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# CDR WEEKLY



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### Prevalence of *Chlamydia trachomatis* among women seeking termination services

A study of the feasibility of monitoring *Chlamydia trachomatis* prevalence at termination of pregnancy clinics has recently been published (1). Urine samples were collected from patients attending for termination of pregnancy at participating British Pregnancy Advisory Service (BPAS) branches. Nucleic acid amplification tests on specimens from 1001 women (77% response rate) showed an infection rate of 7.5% among women tested. The highest age-specific prevalence was 11.5% among women aged between 20 and 24 years, followed by 10.8% in those aged under 20 years. Factors associated with infection with chlamydia were age and previous diagnosis of chlamydia infection. Similar prevalence levels were seen at clinics in Portsmouth and the Wirral that participated in the Department of Health's Chlamydia Screening Pilot (2).

The study also found that only 35% of women who had the screening test would have done so had they been asked to pay the £20 clinical, administrative, and laboratory costs of the examination. The study's authors concluded that screening women at termination clinics is feasible and can assist in prospectively monitoring chlamydia prevalence across the nationwide BPAS service. Charging patients directly for the test could, however, reduce uptake of chlamydia screening and have negative consequences for public health and prevalence monitoring.

1. Mallinson H, Hopwood J, Skidmore S, Fenton K, Phillips C, Jones I. Provision of chlamydia testing in a nationwide service offering termination of pregnancy: with data capture to monitor prevalence of infection. *Sex Transm Infect* 2002; **78**: 416-21. Available at <<http://sti.bmjournals.com/cgi/content/abstract/78/6/416>>.

2. Department of Health. *Chlamydia screening pilot: report of 1999-2000 study*. London: Department of Health, 2002. Available at <<http://www.doh.gov.uk/sexualhealthandhiv/chlamydscreenpilot.htm>>.

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### Chief Executive for the Health Protection Agency announced

It has been announced that the first chief executive of the new national Health Protection Agency will be Dr Pat Troop, currently Deputy Chief Medical Officer in the Department of Health <<http://www.doh.gov.uk/cmo/hpa/index.htm>>. Dr Troop, who has been closely involved in work to create the new Agency in her role as chairman of the HPA Steering Group, will be shadow chief executive from 1 March 2003 before taking on the substantive post from April when the new Agency will come into being. Dr Troop has worked as a public health professional since 1975, both in the North

West and with Cambridge Health Authority where she was director of public health from 1988 to 1990 and chief executive from 1991 to 1993. She was a Regional Director of Public Health from 1994 to 1999, latterly with Eastern Regional Office of the NHS, before taking up her current post as Deputy Chief Medical Officer.

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# HIV/STIs

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[Sexually transmitted infections quarterly report: update on genital chlamydial infections in the United Kingdom](#)

## Sexually transmitted infections quarterly report: update on genital chlamydial infections in the United Kingdom

This report summarizes recently released data from the 2001 annual report on sexually transmitted infections (STIs) (1) and on-going developments in routine and enhanced chlamydial infection surveillance in the United Kingdom. An update on the final report from the Chlamydia Pilot Project, the Department of Health's proposed roll-out of opportunistic screening for genital chlamydial infection, and a new initiative to study re-infection rates and screening intervals are also described.

Routine statistics on genital chlamydial infection are available through genitourinary medicine (GUM) clinics in the United Kingdom, and voluntary reports from laboratories in England, Wales and Scotland. In England, Wales, and Northern Ireland, aggregated GUM clinic data are collected on the quarterly KC60 statistical return and sent to the CDSC Colindale, CDSC Wales, and CDSC Northern Ireland. In Scotland, disaggregated data are collected on the ISD(D)5 statistical return and collated by the Information Statistics Division (SD) of the Common Services Agency in Scotland (1).

