CDR WEEKLY

the Communicable Disease Report Weekly

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News

- Rate of increase in sexually transmitted infections slows
- NICE clinical practice guideline on tuberculosis published for consultation

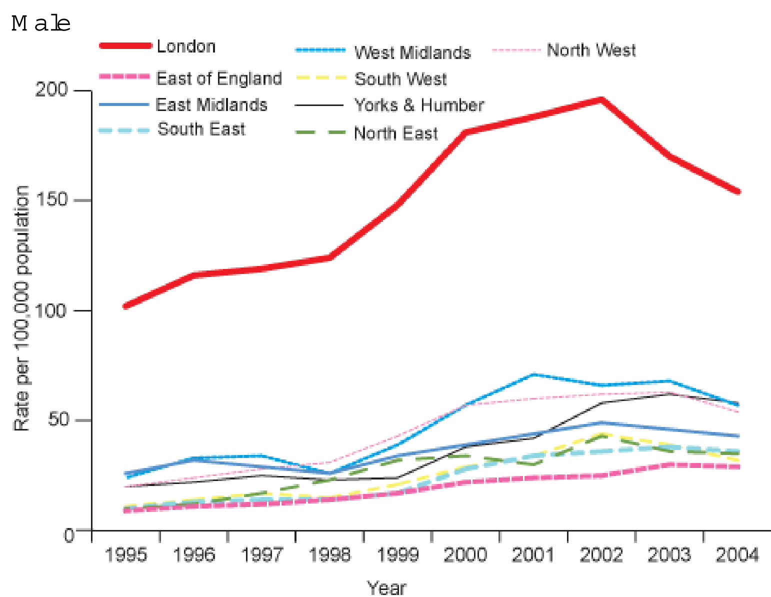
Rate of increase in sexually transmitted infections slows

Data released on 30 June 2004 by the Health Protection Agency (HPA) shows that in 2004, 751,282 new diagnoses were seen in genitourinary medicine clinics (GUM) in the United Kingdom (UK) an increase of 2% on 2003. There was a decrease in cases of gonorrhoea and genital herpes but an increase in the cases of genital chlamydia, syphilis, and genital warts. These data are from cases diagnosed in GUM clinics, and do not include cases diagnosed in primary care or other clinical settings.

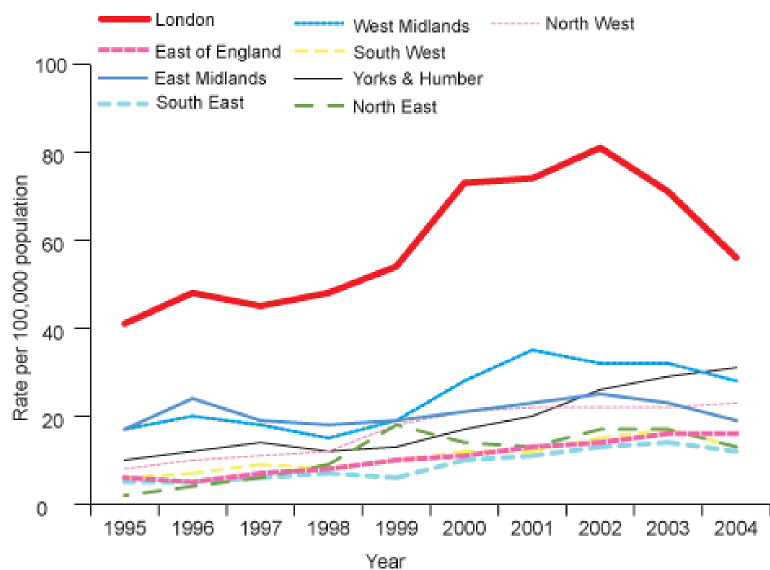
Genital chlamydial infection is the most commonly diagnosed sexually transmitted infections (STI) with a total of 103,932 diagnoses in 2004, an 8% increase on 2003. Rates of new diagnoses exceeded 1% among women aged between 16 and 24 years, which is greater than 1000 cases per 100,000 population, in most English regions. Among men aged between 20 and 24 years, diagnostic rates exceeded 1% in London, North East, North West, and Yorkshire and the Humber regions. This increase reflects increased case ascertainment brought about by the increased availability of diagnostic testing, improved sensitivity of diagnostic tests, and increased awareness. These data do not include cases diagnosed through the national chlamydia screening programme unless they are referred to GUM clinics for management.

