

MATTERS ARISING

Women's health: potential for better co-ordination of services

We agree with the article by Queen *et al*¹ that the opportunities presented at genitourinary medicine (GUM) clinics to reduce the incidence of unwanted pregnancy should not be missed. Co-ordination of family planning and GUM services would provide a much-needed opportunity to boost the effectiveness of both.

Unwanted pregnancy is a major problem in the Riverside Health District. As part of the investigation of this we carried out a survey of contraceptive use by 100 consecutive women attending the three GUM clinics in the District. Women who were sexually active at the time of the study were asked if they were using contraception and if so whether this was employed every time they had intercourse. Coitus interruptus was not considered an adequate method of contraception for the survey. Women not using contraception were asked if they were planning to conceive and if so were not included in the analysis. The results are shown in the table. No patients refused to comply with the study but in some cases incomplete information was given. In 1990, 41% of women attending the John Hunter Clinic, 26% of women attending Charing Cross Hospital and 21% attending Westminster Hospital were at risk of unplanned pregnancy. In 1991, a year after the commencement of a family planning service within the John Hunter Clinic building, the percentage of women attending the GUM clinic at risk of an unplanned pregnancy, had fallen to 31% (not statistically significant).

Figures for pregnancy terminations strongly support our findings. In 1988, 2564 terminations of pregnancy were performed in

the Riverside. This figure represented around 40% of all conceptions in women aged between 15 and 44 years. The termination rate was 29.8 per 1000 women compared with the national rate of 12.1 per 1000. For younger women (aged 20 to 24) the rate in Riverside was 73.9 per 1000 compared with 23.8 per 1000 nationally.²

Under-use of available health services must contribute to the demonstrably poor record of contraception (as seen by the positive relationship between non-registration with a general practitioner and risk of unwanted pregnancy in the paper by Queen *et al*). The John Hunter Clinic is at present isolated from a general hospital. The installation of a family planning clinic within the same building may possibly have contributed to the reduction in the number of women at risk of unwanted pregnancy. The Westminster clinic has an integral family planning clinic to which all women can be referred and the Charing Cross clinic has easy access to the family planning clinic held within the hospital.

We believe significant ground can be made by co-ordination of genitourinary medicine and family planning services with potential social, medical and economic benefits.

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2 L Durman, Director of Public Health. *Health in Riverside*. Riverside Public Health Dept, Annual Report 1990.

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Table Contraceptive use in sexually active women attending GUM clinics

	Total	Always using Contraception	Sometimes using Contraception	Never using Contraception
John Hunter Clinic (1990)	86	51	25	10
(1991)	94	65	12	17
Charing Cross Hospital	102	75	10	17
Westminster Hospital	93	73	10	10

Chlamydia trachomatis detection

Recently there have been two encouraging reports for solid phase antigen detection systems in this journal.^{1,2} Although this technique is best suited to clinic testing neither group of authors appears to have appraised the method directly in this setting.

At our clinic we have investigated the use of a solid phase antigen detection system (Clearview Chlamydia, Unipath, Bedford UK) as an instant bench test performed by

our nurses. Two sequential cervical swabs were taken specifically for the study from all new female attenders. One swab was tested by Clearview and the other by a conventional enzyme linked immunosorbent assay (Pharmacia BV). The order of swabbing was random and both tests were carried out according to the manufacturers instructions.

Paired samples from 108 women were obtained. The test was found easy to perform by our staff and the results were ready in all cases within 30 minutes. Tests for *C trach-*

omatis were positive in 12 patients and negative in 93 patients by both methods. Discrepant results occurred for three patients, all of whom were Clearview positive but Pharmacia negative. The sensitivity and specificity of the solid phase antigen detection system in our hands were 100% and 96.8% respectively compared with the standard enzyme immunoassay. We would suggest from this small pilot study that solid phase antigen detection systems are as accurate as some EIA methods and that they certainly warrant further assessment to determine their exact role. Further, since this product is best suited to an outpatient environment, future assessment should be made in as close to a clinical setting as possible.

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STDs in injecting drug users

The description of the source of information on HIV-1 status in our report on STDs in injecting drug users¹ is open to several interpretations. As clarification, sources of HIV-1 estimates were either the dried blood spots or, following the method of McCusker *et al*² in a major national study in the United States, results reported by respondents who had already tested HIV-1 seropositive using conventional serum tests. This decision was based both on standard practice² and the fact that in a previous study in this city,³ self-reports of serostatus by 132 injecting drug users were 100% concordant with their subsequent serological testing. Thus, HIV-1 prevalence data were based on laboratory analysis of dried bloods obtained at interview for 14 of 696 respondents (dried blood spot seroprevalence = 2.0%), and for the remainder data were based on report of previous laboratory analysis (combined prevalence = 6.8%, combined $n = 939$).

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3 Wolk J, Wodak A, Morlet A, *et al*. HIV-related risk-taking behaviour, knowledge and serostatus of intravenous drug users in Sydney. *Med J Aust* 1990;152:453-8.