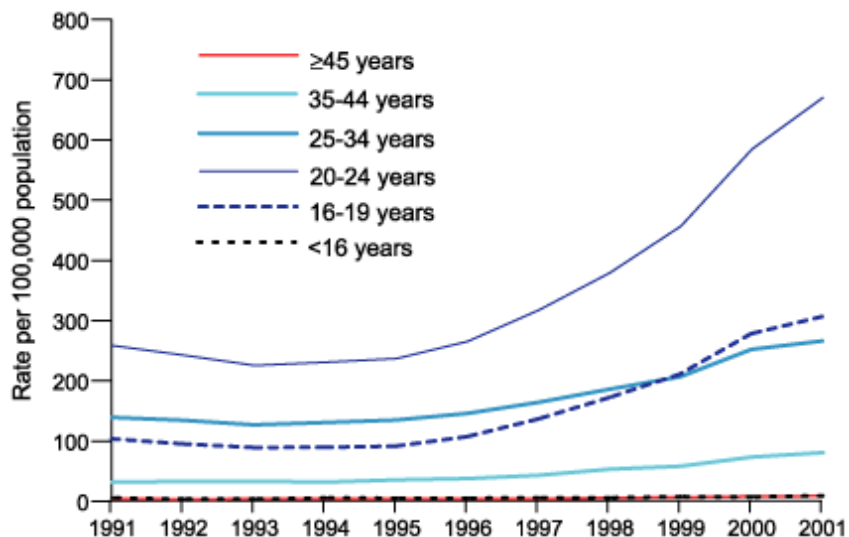
### Chlamydia trachomatis infection

Genital chlamydial infection can cause pelvic inflammatory disease, which may lead to tubal factor infertility, and represents a major public health problem to the reproductive health of women in developed and developing countries (2,3). The World Health Organization estimates that 89 million cases occur each year (4). In 2001, genital chlamydial infection became the most common STI seen in GUM clinics, with 71,125 diagnoses made in the England, Wales, and Northern Ireland.

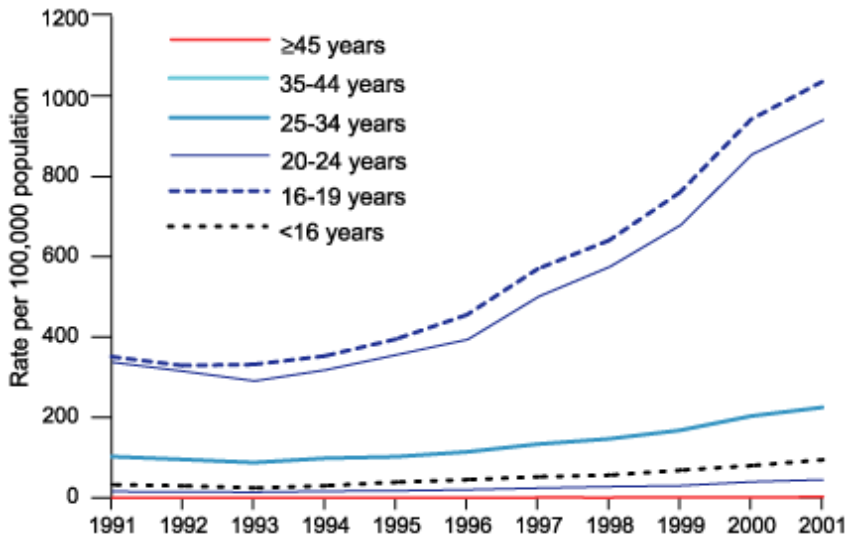
The most recent STI trend data for the United Kingdom confirmed the continued increase in genital chlamydial infection, particularly since 1996 (1). The rates of diagnoses of uncomplicated genital chlamydial infection in GUM clinics remained fairly stable until 1995. Since 1996, there has been a nearly three-fold increase in the rate of diagnosis of genital chlamydial infection for both males and females. This increase is partly due to the introduction of highly sensitive nucleic acid amplification tests, practice changes in GUM clinics that incorporated testing all attendees for genital chlamydial infection, and increased statistical reporting of diagnoses via the KC60 return. For the most recent year available (2001), rates of diagnosis in GUM clinics were highest among women, particularly those aged 16 to 19 years (1035 per 100,000) and 20 to 24 years (941/100,000) respectively (figure 1). Among men, the peak rate of diagnosed chlamydial infection was among those aged from 20 to 24 years (669/100,000). Diagnoses among women are higher than men due to increased detection efforts for asymptomatic infection.