The number of diagnoses of gonorrhoea decreased by 10% between 2003 and 2004. In women the number of diagnoses fell by 12% from 7548 to 6647; a similar 12% reduction was seen in heterosexual men, from 13,298 to 11,709. A smaller reduction of 3% was seen in men who have sex with men (MSM), from 4069 to 3964. There were important geographical variations in gonorrhoea trends in both men and women (figure 1). Among MSM, there was an 8% increase in London, compared with a 21% decrease in the North West region.

Figure 1 Rates of new cases of gonorrhoea diagnosed in genitourinary medicine clinics by sex and region: England: 1995 to 2004Male

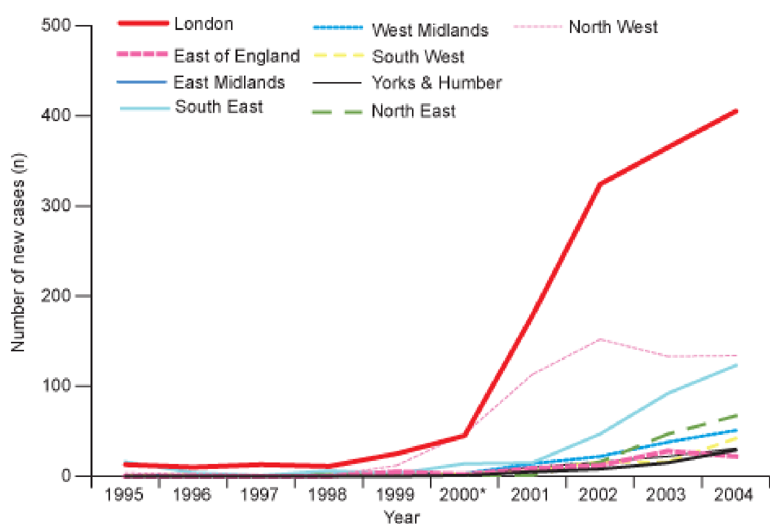


Female



Infectious syphilis continues to rise rapidly. Diagnoses of syphilis increased by 37%, from 1641 to 2252 between 2003 and 2004. The most rapid increase has been seen in women (47% increase) and heterosexual men (45%), but the epidemic is also persisting in MSM, with a further 29% increase in the number of cases. Cases are now occurring across the regions, although there is substantial regional variation reflecting local outbreaks. There has been an ongoing syphilis outbreak in Greater Manchester since 1999; although the number of cases increased by 36% in all males there was only a small increase of 1% between 2003 and 2004 in MSM (figure 2). In contrast, London, the site of the largest syphilis outbreak in the UK, saw an increase of 18% in men (11% in MSM), and 12% in women.

Figure 2 Number of new cases of infectious syphilis (primary and secondary) diagnosed in genitourinary medicine clinics in men who have sex with men by region: England: 1995 to 2004



Diagnoses of genital herpes simplex (HSV) infection decreased by 1% between 2003 and 2004, and diagnoses of genital warts increased by 4%, with little regional variation.

The decline in the number of cases of gonorrhoea has continued, although the data have to be interpreted with some caution. These data are only for cases diagnosed in GUM clinics, and increasing numbers of people may be seeking care through their general practitioner (GP), particularly as waiting times for GUM clinics are often long <http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/wtimes.htm>. STI surveillance systems do not yet include cases diagnosed outside GUM clinics, making it difficult to interpret the observed decline in gonorrhoea.

There are a number of areas that give cause for concern. First, the burden of STI remains considerable, and total numbers of diagnoses are increasing. Second, the increase in infectious syphilis has continued. Although overall numbers remain much smaller than for other STIs, there has now been a fivefold increase since 2000, with wider geographical and behavioural spread. The increase in female cases means that there would be a possibility of congenital syphilis re-emerging if antenatal screening in pregnancy was not applied universally (1,2). Third, the increase in diagnoses of gonorrhoea and syphilis in MSM in London reflects ongoing risk behaviour, and these bacterial STIs are known to facilitate the transmission of HIV.

In summary, data from the 2004 KC60 returns indicate that there is no room for complacency in relation to STI, and there should be no reduction in control and prevention efforts. This underlines the timeliness of the focus on sexual health in Choosing Health (3) and shows the importance of the forthcoming investment in prevention campaigns, in efforts to reduce waiting times in GUM clinics, and in modernisation of specialist services. Prevention initiatives for MSM remain crucial, particularly in those areas where syphilis and gonorrhoea are continuing to rise.

The HPA, in collaboration with the Department of Health and national stakeholders, is developing national surveillance methodologies to improve capture of STI data at local level, including non-GUM settings, to monitor waiting times for GUM services and to inform prevention activities. In addition to national responses, many initiatives for sexual health are developed at the local level, with strategic health authorities and primary care trusts focussing on sexual health improvement. The HPA, at local and national level, is working to provide timely and appropriate local data to inform the implementation of these initiatives.

