

Continued increase in sexually transmitted infections: An analysis of data from UK genitourinary medicine clinics up to 2007

Detailed tables of the latest data from GUM clinics are available [here](#).

Key points:

- Numbers of new STI diagnoses at GUM clinics have risen steadily over the last 10 years.
 - Genital chlamydia and genital warts accounted for over a half of all new STI diagnoses at GUM clinics in 2007.
 - Increased testing for STIs, more sensitive diagnostic methods and changes in sexual behaviour probably all contribute to rising numbers of diagnoses.
 - Young people aged 16 to 24 years and men who have sex with men experience the highest rates.
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Numbers of diagnoses of sexually transmitted infections (STIs) made at genitourinary medicine (GUM) clinics in the UK rose in 2007, continuing the upward trend of the last 10 years. Between 2006 and 2007, numbers of new STI diagnoses rose by 6% (from 375,843 to 397,990¹) while recurrent and other STI presentations rose by 7% (from 244,442 to 260,544) (see Box; figure 1).

Genital chlamydial infection remained the most commonly diagnosed STI in GUM clinics with 121,986 diagnoses in 2007, a rise of 7% on 2006 (figure 2a). First episode genital warts diagnoses also increased by 7% over this period, from 83,624 to 89,838 (figure 2a). Together these two infections accounted for over a half (211,824/397,990) of all new STI diagnoses at GUM clinics in 2007. However, the most significant percentage increase in numbers of diagnoses was seen for first episode genital herpes infections, which rose by 20% from 21,797 to 26,062 (figure 2b). All these rises were observed in both men and women.

Syphilis remains a relatively rare infection in the UK overall, and the pronounced increase in total primary and secondary syphilis diagnoses observed since the late 1990s stabilised in 2007, at 2,680 cases (figure 2b). However, diagnoses of syphilis among men who have sex with men (MSM) have continued to rise, and between 2006 and 2007 primary and secondary diagnoses rose from 1,428 to 1,463 and those of early latent syphilis from 466 to 542 (figure 3). Although there has been a modest rise in diagnoses among women over the last decade, most of the increase occurred among men, and has been strongly associated with high risk sexual behaviours among MSM¹. Numbers of diagnoses of infectious and early latent syphilis among women declined in 2007, from 295 to 285 and 196 to 163, respectively (figure 3). Total numbers of diagnoses of late complications of syphilis rose by 5% (1,923 to 2,025) between 2006 and 2007.

In contrast to most other STIs, numbers of gonorrhoea diagnoses have been declining since 2002 and fell again slightly in 2007, to 18,710 diagnoses (figure

¹ This is not the number of people with a new diagnosis of an STI as multiple diagnoses can be made in individual patients.

2b). However, trends in diagnoses among men and women differed: Numbers fell by 5% in men and rose by 8% in women. Like syphilis, gonorrhoea tends to be geographically localised and concentrated in specific population 'core' groups, predominantly black ethnic minorities and MSM¹. Effective local interventions may therefore have a significant influence on transmission and frequency of this infection.

Although young people aged 16 to 24 years represent only 12% of the population, they account for nearly half of STIs diagnosed in GUM clinics. Young people experience higher rates of infection because they are more sexually active and more susceptible to infection². In 2007, rates of chlamydia, genital warts and gonorrhoea were highest in women aged 16 to 19 (1423, 830 and 137 per 100,000 population, respectively) and men aged 20 to 24 (1183, 815 and 174/100,000), while rates of genital herpes were highest in women and men aged 20 to 24 (242 and 122/100,000) (figure 4). Rates of diagnoses have also been increasing steadily among young adults, and in 2007, rates of gonorrhoea diagnoses rose by 10% (from 125 to 137/100,000) in young women despite overall numbers of gonorrhoea stabilising (figure 4).

Although diagnosis rates in young adults are increasing, because infections like chlamydia and genital herpes are often asymptomatic, substantial numbers of young people may remain undiagnosed and untreated. The National Chlamydia Screening Programme in England aims to control chlamydial infection and its associated complications by offering regular chlamydia tests to asymptomatic young adults at a broad range of health care and community settings outside the GUM clinic setting³. All programme areas are now screening and efforts are underway to improve coverage of the target population.