**Figure 1 Rates of diagnoses of uncomplicated genital chlamydial infection made in GUM clinics by sex and age group, UK: 1991-2001\***

### Males



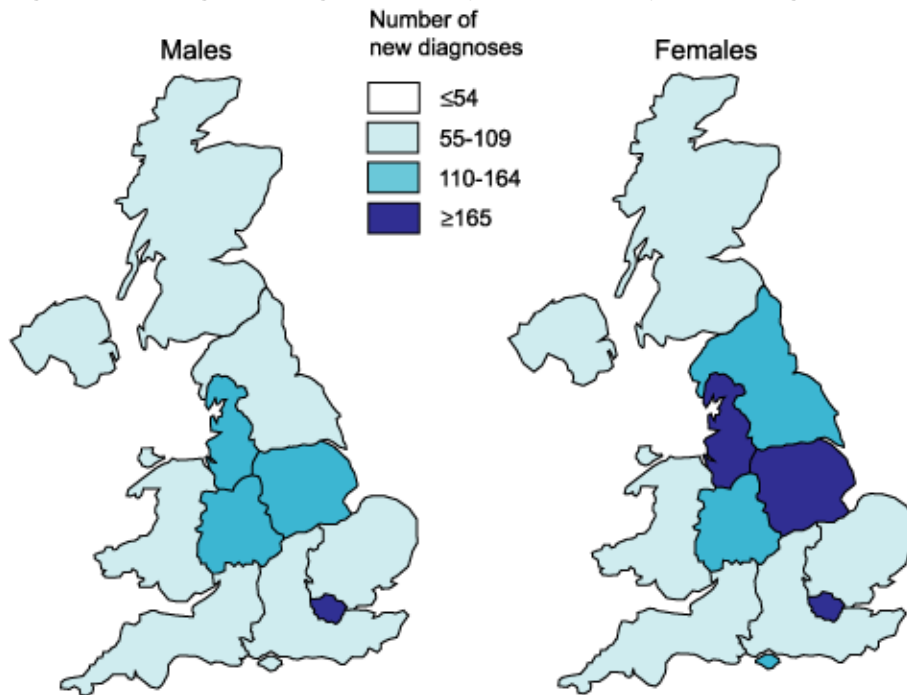
**Females**



\* Data are currently unavailable for 2000 and 2001 from Scotland.

Rates of diagnosed genital chlamydial infection continue to vary by region. Rates for women and men were highest in London, at 249/100,000 and 229/100,000 respectively. Rates were also high in Trent region (190/100,000) (figure 2).