References

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2. Connor N, Roberts J, Nicoll A . Antenatal screening for syphilis a cost effectiveness analysis *J Med Screening* 2000; **7**: 7-13.
3. Department of Health. *Choosing health: making healthier choices easier.* London : Department of Health, 2004.

NICE clinical practice guideline on tuberculosis published for consultation

The National Institute for Health and Clinical Excellence (NICE) has published a draft guideline document Tuberculosis: clinical diagnosis and management of tuberculosis, and measures for its prevention and control, which is being developed for use in the National Health Service in England and Wales. Initial consultation on these draft guidelines is open from 23 June to 21 July 2005. Registered stakeholders for the tuberculosis guidelines are invited to comment on the recommendations via the NICE website <http://www.nice.org.uk/page.aspx?o=262346>. Individuals and other organisations can comment directly to NICE, but are recommended to contact a registered stakeholder organisation if they want to comment. Comments should be made using a form available from the NICE website and submitted either by post to Elaine Paton, Guidelines Coordinator, National Institute for Health and Clinical Excellence, MidCity Place, 71 High Holborn, London, WC1V 6NA or email to <tuberculosis@nice.org.uk>.

The Health Protection Agency (HPA) is a registered stakeholder. The Agency's Tuberculosis Programme Board will coordinate the formal response from the HPA. Staff from all HPA divisions are invited to submit their comments to Irene Gonsalvez, Secretariat Scientist, HPA Programme Board and HPA Expert Advisory Groups, Expert Advice Support Office, at the HPA Centre for Infections/Corporate Services, 61 Colindale Avenue, London NW9 5DF, email: <irene.gonsalvez@hpa.org.uk>.

Following the consultation period, comments from registered stakeholders will be sent to the developers. A response to comments from stakeholders will be published on the NICE website. It is anticipated that the final report will be published in February 2006.

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HIV/STIs

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Update on the roll-out of the National Chlamydia Screening Programme (NCSP)
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Update on the roll-out of the National Chlamydia Screening Programme (NCSP)

The National Chlamydia Screening Programme (NCSP) is a Department of Health (DH) led initiative in England, which began in April 2003 in ten programme areas and was extended to an additional 16 areas in April 2004 (table 1). The programme aims to control genital chlamydia through the early detection and treatment of asymptomatic infection to prevent the development of sequelae (1,2) (and in particular pelvic inflammatory disease [PID], ectopic pregnancy, and infertility) and to reduce onward transmission.

Table 1 UK locations of phase 1 and 2 NCSP programme areas:April 2003 to March 2005

Phase 1	Phase 2
Camden and Islington	Birmingham
Cornwall	Brent & Harrow
Hull and East Riding	Brighton
Lambeth, Southwark, & Lewisham	Coventry
Leeds	Durham
Nottingham	East Cheshire
Portsmouth	East Kent
Southend-on-Sea	Enfield
Wirral	Liverpool
York	Luton
	Norfolk
	Sheffield
	Slough
	Stoke
	West Cheshire
	Winchester

The programme currently covers over 25% of all primary care trusts (PCTs) in England and offers screening to all sexually active people aged under 25 years in a variety of health and non-health care settings, particularly outside genitourinary medicine (GUM) clinics. Treatment, partner notification, and follow-up services are provided in a variety of ways including health advisors in GUM clinics, trained staff in central screening offices, or trained health workers at community testing venues The HPA works in partnership with the DH and provides epidemiological support for the monitoring of the programme.

Preliminary findings from the first two years of screening data (April 2003 to March 2005) show that screening volumes are increasing over time and across all programme areas. The total number of screens increased from just over 17,000 in the first year to over 63,000 in the second year (figure 1). Screening occurred in 21 different venue types, with approximately half of screens performed in family planning clinics and a fifth in young people's services (figure 2). Men accounted for 11% of screens. Nearly all of the men and over half of the women were screened via urine samples . A third of women were screened by self-taken vulva-vaginal swabs. The rate of positive tests among screened women aged under 25 years was 10.9%, and was 11.7% for men aged under 25 years. Follow-up information from the first years data shows that 98% of positive people screened received treatment, with a 76% effective partner treatment rate.

