Figure 1 Results of selected questions and differences between medicine and AMR students groups (Antofagasta University, Antofagasta, Chile, 2005). AMR, attention to mental retardation.

medicine, 44.8% AMR). After this initial selection none of the students refused to participate in the survey. Mean (SD) age was 20.5 (2.7) years (range 15–29 years; no significant differences were observed between medicine and AMR groups, $p > 0.05$). About 44.2% of the students had been sexually active in their life (23.4% only once; no significant differences were observed between medicine and AMR groups, $p > 0.05$). Nearly all were heterosexual (99%; no significant differences were observed between medicine and AMR groups, $p > 0.05$). About two-thirds (66.1%) did not use condoms for sexual intercourse (70.2% medicine, 20% AMR; $p < 0.001$), but about half (52%) reported using a condom at the last episode of sexual intercourse (60% medicine, 100% AMR; $p < 0.001$; fig 1). From this group, 61.3% reported having had unsafe sex after alcohol or drug misuse (75.4% medicine, 40% AMR; $p < 0.001$). About 1 in 40 (2.6%) described a previous STI (no significant differences were observed between medicine and AMR groups, $p > 0.05$). Concerning testing for HIV infection, only 0.6% had taken an HIV-ELISA test once, but 73.9% stated that they were willing to do so (85.9% medicine, 48.2% AMR; $p < 0.001$; fig 1). However, 94.8% considered it important to try to prevent becoming infected with the HIV/AIDS virus.

In Chile, the first HIV case was notified in 1984. Up to December 2003, >6060 cases of AIDS and 6514 people with HIV have been reported. The burden of mortality has risen to 3860 deaths in the 13 regions of the country.⁴ The 18–49-year-old group accounts for 85% of cases in Chile, and is the main age group infected in the second region of the country (Antofagasta) where this study was carried out.⁴

Today, studies taking into account the epidemiology of HIV/AIDS should be tailored to survey those populations at risk and those people who manage infected individuals. Many studies have demonstrated the importance of such epidemiological research.^{5–8} Current results, although limited with respect to other factors related to behaviour for the prevention of the HIV (that should be expanded in further studies), based on the observed risky behaviour in this evaluated young population (which represented a significant sample of health

sciences students from a Chilean university), indicated the importance to educate and provide more instruction on different aspects of HIV/AIDS and STIs, particularly about prevention, and reproductive and sexual education. We concluded that sexual and related behaviour among the health sciences students surveyed in Chile is risky for HIV/AIDS and STIs, and that knowledge about these diseases is limited, compromising an appropriate practice of self-prevention. Further studies in this setting are expected.

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Impact on gonorrhoea case reports through concomitant/dual testing in a chlamydia screening population in Liverpool

A recent Commentary in this journal¹ encourages wider implementation of nucleic acid amplification tests (NAATs) to detect gonorrhoea (GC). We have used GC NAATs (APTIMA Combo2; Gen-Probe Inc., San Diego, California, USA) since 2003, with high uptake, in a Liverpool chlamydia screening population and with referral of GC-positive patients to our local genitourinary medicine (GUM) clinic for management.² We have now observed a doubling of female cases of GC and a reversal of

Figure 1 Comparison of GC cases from KC60 returns and GC cases found during chlamydia screening of (A) female patients and (B) male patients (direct testing plus assumed 50% contact tracing of female patients).

the downward trend for male GC as reported through KC60, the national indicator of GC activity that is based on central reporting but essentially only of cases seen at GUM clinics. For female patients (fig 1A), compared to a 4-year average baseline (2000–2003) of 101 cases/year, KC60 reports showed an extra 51 cases in 2004 and an extra 99 cases in 2005. These extra numbers reflect closely the 45 cases in 2004 and the 107 cases in 2005 detected by concomitant screening for GC in the community chlamydia screening programme. For male patients (fig 1B), the upturn in KC60 reports can be matched to the total of cases detected directly by community screening plus by contact tracing of female community cases (assumed 50% success).

This significant local impact on detection of GC cases suggests that concomitant/dual testing in the community can benefit the wider provision of services for sexual health. Empirical evidence gained from screening in Liverpool has been recognised by the Cheshire and Merseyside Sexual Health Network; the development of a care pathway for asymptomatic low-risk individuals recommends concomitant screening for chlamydia and gonorrhoea using APTIMA.³ This facilitates prompt, easy access to more comprehensive screening for sexually transmitted infections at a wide range of venues, and may also promote opportunities for increased participation in the National Chlamydia Screening Programme.