**Figure 2 New diagnoses of genital chlamydial infection by sex and region, 2001\***

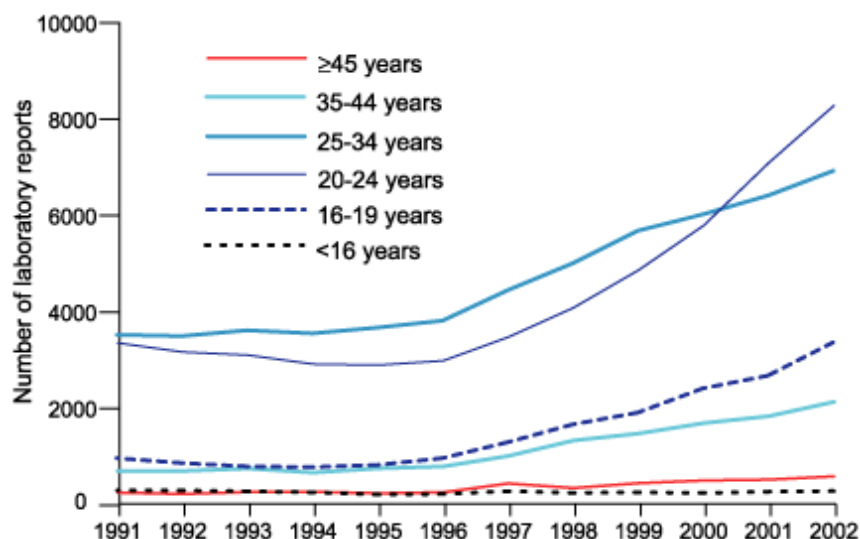


\*1999 data used for Scotland

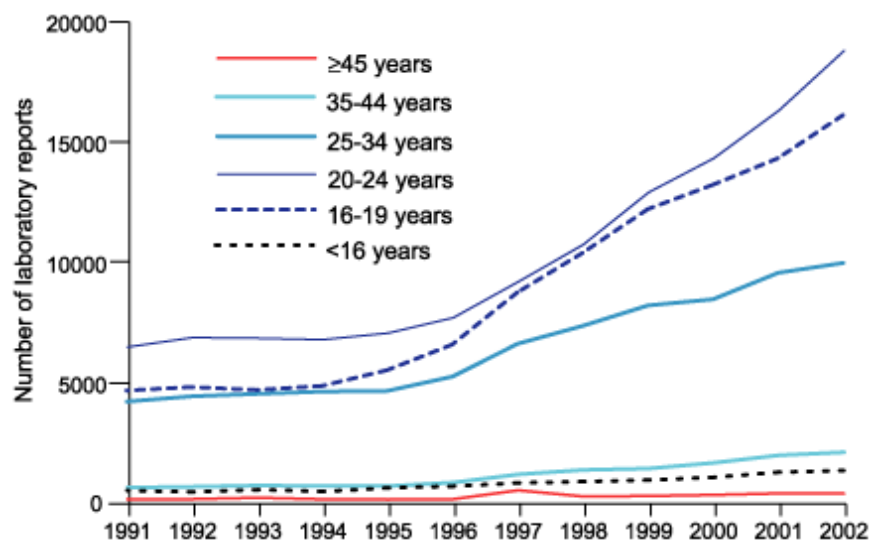
Laboratory reports of confirmed genital chlamydial infection provide an additional surveillance tool for understanding the epidemiology of genital chlamydial infection in the UK. Preliminary data to the end of 2002 show no reduction in the rate of increase in laboratory reported cases since 1996, particularly for the highest risk age groups, those aged 16 to 19 and 20 to 24 years (figure 3). Among men, there were 21,469 cases reported from laboratories in the UK in 2002, an increase of 15% from the previous year. Those aged 20 to 24 years accounted for 39% of reports among men. An additional 32% of reports in men were among 25 to 34 year olds. Laboratory reports of genital chlamydial infection among females were more than double that of men, principally due to the detection efforts targeting females. In 2002, the total number of female cases of chlamydia reported by laboratories in the UK was 48,868, of which 38% were among 20 to 24 year olds and 33% among 16 to 19 year olds. The marked differences in age for peak rates among men and women might reflect sexual mixing patterns based on age of partners (5).

**Figure 3. Number of laboratory reports of genital chlamydial infection by sex and age group, England, Wales and Scotland: 1991-2002\***

**Males**



**Females**

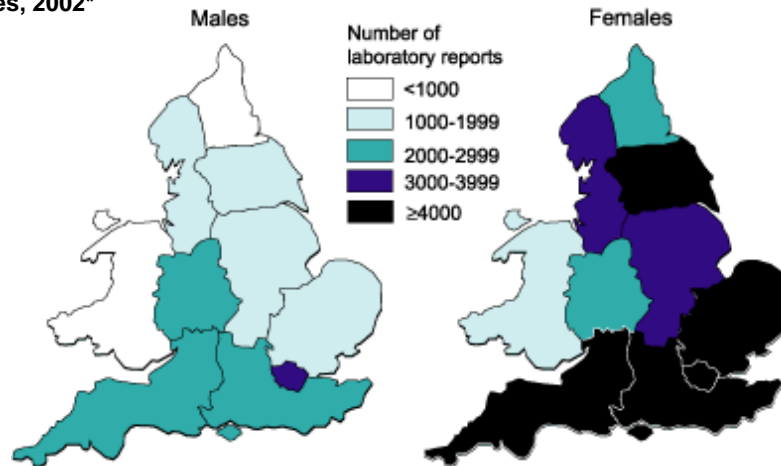


\* Data are preliminary, pending additional reporting from laboratories in England and Wales. Scotland data courtesy of Scottish Centre for Infection and Environmental Health (SCIEH).

Figure 4 illustrates the regional variation in laboratory reporting for genital chlamydial infection. Higher numbers of reports for women may reflect variations in local chlamydia testing and screening practices between regions.

**Figure 4. Number of laboratory reports of genital chlamydial infection by sex and region, England and Wales, 2002\***

**Figure 4. Number of laboratory reports of genital chlamydial infection by sex and region, England and Wales, 2002\***



\*Preliminary data from 2002 laboratory reporting.

Although comprehensive, a key limitation of the KC60 and laboratory reporting datasets collected for England, Wales, and Northern Ireland, is the lack of demographic, socio-economic, and sexual behaviour data which can provide more detailed contextual information on the determinants and distribution of STI transmission in the UK. The Department of Health (England) is funding the introduction of a programme for enhanced surveillance of sexually transmitted infections (ProgrESS), a disaggregate dataset (data collected on individual attendance) from GUM clinics, similar to the system that has been used successfully in Scotland since April 1995. ProgrESS began collecting patient -based data with expanded demographic variables, including ethnic group, from GUM clinics in Spring 2002. This system will better determine the distribution and risk factors associated with chlamydial infections, and will help inform budgetary planning and health promotion activities at the local and national levels. Twenty-nine GUM clinics in London and 20 GUM clinics from south east England are currently participating in this enhanced surveillance effort. Preliminary data have been published in the STI annual report (1) and further data will be available later this year.

