can be backed up by the availability of effective drug therapy that patients can use when symptoms become troublesome, so much the better. However it is important to realise that non-drug interventions, applied to well-selected patients, also have significant symptomatic benefits and have the advantage of shifting the locus of control, so that patients themselves may feel more able to cope and deal with their symptoms.[18] While IBS is not considered to be associated with the development of serious organic disease, it is, as these new studies remind us, a common and troublesome condition that deserves our clinical and research attention. It is also a condition in which the management of expectations is important, and, at our present level of understanding, one in which diagnosis and management should best be approached within a paradigm of care, rather than cure.

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Chlamydia screening in primary care

SEXUAL health in the United Kingdom (UK) has shown little improvement over the past decade. Diagnoses of chlamydia are increasing, teenage pregnancies are not yet down and there are long waits for genitourinary medicine (GUM) clinic appointments.[1] Two articles in this month's Journal and a parliamentary report highlight further problems. A qualitative focus group study by McNulty *et al* found that general practitioners (GPs) are often too busy to screen for chlamydia and feel that they don't know enough.[2] Similarly, interviews with 71 female street-based commercial sex workers in Bristol revealed that although they do attend general practice, they do not disclose their occupation and they do not receive optimal care.[3] Finally, a House of Commons Select Committee recently completed an inquiry into the sexual health of the nation.[4] They found a 'crisis in sexual health' and little evidence that primary care trusts were ready to take on responsibilities for sexual health commissioning. 'The whole sexual health service seems to be a shambles'.[5]

National screening programme for chlamydia

A major recommendation of the *National strategy for sexual health and HIV*, published in 2001,[6] was that chlamydia screening be rolled out more rapidly. What are the implications for primary care and what do GPs need to know? *Chlamydia trachomatis* is a much publicised, common, treatable sexually transmitted infection (STI) that can cause pelvic inflammatory disease but produces few symptoms in up to 70% of women and 50% of men. After one episode of pelvic inflammatory disease, around 15% of women may become infertile, 10% suffer chronic pelvic pain and 10% of subsequent pregnancies may be ectopic, which can be life threatening. Chlamydia costs the National Health Service >£100 million annually, but the human costs are borne disproportionately by women. Screening for chlamydia has been shown to reduce the incidence of pelvic inflammatory disease[7] and to be cost-effective at prevalences of ≥5%.[8] Although the national screening programme has not yet focused on primary care, many practices offer opportunistic chlamydia testing.

Which chlamydia tests should GPs use?

DNA detection tests for chlamydial infection (such as polymerase chain reaction assays) are currently being made available to UK GPs and are much more sensitive and specific than the outdated non-molecular tests. They have the great advantage that they perform well on samples that can be obtained non-invasively. Most people much prefer to provide a urine specimen or self-collected swab than to undergo a clinical examination. This is also a more efficient use of time for GPs. In women, first-catch urine specimens (from the beginning of the stream sensitivity >80%) and self-taken vaginal swabs (sensitivity >85%) are acceptable methods of chlamydial screening, even during pregnancy.[9] However, young women with possible symptoms of infection such as abnormal vaginal discharge, intermenstrual or post-coital bleeding or pelvic pain should ideally undergo a speculum examination. A charcoal endocervical swab should be taken first to test for gonorrhoea, and then rotated in the vagina to sample for trichomoniasis, bacterial vaginosis and candidiasis. This is followed by a second endocervical swab, which should be rotated gently in the cervical canal for a few seconds and sent for chlamydia analysis (sensitivity >90%). In young men, first-catch urine testing (sensitivity >90%) is a non-invasive alternative to uncomfortable urethral swabs taken by a physician.

What do the UK chlamydia screening studies tell us?

There have been three important studies.[10] The Department of Health chlamydia screening pilots in Wirral and Portsmouth showed that the opportunistic approach to chlamydia screening in primary care is feasible and acceptable.[11,12] However, this was different from normal practice, as GPs were paid for each patient screened. In addition, the widely quoted chlamydia prevalence rate of around 10% in women aged <25 years is probably an overestimate of the true prevalence. This was opportunistic screening, and GPs and practice nurses were allowed to select those whom they considered were higher risk. Over a third of those tested had symptoms of infection. By contrast, the chlamydia screening studies (ClaSS) involved a postal survey of around 20 000 men and women aged 16–39 years from GP registers in Bristol and Birmingham.[10] They found a prevalence of chlamydia infection of 7% in women aged 20–24 years, but as the response rate was only 34% it is unclear if this is representative. The most reliable prevalence data may be from the 2001 National Survey of Attitudes and Lifestyles (NATSAL) population-based study (response rate 65%).[13] This found the prevalence of chlamydial infection was 3% (95% confidence interval = 1.7 to 5.0) in women aged 16–24 years. This is likely to be nearer the true prevalence in asymptomatic sexually active young women in the UK.

Who should be tested in primary care?