To a certain extent, rising numbers of STI diagnoses reflect increased testing and improved diagnostic methods, especially the increasing use of molecular testing technologies, but this will vary with the different STIs. Changes in sexual behaviour also contribute. The number of sexual health screens done in GUM clinics (which includes a test for chlamydia and gonorrhoea at minimum) has risen considerably over the last 5 years, and by 10% (from 962,791 to 1,062,850) between 2006 and 2007 alone (figure 5). Seventy per cent of sexual health screens in 2007 included an HIV test. Improved uptake of testing and screening, together with decreased waiting times, ensures prompt treatment of those infected, thereby reducing the risk of transmission and the development of complications. If sustained, this could have a significant impact on the control of STIs.

Box.

New STI Diagnoses
Chlamydial infection (uncomplicated and complicated)
Gonorrhoea (uncomplicated and complicated)
Infectious syphilis
Genital herpes simplex (first attack)
Genital warts (first attack)
New HIV diagnosis
Non-specific genital infection (uncomplicated and complicated)
Chancroid/lymphogranuloma venerum (LGV)/Donovanosis
<i>Molluscum contagiosum</i>
Trichomoniasis
Scabies
<i>Pediculus pubis</i>
Other STI Diagnoses
Early latent, congenital and other acquired syphilis
Recurrent genital herpes simplex
Recurrent and re-registered genital warts
Subsequent HIV presentations (including AIDS)
Ophthalmia neonatorum (chlamydial or gonococcal)
Epidemiological treatment of suspected STIs (syphilis, chlamydia, gonorrhoea, non-specific genital infection)
Other diagnoses made at GUM clinics
Viral hepatitis B and C
Vaginosis and balanitis (including epidemiological treatment)
Anogenital candidiasis (including epidemiological treatment)
Urinary tract infection
Cervical abnormalities
Other conditions requiring treatment at a GUM clinic
Services provided
HIV antibody test
Sexual health screen
Hepatitis B vaccination
Contraception (excluding condom provision)
Other episode not requiring treatment

Figure 1. Trends in diagnoses made in GUM clinics in the UK

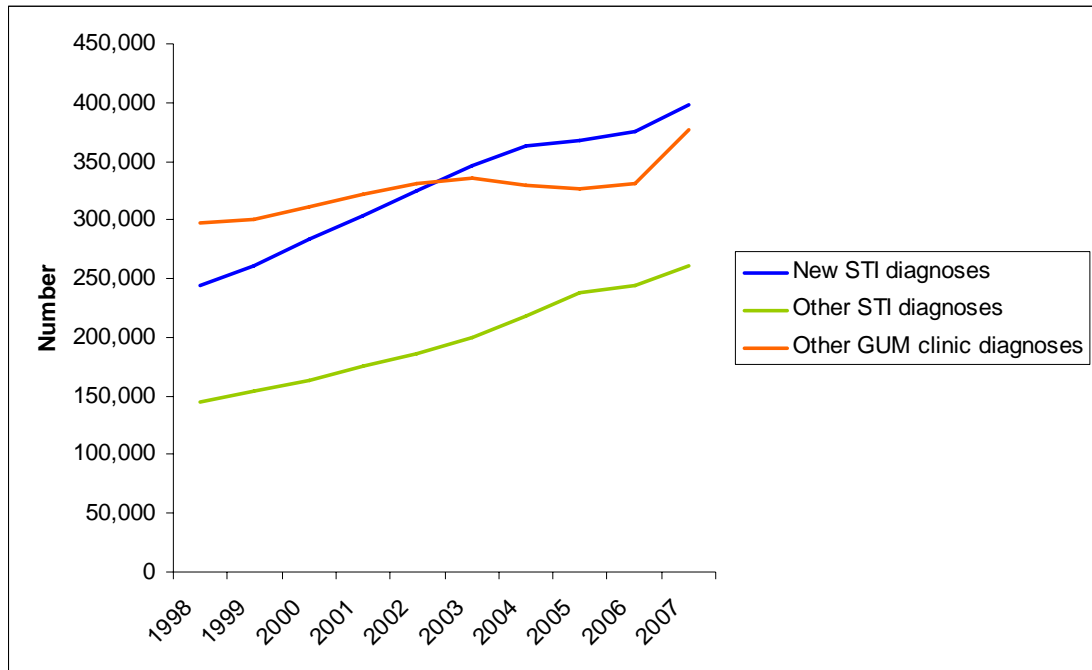
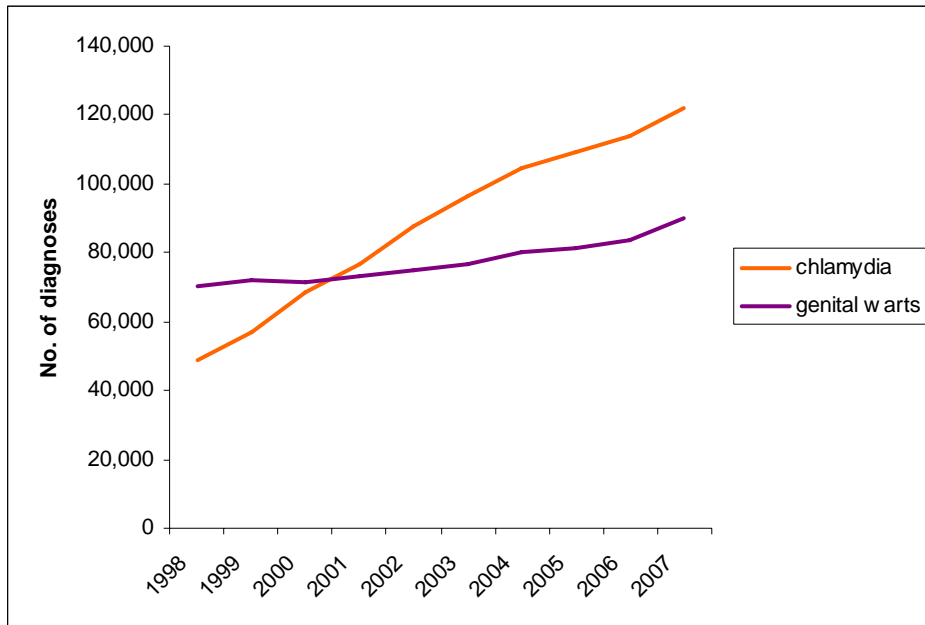