### Chlamydia screening

Screening for genital chlamydial infection is focused on women because they suffer the largest burden of illness and subsequent effects if left untreated, including pelvic inflammatory disease, ectopic pregnancy, and infertility (6). The Department of Health's pilot of opportunistic screening for young women revealed significant levels of genital chlamydial infection in Portsmouth and Wirral. Overall prevalence among screened females aged 16 to 24 years was 9.8% in Portsmouth and 11.2% in the Wirral (7). Prevalence of chlamydia varied by health setting. The highest prevalence in Portsmouth was 16.7% at youth sexual health clinics and in Wirral was 17.6% at GUM clinics. The epidemiology of chlamydial infection suggests that peak incidence occurs in young females under 20 years of age and declines after this peak (8-10). In Portsmouth, peak prevalence was observed at 18 years of age (13.0%) and among 20 years old in the Wirral (13.6%). Two papers describing the full results and evaluation of this pilot will appear in the February 2003 issue of *Sexually Transmitted Infections* (11,12).

As a result of the pilot project, the National strategy for sexual health and HIV recommended the introduction of a phased national roll-out of chlamydia screening, beginning with eight additional centres in England (13). Implementation plans have been in development over the last year and announcements relating to the progress of the roll-out will be placed on the Department of Health website (14). CDSC will be closely monitoring the roll-out of the chlamydia screening program in partnership with the Department of Health.

The pilot study was not able to determine how often women should be screened for chlamydia. To address this, an incidence and re-infection study, commissioned by the Department of Health, was introduced in Portsmouth and Wirral in March 2002. In this recall study, women aged 16 to 24 years, attending general practice, family planning or genitourinary medicine clinics, are offered chlamydia screening. A subset of these women are recruited to the Recall study, and re-tested for chlamydia every six months for 18 months. The results from this study will inform directions for the national screening programme. To do this, will be necessary to establish if re-attendance rates are sufficiently frequent for the minimum screening interval in an opportunistic screening programme (such as the national roll-out), or whether screening in high risk groups should operate on a call/recall basis.

Evidence from surveillance datasets, the Department of Health chlamydia screening pilot and Natsal 2000, suggest that high rates of genital chlamydial infection exist in heterosexual males (1,6,7). The chlamydia screening roll-out programme's primary target is women; however, men will also be offered screening in some settings. Although, the National strategy for sexual health and HIV did not identify specific interventions for improved sexual health in heterosexual males, the national information campaign (Sex Lottery) launched in November does target this group. Opportunities exist, particularly in primary care, for opportunistic screening of heterosexual males, and the need to screen heterosexual males has recently been discussed (15). Additional efforts to include heterosexual men in chlamydia screening programs may assist in reducing infections in women.

1. PHLS, DHSS&PS and the Scottish ISD(D)5 Collaborative Group. *Sexually transmitted infections in the UK: new episodes seen at genitourinary medicine clinics, 1991-2001*. London: Public Health Laboratory Service, 2002. Available at <<http://www.phls.org.uk/publications/index.htm>>.

2. Scholes D, Stergachis A, Heidrich F, Andrilla H, Holmes KK, Stamm W. Prevention of pelvic inflammatory disease by screening for cervical

chlamydial infections. *N Engl J Med* 1996; **334**: 1362-6. Available at <<http://content.nejm.org/>>