In addition, with regard to data collection, KC60 data is an important tool in assessing progress towards the Department of Health target for a 25% reduction in cases of GC diagnosed at GUM clinics.⁴ Consideration of changes to KC60 reporting may be needed to prevent increased use of GC NAATs and/or dual

testing in the community becoming a confounder to monitoring of this aim.

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Letters from beyond: do patients attending Genitourinary Medicine clinics want their general practitioner to know?

Communication standards between physicians in Genito-urinary Medicine (GUM) and general practitioners (GPs) remain a vital but largely neglected area of study.¹ As a result of historical statutes many clinics still communicate with GPs only when patients are formally referred from general practice, but this policy may not reflect current patient or GP preferences.²

All patients attending the GUM clinic in the Scottish Borders complete a registration form that includes a section concerning communication with their GP; therefore, a retrospective analysis was performed on a random sample of 630 case notes (43% male and 57% female) from patients attending between 2002 and 2006.

Overall, 54% of patients requested no contact be made with their GP, but 36% of patients

Table 1 Factors affecting GUM attendees' preference regarding GP contact

	Overall no.	No. (%) declining GP contact	p value
Patient sexual preference			
Heterosexual	600	312 (52%)	
Homosexual/bisexual	26	20 (77%)	p ≤ 0.01
Reason for attendance			
STI screen, no symptoms	153	105 (69%)	
Symptoms	349	155 (44%)	p ≤ 0.001
Known contact of infection	103	68 (66%)	
Mode of referral			
GP no letter	197	84 (43%)	
GP with letter	65	8 (12%)	p ≤ 0.001
HIV test undertaken			
Yes	317	195 (62%)	
No	313	144 (46%)	p ≤ 0.001

Data analysed using Microsoft Excel and statistical analysis performed using the χ^2 test.

expressed a definite preference for communication with their GP. Patient age did not influence the wish for communication with their GP as patients younger than 20 years old were no more likely to refuse GP contact than those over 20 (57% vs 53%, $p = 0.52$). Similarly, gender had no significant effect (females 53% vs males 56% $p = 0.43$).

Patient sexual preference, however, did influence whether patients wished communication between GUM and their GP with patients being significantly more likely to decline GP contact if self-identified as homosexual or bisexual (table 1). Reason for attendance at the GUM clinic was also an important factor, with patients more likely to decline GP contact if they attended for an asymptomatic STI screen or as a contact of infection than if they had symptoms (table 1).

Forty-two per cent (262/630) of patients were referred by their GP, and 35% of patients self-referred to the GU Medicine clinic (215/630). Self-referred patients were more likely to decline GU Medicine contact with their GP than those initially referred by a GP (65% vs 36%) ($p \leq 0.001$). Of those referred by a GP, patients were more likely to consent to contact between the GU clinic and their GP if referred to the clinic with a GP letter (table 1). Finally, patients who undertook HIV testing were significantly less likely to agree to contact with their GP (table 1).

There is an unwritten assumption that most patients attending GUM clinics would not wish their GP to be made aware, but evidence from this large study refutes this. Providing GP letters for patients may be an addition to the workload for already overstretched GU services but is consistent with other disciplines and may reduce stigma attached to sexual health. Standard letters and electronic systems may reduce the work involved.¹ Many patients initially attend GPs for sexual-health-related issues³; therefore GUM physicians must be aware of the importance of correspondence with colleagues in primary care. Future possibilities include the adoption of an "opt out" clause for patients regarding communication with their GP. Previous work has also highlighted the difficulties both GPs and patients face concerning life-insurance considerations with reference to STIs, and further education is needed in this area.^{4,5}

The potential benefits of increased communication between GUM and GPs include better

relationships between primary care and GU medicine, and more importantly improved overall patient care, a common goal for both community and hospital practitioners.

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CORRECTION

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Several authors' names were omitted from a letter published in the October issue of the journal (Menon-Johansson AS. The extent of self-initiated STI and HIV prophylaxis (auto-PEP) and treatment in MSM attending GUM and HIV clinic services. *Sex Transm Infect* 2007;**83**:498–9.) The full list of authors is as follows: Menon-Johansson AS, Randell P, Mandalia S, Asboe D, Boag FC. Chelsea and Westminster NHS Foundation Trust, London, UK.