Figure 1 Screening volume by sex and number of screening venues: April 2003 to March 2005

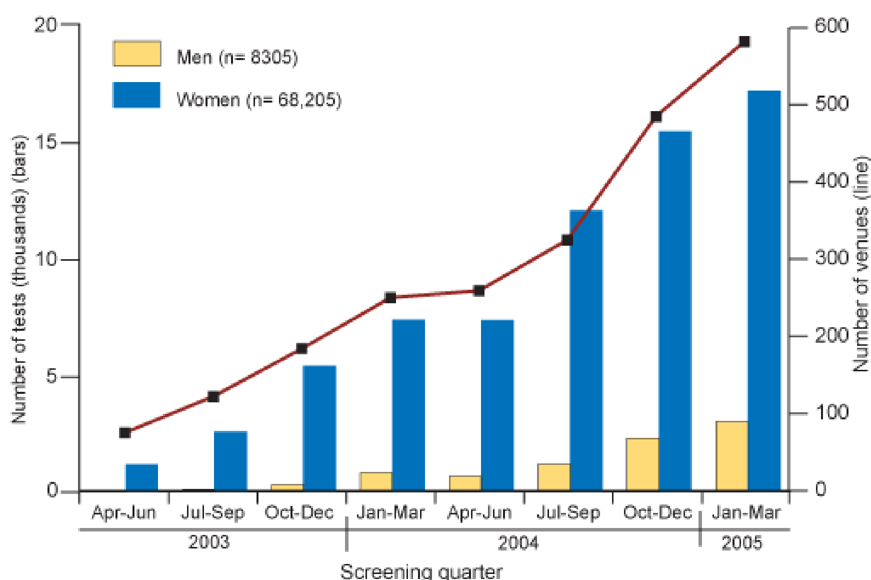
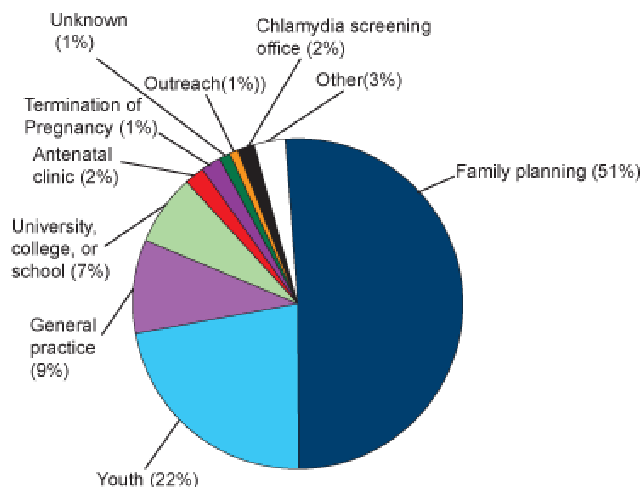


Figure 2 Testing location: April 2003 to March 2005



These results show that the high burden of infection would have been missed in the absence of a screening programme, and re-enforce the feasibility of screening outside GUM settings. The acceptability of vulva-vaginal swabs as an alternative to urine samples for women is also noteworthy given the higher cost and potential transport and processing difficulties with urine samples. Comprehensive analyses of these data will be available in the second NCSP annual report due to be published (in collaboration with the Department of Health) at the end of 2005.

Tackling the prevalence of chlamydia through the accelerated implementation of the screening programme by March 2007 is one of the key commitments in the white paper *Choosing Health* (3) and an additional £80million investment has been made available to take this forward.

From April 2006, screening for chlamydia is included in PCT's local delivery plans with performance management at Strategic Health Authority level. As the programme extends there will continue to be a number of challenges including continuing the increase in screening volume and in the evaluation of the impact on disease prevalence and its sequelae.

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Diary

Course on Hospital Infection Control (HIS/LHCAI)

Course on Hospital Infection Control (HIS/LHCAI)

The next Hospital Infection Control course will be held from Monday 20 to Friday 24 February 2006, and will be held at the Health Protection Agency Centre for Infections, 61 Colindale Avenue, London NW95HT. The course is aimed at infection control doctors and nurses, and will be held at the Centre for Infections, HPA, 61 Colindale Avenue, London NW9 5HT.

The course covers epidemiology, bacterial typing and antibiotic resistance, control and management of outbreaks and bloodborne viruses, hospital hygiene, ventilation and other aspects of infection control, including policies and guidelines. The course is recognised for CPD points (Continuing Professional Development) and is a module for the diploma in hospital infection control offered by the Hospital Infection Society, Centre for Infections and London School of Hygiene & Tropical Medicine. The fee is £500 (non-resident). For further information, registration and an application form, please either write to Greta Howell, PA to Prof. Barry Cookson, Laboratory of HealthCare Associated Infection, HPA, Specialist and Reference Microbiology Division, 61 Colindale Avenue, London NW9 5HT, or email: <greta.howell@hpa.org.uk>.