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8. Centers for Disease Control and Prevention. *Sexually transmitted disease surveillance 2001 supplement: chlamydia prevalence monitoring project annual report 2001*. Atlanta: CDC Division of STD Prevention, October 2002. Available at <<http://www.cdc.gov/std/chlamydia2001/CT2001text.pdf>>.
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10. Swedish Institute for Infectious Disease Control. *Smittsamma Sjukdomar I Sverige* 1998, Posttidning B, pp. 151-2.
11. Pimenta JM, Catchpole M, Rogers PA, Perkins E, Jackson N, Carlisle C, *et al*. Opportunistic screening for genital chlamydial infection I: acceptability of urine testing in primary and secondary health care settings. *Sex Transm Infect* 2003 (in press).
12. Pimenta JM, Catchpole M, Rogers PA, Hopwood J, Randall S, Mallinson H, *et al*. Opportunistic screening for genital chlamydial infection II: prevalence among health care attenders, outcome and evaluation of positive cases. *Sex Transm Infect* 2003 (in press)
13. Department of Health. *The national strategy for sexual health and HIV*. London: Department of Health, 2001. Available at <<http://www.doh.gov.uk/nshs/index.htm>>
14. Department of Health. *Sexual Health and HIV Programme*. [online] [cited 30 January 2003]. London: Department of Health, 2003. Available at <<http://www.doh.gov.uk/sexualhealthandhiv/index.htm>>.
15. Hart GJ, Duncan, B, Fenton KA. Chlamydia screening and sexual health. *Sex Transm Inf* 2002; **78**: 396-7.

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## Primary care

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### Sexually transmitted infections in the Weekly Returns Service



The Weekly Return Service (WRS) has been operating since 1967, but sexually transmitted infections (STIs) were only included after it was fully computerised in 1994. General practitioners (GP) in sentinel practices throughout England and Wales send data on diagnoses and episode types to the Birmingham Research Unit (BRU). Currently 78 practices are involved in the surveillance programme that covers a population of about 600,000. The content of each consultation is summarised in a 'working diagnosis' by the GP, and the number of patients consulting by age group and sex together with diagnostic Read codes and the number of patients on the age/sex register are extracted from the practice computer systems. At the BRU, data are analysed to provide the age and sex-specific weekly incidence of disease episodes. Read codes are mapped to the International Classification of Disease (ICD), ninth revision for analysis. Some STIs are coded to the infectious agent, whereas others such as pelvic inflammatory disease are coded by site of infection. The working diagnosis may be corrected or altered by the GP at a later date when further information such as laboratory results are available. Revised diagnostic information is only reported to the BRU if the revision is made within the recording week, or if the patient consults with a new episode. The WRS collects data on persons consulting and thus does not provide data on non-consulting populations, or persons with asymptomatic disease. People consulting other clinical services or visitors to the practice are included if they require treatment. Most people are registered with a GP.

The data shown here are for the STIs commonly reported through the WRS service. The data are expressed as mean weekly incidence per 100,000 population calculated for each quarter from 1994 to the end of 2002. Since the WRS includes 600,000 patients, a rate of 10/100,000 is equivalent to 60 episodes per week.

Each STI has its own distinct epidemiology. Some, such as syphilis and gonorrhoea are generally confined to core groups whereas genital chlamydial infection, genital herpes simplex (HSV) infection, and genital warts are widely distributed within the population. The conditions shown in this report are those STIs that are most commonly encountered in primary care. Data for genital chlamydial infection are not shown because this condition is usually described by the site of infection in primary care.

#### Genital herpes and genital warts

Genital warts are the clinically visible manifestations of infection with human papillomavirus. The mean weekly incidence is similar in males and females and for both sexes the highest rates are seen among women aged between 15 and 24 years (figures 1 and 2). Few cases were seen in patients outside this age group. In contrast, the mean weekly incidence of HSV is higher in females than males (figures 3 and 4). The excess diagnoses seen in females is similar to the pattern seen in data from genitourinary medicine (GUM) clinics.

#### Pelvic inflammatory disease

General practice is important for the diagnosis and treatment of pelvic inflammatory disease (PID). Highest numbers of episodes of PID are seen in the 15 to 24 and 25 to 44 year age groups (figure 5). In England and Wales, the dominant cause of PID is *Chlamydia trachomatis*. Highest rates of genital chlamydial infection are seen in teenage women whereas the morbidity associated with infection affects the reproductive health of women over a substantial age range. Although *C. trachomatis* is the

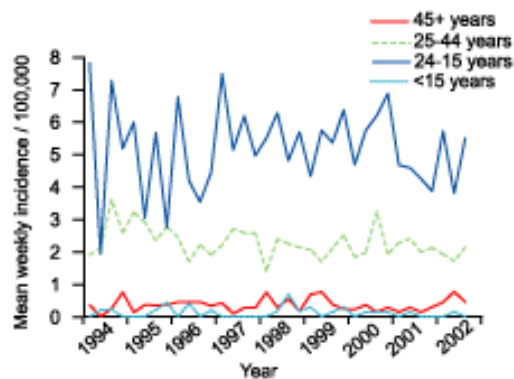
commonest cause of PID, up to 60% of cases are idiopathic.