Figure 2. New diagnoses of selected STIs in GUM clinics in the UK, 1998-2007

A. Uncomplicated genital chlamydial infection and first attack genital warts



B. First attack genital herpes, uncomplicated gonorrhoea and primary and secondary syphilis

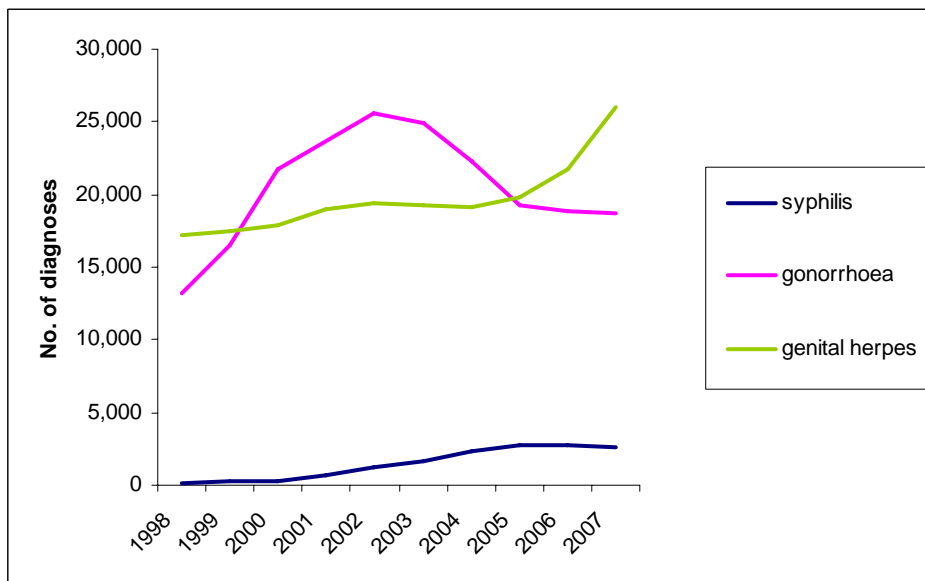
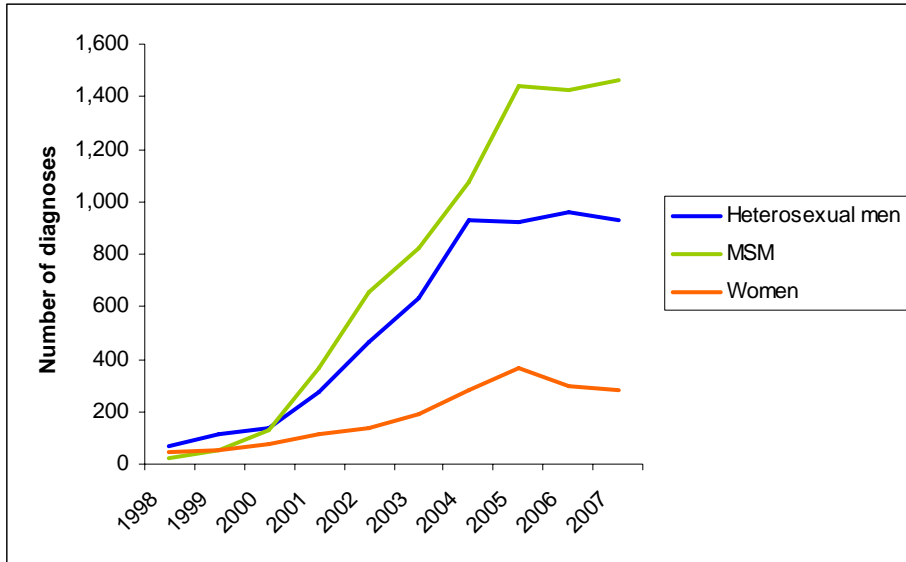