It is clearly important to target the right population rather than increasing testing of those at relatively low risk. Laboratory reports from St George's and Kingston Hospitals show that at present, GPs in south London are mainly testing older, low-risk women.[14] Only 30% (1950/6527) of tests done in 2002 were in women aged ≤25 years in whom the prevalence of chlamydia was 9%.

- Women requesting termination of pregnancy
- Women with abnormal vaginal discharge, intermenstrual bleeding, pelvic pain
- Men aged <35 years with urethral discharge, dysuria or epididymitis
- Age <25 years, especially sexually active teenagers
- New sexual partner or multiple partners
- Afro-Caribbean or black African ethnic origin
- Partner recently diagnosed with sexually transmitted infection

Box 1. Who to test.

Nearly half (46%) of women tested were aged >30 years, in whom the prevalence was only 1%. GPs and practice nurses need to focus their efforts on sexually active women at higher risk — the young, those with multiple partners and those in black ethnic minority groups[13,15] as well as those with symptoms. In addition, women undergoing a termination of pregnancy have a high prevalence of chlamydia and a high risk of developing pelvic inflammatory disease after cervical instrumentation if they have untreated chlamydial infection (Box 1).

Evidence of the effectiveness of screening in men is lacking.[12] However, opportunistic testing of sexually active young men, especially those with penile discharge or dysuria or who are partners of those with chlamydial infection, is likely to be cost-effective.[8] In addition, effective partner notification is clearly vital for chlamydia control. In symptomatic men all sexual contacts for the month prior to the onset of symptoms should be screened and treated. In asymptomatic men and in women (in whom symptoms are often absent), sexual partners from the previous 3 months should be notified. One method may be for the GP to give the patient a note and GUM clinic leaflet for their partner to take to the clinic.

What can GPs do?

GPs in the UK are currently drowning under quality targets and 'a flood of guidelines of biblical proportions' (D Jewell, personal communication, 2004). What are the bare essentials for chlamydia screening? Ten years ago we did a cluster randomised trial of introducing simple chlamydial management

Box 2. Management of chlamydia-positive patients.

- Give patient chlamydia and GUM clinic leaflets (and condoms if available)
- Antibiotics
  - Azithromycin 1 g stat or doxycycline 100 mg twice daily for 7 days. (No test of cure needed)
  - If pregnant or lactating: erythromycin 500 mg four times daily for 7 days or twice daily for 14 days
- Partner notification
  - Sexual partners should be screened and treated. The patient should be told not to have sex until this has been done. The patient should be given a note and GUM clinic leaflet for their partner to take to the clinic
- Optional follow-up by GUM
  - For help with partner notification or full STI screen

guidelines[16] into general practices.[17] Boxes 1 and 2 summarise the basics for a non-specialist GP or practice nurse. In addition, practices need good working relations with GUM clinics. Local care pathways should be developed in collaboration with primary care trusts. This should ensure that, when appropriate, patients diagnosed with chlamydial infection in primary care can be referred directly to a genitourinary clinic nurse for partner notification and a full STI screen without a long wait either for an appointment or in the clinic. Although GPs, GUM and family planning clinics are doing their best, current funding for sexual health in the UK remains 'manifestly insufficient'.[1] 'No one should underestimate the challenge of introducing a chlamydia screening programme into primary care'.[12]

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Engaging with the public?

THE recent controversy surrounding the use of the measles, mumps and rubella (MMR) vaccine highlights a series of issues facing society at large. These issues have had a dramatic impact on general practitioners in particular. The issues include public trust in the advice provided by the government; the public's perceptions of the medical profession and of the advice that it provides; the lack of research into how people take into account potential and actual risks when making important decisions; how scientific findings are presented to the public by professionals and through the media; and the views of the public held by policy makers, scientists and health practitioners.

It is easy to understand the frustration felt by many in the medical and health professions at the behaviour of the public in general. The waste of resources caused by smoking, alcohol and other drug abuse, and inappropriate dietary habits in the face of overwhelming evidence is a constant drain on morale and budgets. There are innumerable instances of people ignoring what is widely known and well understood about health and wellbeing.

However, the MMR issue highlights other concerns that deserve to be addressed by policy makers, researchers and practitioners. In the case of MMR, many experts appear to be arguing that 'if only the public knew the facts then they would act differently'. This deficit model of the public is a common feature identified by research into professionals' views of the public.

In the latter half of the 20th century, there emerged a concept that became known as the 'public understanding of science'. In effect, this was a polite way of referring to the public's lack of understanding of what experts thought they should know. With the same degree of subtlety associated with talking loudly to foreigners, the antidote to public misunderstanding was assumed to be 'more understanding', whether the issue was nuclear power, genetic engineering or emissions from electricity pylons.

If the solution was 'more understanding', what was the problem? In many cases, public ignorance was attributed to an inadequate science education, untrained and ignorant journalists, the difficulty of the issues involved and the lack