treatment of gonorrhoea, and the other provides an up to date picture of the chlamydia screening programme in England, a subject of great interest to the specialty, to patients, and to the media. In future, if you think you have something worthy of rapid publication please include a justification for this in your letter at the time of submission.

**See p 330 and 335**

## SORTING OUT GONORRHOEA TREATMENT

The recommended first line treatment for gonorrhoea recently changed from ciprofloxacin to a cephalosporin, in line with results from surveillance data on antibiotic resistance.<sup>1</sup> But which cephalosporin? Ison and colleagues review existing evidence, and present new pharmacodynamic data to support the use of ceftriaxone or cefixime rather than other preparations. In a linked editorial, Bignall highlights the results from this paper and points to other changes proposed in recently revised guidelines for the management of gonorrhoea, published by the British Association for Sexual Health and HIV ([www.bashh.org](http://www.bashh.org)).

1. **Fenton KA**, Ison C, Johnson AP, *et al*. Ciprofloxacin resistance in *Neisseria gonorrhoeae* in England and Wales in 2002. *Lancet* 2003;**361**:1867–9.

**See p 330 and p 386**

## ON THE THEME OF CHLAMYDIA

Although we did not plan this to be a special issue on chlamydia, we found

that we had received several key papers on this theme and decided to put them together. This collection of papers includes a detailed report of the first phase of implementation of the national screening programme in England (*see p 335*). This and three other papers relating to the screening programme in England are discussed in an editorial (*see p 331*), and one common theme is the limited involvement of men in screening uptake and in research. This programme could benefit from the findings in a paper from Ireland (*see p 349*), where men were screened in two novel settings: an orthopaedic outpatient clinic and a university sports centre. There was a good response rate (70%) and a prevalence of 6%. The final paper (*see p 371*) shows that samples taken for liquid based cytology in the cervical screening programme could be used to test for chlamydia. However, it is not clear whether this would provide an appropriate population for screening, particularly as the age at first cervical smear is being raised to 25 years, the age at which chlamydia prevalence falls.

**See p 331, 335, 349, and 371**

## LIMITATIONS OF SYNDROMIC MANAGEMENT

Syndromic management for symptomatic STI has been widely adopted in resource poor settings, and has the potential for significant health gain, as Vuylsteke outlines on page 333. But it may not work very well in some populations. In Addis Ababa, almost one third of women given syndromic treatment reported no symptomatic improvement at follow up (*see p 392*). Failure was particularly associated with having genital ulceration, much of which is due to herpes simplex rather than bacterial infection. Wolday and colleagues point out that the high levels of herpes simplex virus ulcer disease are associated with the very high prevalence of HIV in this population—67% of the women enrolled were infected.

**See p 333 and p 392**

## VAGINAL LEUCOCYTE COUNT IN WOMEN WITH BV

Bacterial vaginosis (BV) is generally considered to be non-inflammatory, so what is going on when a woman with BV has a raised leucocyte count on her vaginal smear? Geisler and colleagues looked at 296 women with BV, and found raised counts to be associated with candida, chlamydia, gonorrhoea, and trichomoniasis. In their population, low pus cell counts were quite helpful at ruling out infections, with a negative predictive value of over 90% for gonorrhoea and chlamydia. The presence of pus cells is slightly less helpful, given a positive predictive value of 59% for any infection. The authors suggest that leucocyte count could help direct therapy for gonorrhoea and chlamydia in settings where full screening is not available.

**See p 401**

## IMPROVING THE DIAGNOSIS OF GENITAL HERPES

The wait for a positive culture result to confirm a clinical diagnosis of genital herpes can be frustrating for both clinician and patient, but it is even worse when the culture is negative yet it remains the most likely diagnosis. Thankfully, help may now be coming to a laboratory near you. Ramaswamy and colleagues report the use of a real time PCR for herpes simplex in routine clinical practice in a busy clinic. The test appears to perform well, producing quicker results, being more labour efficient, and producing fewer false negatives than culture.

**See p 406**