Correspondence

Letters should not exceed 400 words and should be typed double spaced (including the references) and be signed by all authors

TO THE EDITOR, *Genitourinary Medicine*

Antibodies to *Chlamydia trachomatis*

Sir,

Meyer and colleagues (*Genitourin Med* 1987;**63**:22–5) evaluated a whole inclusion assay for detecting IgG antibodies to *Chlamydia trachomatis* and found its value to be questionable. In 1975 Richmond and Caul[1] reported that this technique detects antibodies to both *C psittaci* and *C trachomatis*. I have also found this test to be genus specific, capable of detecting antibodies to both chlamydial species as well as to an atypical chlamydial strain (*C IOL-207*) now tentatively designated as a "TWAR" strain of *C psittaci*. TWAR agents appear not to be sexually transmitted but to cause respiratory disease in adults. Antibodies to these agents are common in human populations and have been detected in groups from Great Britain, western and eastern Europe, the Middle East, and Africa[2] as well as from the United States of America.[3] Serological tests that detect genus specific chlamydial antibodies, such as inclusion assays and some enzyme linked immunosorbent assays (ELISAs) will give positive results with antibodies to TWAR agents. In one study we estimated that around 50% of antibodies detected by an inclusion assay were due to exposure to TWAR agents and not *C trachomatis*.[4] Schachter has also reported that repeat testing of serum samples from early antibody studies has shown that seroconversions attributed to *C trachomatis* were actually due to cross reacting antibodies to TWAR agents.[5]

Several kits are now commercially available for detecting antibodies to *C trachomatis*. I would urge that the specificity of any serology test be considered carefully when evaluating the results obtained.

Yours faithfully,
T Forsey

Subdepartment of Virology,
Institute of Ophthalmology,
University of London,
London WC1H 9QS

References

1 Richmond SJ, Caul EO. Fluorescent antibody studies in chlamydial infections. *J Clin Microbiol* 1975;**1**:345–52.
2 Forsey T, Darougar S, Treharne JD. Prevalence in human beings of antibodies to Chlamydia IOL-207, an atypical strain of chlamydia. *J Infect* 1986;**12**:145–52.
3 Grayston JT, Kuo C-C, Wang S-P, Altman J. A new *Chlamydia psittaci* strain, TWAR, isolated in acute respiratory tract infections. *N Engl J Med* 1986;**315**:161–8.
4 Forsey T, Stainsby K, Hoger PH, Ridgway GL, Darougar S, Fischer-Brugge U. Comparison of two immunofluorescence tests for detecting antibodies to *C trachomatis*. *European Journal of Epidemiology* 1986;**2**:163–4.
5 Schachter J. *Chlamydia psittaci*—"reemergence" of a forgotten pathogen. *N Engl J Med* 1986;**315**:189–91.

TO THE EDITOR, *Genitourinary Medicine*

Follow up study of sexually transmitted disease (STD), sexual practice and human immunodeficiency virus (HIV) serology in homosexual men attending an STD clinic

Sir,

We report here on a two year follow up study of the male homosexual patients who originally participated in our study in 1984.[1] Of the original 63 men, 30 completed the two year follow up. Patients were asked to answer questionnaires about their sexual practices and the number and origin of sexual partners during the two year period. A record was kept of sexually transmitted disease (STDs) acquired during the two years, including results of serological testing for syphilis, hepatitis B surface antigens and antibodies, and cytomegalovirus antibody titre. Lymphocyte T cell OKT4 and OKT8 subsets were counted two years after the original count. All tests were carried out in accordance with the methods in our original study. In addition all 63 stored sera from our original study were tested for HIV antibodies using the enzyme linked immunosorbent assay (ELISA) (Organon Teknika) and, if positive, results were confirmed by other tests (by the Department of Virology, Middlesex Hospital). All patients participating in follow up consented to HIV serology tests being repeated.

Sexual contact had been completely discontinued by two of the 30 patients. The mean number of sexual partners of the 28 patients continuing sexual contact was 20·8 a year during the previous two years compared with 16·6 in the year before the original questionnaire. This apparent rise in number of partners was confounded by the replies to the question "has your estimated number of partners changed during the two year period?" Eleven of the 28 claimed they had reduced their number of partners in the interim period and none claimed to have increased their number of partners. The sexual practices of these 28 patients showed that one was now practising safer sex (no active or passive oral or anal intercourse),[2] (two had stopped all anal intercourse, and five had reduced the incidence of anal sex. One patient now used condoms for anal intercourse.

In the 1983–4 study, 18 of these patients had had sexual contact with someone from outside the British Isles in the previous year. In the present study 10 had had such a contact and in addition five others had had a sexual contact who lived in the London area during the two year period.

Table 1 shows the rates of seroconversion to syphilis (3%), hepatitis B (7%), and cytomegalovirus (CMV) (0%) infections during the two year follow up period. All 30 patients' stored sera were negative for HIV antibodies in the original study and none had seroconverted in the interim. Of the 33 stored sera from patients not participating in the follow up study, one was seropositive for HIV, and this was confirmed by other tests. Little change was noted in the episodes of gonorrhoea, non-specific genital infection, and anogenital warts comparing the two questionnaires (table 2). OKT4 and OKT8 T cell subset ratios did not show any

Table 1 *Serological evidence of syphilis, hepatitis B, cytomegalovirus (CMV), and human immunodeficiency virus (HIV) infections in 30 homosexual men*

	No positive in:		
	1984	*1985–6*	*% Change*
Syphilis	1	2	3
Hepatitis B	6	8	7
CMV	17	17	0
HIV	0	0	0

Table 2 *Episodes of gonorrhoea, non-specific genital infection (NSGI), and anogenital warts in 30 homosexual men*

	No during:	
	1984	*1985–6*
Gonorrhoea	4	4
NSGI	36	37
Anogenital warts	5	3