## Candidiasis

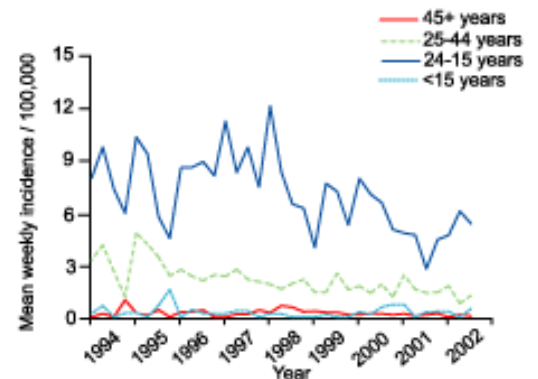
Candidosis (thrush) is caused by fungal infection, most commonly *Candida albicans*. Sexual transmission is thought to play a limited part in the epidemiology of candidiasis and, although it is not associated with high morbidity or high mortality, it can be distressing. The WRS data shows a consistent decline in the burden of disease seen in females with a much lower incidence in males. The decline in female episodes in the WRS contrasts with a rise in attendances at GUM clinics over the same period (figures 6 and 7).

**Figure 1 and 2 Weekly incidence of genital warts in males by age group: 1994 to 2002**

### Male

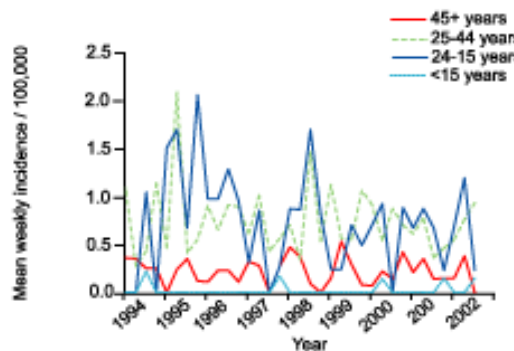


### Female

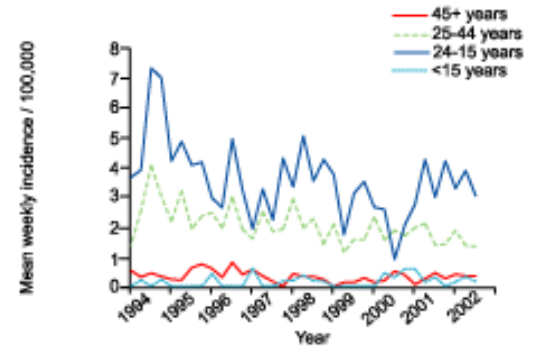


**Figure 3 and 4 Weekly incidence of genital herpes simplex virus infection in males by age group: 1994 to 2002**

### Male

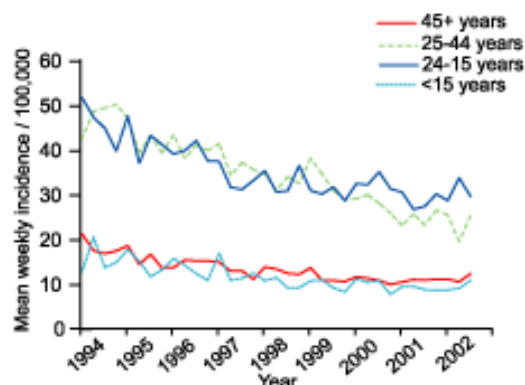


### Female



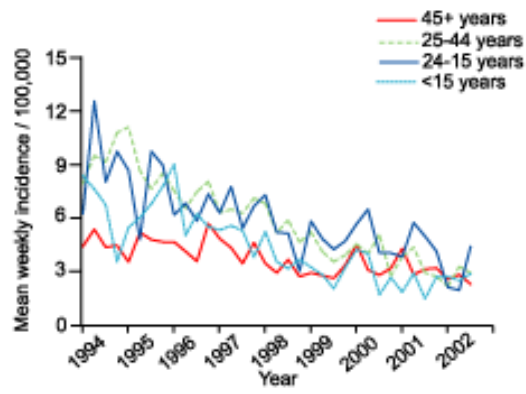
**Figure 5 Weekly incidence of pelvic inflammatory disease by age group: 1994 to 2002**

### Female



Figures 6 and 7 Weekly incidence of candidiasis in females by age group: 1994 to 2002

Male



Female