Figure 3. New diagnoses of syphilis at GUM clinics in the UK, by gender and sexual orientation, 1998-2007

A. Primary and secondary syphilis



B. Early latent syphilis

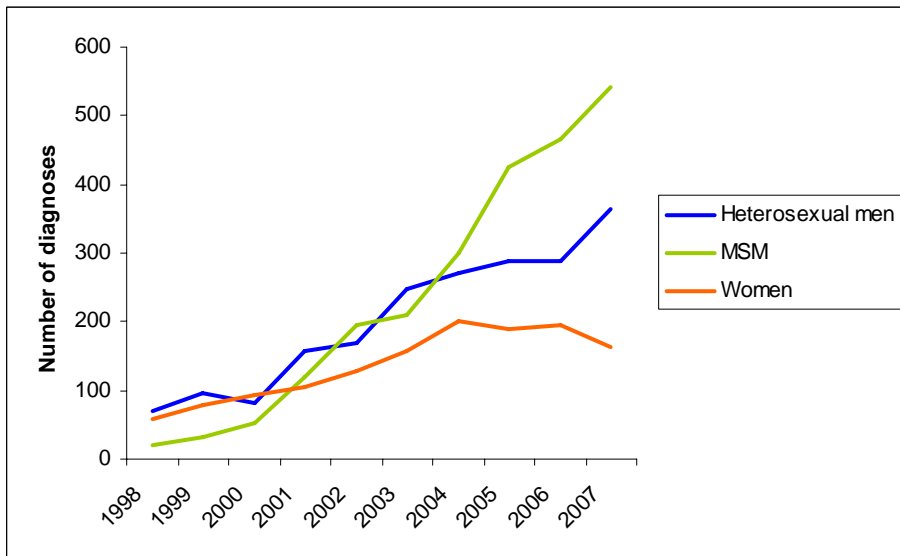


Figure 4. Rates of diagnoses of selected STIs in those aged under 25 years, UK, 2003-2007

