Sexual health

Estimating STI morbidity in primary care

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Are we approaching reliable data?

In many developed countries, understanding of the morbidity, workload, and epidemiology of sexual health related problems in primary care remains elusive, despite good quality data from specialist clinical settings. Reasons for this deficit in the United Kingdom include a lack of statutory surveillance for sexually transmitted infections (STIs) in this setting,¹ the unknown extent of syndromic diagnosis and management in primary care, and anecdotally, reluctance among primary care practitioners to record STIs because of concerns about confidentiality and insurance.

Nevertheless, it is clear that a substantial burden of STIs is managed in primary care in the United Kingdom, with a further shift to primary care sexual health provision encouraged by national policy.² In the 2000 Natsal survey, 36.2% of women and 16.2% of men who had had genital chlamydia infection in the past 5 years reported treatment in primary care,³ while by 2001 half of chlamydia tests in some districts came from primary care.⁴

Freedman *et al* in this issue of *STI* (p 61) present an interesting analysis of a cross sectional survey of Australian primary care activity, in which they used inclusive symptomatic criteria to identify consultations in which a sexual health problem was managed. These data are similar to the UK Morbidity

Statistics from General Practice, last collected in 1992.⁵ Following analysis of 1998–9 “BEACH” data using narrow diagnostic criteria,⁶ the authors have now shown much higher rates of sexual health associated consultations using the new strategy.

Compared to the 1998–9 analysis, Freedman *et al*’s methodology is likely to provide a more realistic estimate of sexual health related workload. The high rate of syndromic treatment for possible or presumptive STIs provides strong evidence that the use of distinct pathological diagnoses as an outcome measure will lead to substantial underestimates both of workload and of incidence rates. However, while showing a substantial sexual health related workload, these data give little information about the actual epidemiology of STIs in the populations consulting. The positive predictive value of symptoms such as dysuria for non-specific urethritis, chlamydia, or gonorrhoea is likely to differ between primary care and sexual health clinics, while primary care practitioners manage vaginal discharge in women at very low risk for STIs as well as those in the higher risk demographic and behavioural groups. As the authors acknowledge, consultation based data do not allow accurate estimates of how many patients with a given symptom (say, urethral discharge) undergo tests or referral.

The finding that younger, better qualified, female GPs working in larger practices undertake more sexual health related work merits further inquiry by those responsible for planning sexual health services at population level. It is not clear to what extent this represents patients choosing to access certain types of practitioner for sexual health problems, or a higher level of awareness of sexual health among these doctors.

In planning accessible and effective sexual health services, particularly for men who have lower consultation rates, it will be important to gather both qualitative and quantitative evidence on this issue. The emergence of large primary care datasets will provide an important means for studying this important aspect of sexual health provision, and developing surveillance of the morbidity caused by STIs in UK primary care.⁷

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