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JS working on Chlamydia trachomatis infections, database management, writing of the manuscript; CS responsible for the statistical analyses; IV and SM, technicians performing all chlamydia typing experiments (culture and PCR based RFLP typing) and sample database management; HSAF, in charge of the STD outpatient clinic in Amsterdam, responsible for the logistics of the sample collection critically reviewing the manuscript; ASP and RAC, providing the setting for the work performed, guidance of JS on this topic, and critically reading the manuscript; SAM, responsible for the study design, final guidance of JS on collection, critically reviewing the manuscript for the work performed, guidance of JS on collection, critically reviewing the manuscript.

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Surveillance of sexually transmitted infections in primary care

Surveillance for sexually transmitted infections must respond to increases in the provision of sexual health services outside genitourinary clinics. Simms et al1 propose repeated panel surveys in general practices to improve surveillance in primary care, monitor changes in prevalence over time, and address the current lack of behavioural data. There are some limitations to this approach. Firstly, prevalence surveys will not measure diagnostic activity in primary care and other clinical settings. This is essential for determining whether proposals from the National Strategy for Sexual Health2 are being implemented effectively. Secondly, periodic surveys in different areas could not readily identify outbreaks. In the Bristol area, for example, most cases in an ongoing outbreak of sexually transmitted hepatitis B infection have presented to general practitioners. All genitourinary medicine clinics are the main setting for detecting outbreaks their impact in primary care should be monitored. Thirdly, the validity of panel surveys will depend on a high response rate and postal invitations often have low uptake.4 A single system cannot fulfill all the requirements for infectious disease surveillance. Laboratory reporting remains incomplete5 and demographic and socioeconomic data need to be available for infections other than chlamydia for appropriate interpretation of time trends. Routine collection of data on laboratory diagnosed sexually transmitted infections from all clinical settings and linkage to demographic data could complement current proposals.

The Avon Surveillance System for Sexually Transmitted Infections (ASSIST) integrates person based genitourinary clinic and laboratory data to provide information for action at local level and to inform national initiatives.6 Data on positive and negative tests for laboratory diagnosed infections taken in any clinical setting are collected from the Health Protection Agency and trust laboratories. Postcode information for geographical mapping and small area analysis is obtained by matching pseudoanonymised data with GP registration databases. These data are also matched to disaggregate data from genitourinary and Brook clinics to identify duplicate tests and obtain geographic data for infections diagnosed in these settings. ASSIST project data can be used to estimate the population burden of diagnosed infections and explore associations with demographic and socioeconomic characteristics over time. Automating regular data downloads and reporting will improve the timeliness of data collection to facilitate identification and monitoring of outbreaks. The wide coverage of the system can guide local service development and clinical practice and monitor the impact of the Sexual Health Strategy. For example, in 2001 half of all chlamydia tests and 44% of positive results came from GP, family planning, or Brook clinics. Nearly two thirds (62%) of those tested in general practice were over 25 years old in whom the positivity rate was 4% compared with 11% for under 25 year olds.

We propose that, while behavioural data obtained from panel surveys in primary care provide depth, sentinel surveillance of laboratory diagnosed infections in all clinical settings provides breadth, and both are needed for effective surveillance.

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Comparison of the serological response to treatment of early syphilis in HIV positive versus HIV negative individuals

The effectiveness of treatment for syphilis is evaluated by demonstrating declining titres of the non-treponemal antibody tests—for example, the rapid plasma reagin (RPR). The serological response in HIV co-infected individuals has been the subject of debate, with some studies reporting a similar serological response7,8 and others a delayed response in HIV positive patients.9

A resurgence of infectious syphilis has occurred in Manchester, United Kingdom, in recent years.1 From January 1999 to August 2002, 379 cases of early syphilis were