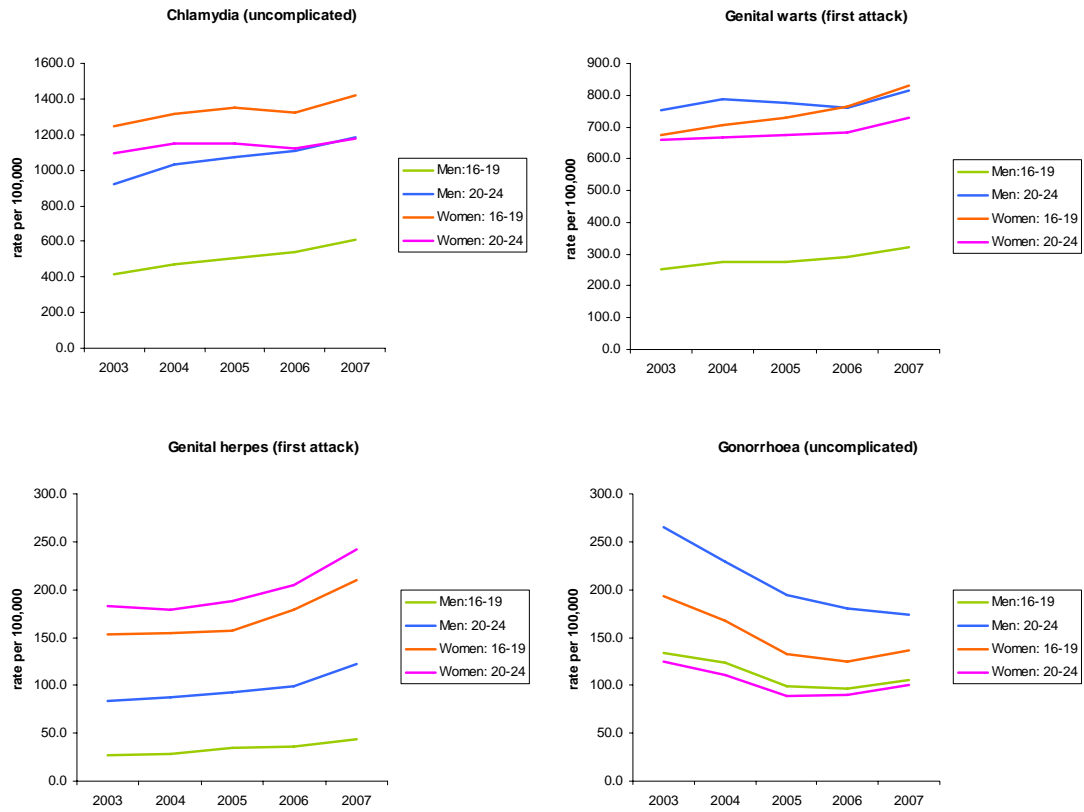
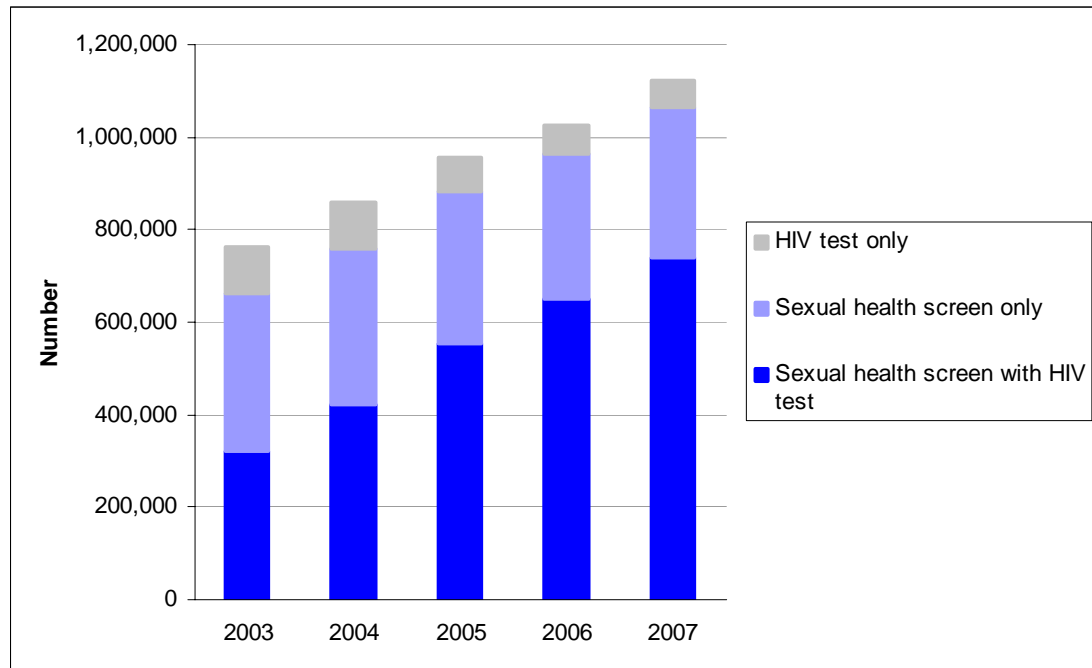


Figure 5. Numbers of sexual health screens and HIV tests at GUM clinics, UK, 2003-2007



References:

1. The UK Collaborative Group for HIV and STI Surveillance. Testing Times. HIV and other Sexually Transmitted Infection in the United Kingdom: 2007. London: Health Protection Agency, Centre for Infection. November 2007.
2. The UK Collaborative Group for HIV and STI Surveillance. Sexually Transmitted Infection in Young People in the United Kingdom: 2008 report. London: Health Protection Agency, Centre for Infection: 2008.
3. National Chlamydia Screening Steering Group. Maintaining Momentum: Annual Report of the National Chlamydia Screening Programme in England 2006/7. London: Health Protection Agency, 2007.