Table 1 Characteristics of presentation of study population at time of HIV diagnosis (n = 117)

	Heterosexual men (n = 45)	Homosexual men (n = 36)	Heterosexual women (n = 27)	Other risk groups (n = 9)
AIDS illness at presentation	16 (36%)	6 (16%)	2 (7%)	1 (11%)
Median CD4 cell count $\times 10^6$/l (range)	178 (3–1,023)	381(4–810)	377 (10–1,104)	151(50–795)
Median HIV viral load copies/ml (range)	24 500 (50–1 000 000)	24 636 (425–3 000 000)	7822 (173–489 184)	12 870 (6676–57 530)
Reasons for HIV test				
AIDS/symptomatic	27 (60%)	11 (31%)	7 (26%)	2 (22%)
Known HIV+ sexual partner	3 (7%)	4 (11%)	12 (44%)	0
Routine screen for sexually transmitted infections	1 (2%)	16 (44%)	1 (4%)	0
Patient request	7 (15%)	3 (8%)	2 (8%)	2 (22%)
Child positive	3 (7%)	0	3 (11%)	0
Insurance/visa purposes	3 (7%)	1 (3%)	0	2 (22%)
Antenatal screening	0	0	2 (7%)	0
Other	1 (2%)	1 (3%)	0	3 (34%)

January 1985 to December 2002 attending four HIV treatment centres in London. Information was collected on demography, mode of first presentation, and clinical stage of HIV infection.

In all, 117 patients were identified, 30 women and 87 men. The number of new diagnoses among south Asians increased by more than threefold over the period 1996 to 2002 compared to earlier years (25 diagnoses before 1996, 90 diagnosed from 1996–2002).

The median age at diagnosis was 38 years (range 19–64 years) for men and 28 years (range 20–55 years) for women. Forty five patients (38%) had originated from Africa, 28 (24%) from India, and 18 (15%) from the United Kingdom. The majority were of Indian ethnicity (95/117; 81%) with the next largest ethnic group being Sri Lankan (12/117; 10%).

The primary mode of transmission was heterosexual sex (72/117; 62%) with transmission through sex between men accounting for a further 31% (36/117) of cases. Four infections were acquired through blood transfusion, two through injecting drug use, one from a needle stick injury, and in two cases risk behaviour could not be identified. The majority (39%, 45/117) of patients identified Africa as the probable place of infection with 28% and 15% probably infected in the United Kingdom and India, respectively.

There were substantial differences in the reasons for testing between individuals in the main risk groups. In particular, heterosexual men and women were both significantly less likely than homosexual men to be diagnosed via routine attendance at a GUM clinic (2% and 4%, compared to 44%, respectively, $p = <0.001$, Fisher's exact test). Among heterosexuals, the main reason for testing in men was symptomatic HIV infection/AIDS (60% of men but only 26% of women), whereas women were more likely to be tested through partner notification of a known HIV+ sexual contact (44% v 7% in males) (table 1).

The median CD4 count at presentation overall was 300 (range 3–1104) cells $\times 10^6$/l . However, male heterosexuals presented with significantly lower CD4 counts (median 178, range 3–1023 cells $\times 10^6$/l) than either homosexual men (median 381, range 4–810 cells $\times 10^6$/l; $p = 0.01$) or heterosexual women (median 377, range 10–1104; $p = 0.02$).

While there are methodological limitations with retrospective case note reviews and differing reporting categories used for Asian ethnicity, our data confirm national surveillance reports of increasing HIV infection among Britain's south Asian communities.[5] The four centres taking part in this study reported 90 cases from 1996–2002 representing one in three of all HIV positive south Asians reported in this time period. Despite the fact that the majority of these were not diagnosed through routine GUM screening the median CD4 count at presentation of heterosexual and homosexual men was consistent with national trends.[6] Indeed, south Asian women presented higher CD4 counts than seen nationally, primarily attributable to effective partner notification. While south Asians still represent less than 5% of all reported HIV positive diagnoses in UK ethnic minority groups[5] (Asians 334; black Africans 8848; black Caribbeans 844) numbers are likely to continue to increase in the future and methods for encouraging early presentation need to be developed in response to this.

G Sethi, C J Lacey
St Mary's Hospital, London W2 1NY, UK

K A Fenton, I G Williams
Department of Sexually Transmitted Diseases, Royal Free and University, College Medical School, London WC1E 6AU, UK

E Fox
St George's Hospital, London SW17 0RE, UK

C A Sabin
Department of Epidemiology and Population Sciences, Royal Free and University College Medical School, London, UK

A Shaw, M Kapembwa
Northwick Park Hospital, Harrow HA1 3UJ, UK

Correspondence to: Dr Gulshan Sethi, Jefferiss Wing, St Mary's Hospital, London W1 2NY, UK; gsethi@doctors.org.uk

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Failure to maintain patient access to GUM clinics

We read with interest the article published by Cassell *et al*[1] about the maintenance of patient access to genitourinary medicine (GUM) clinics following a switch to an appointment based system. Their data show no significant change in the age, ethnic mix, symptom status, and disease mix following the change to appointments. In addition, such a system of 35% prebooked appointments produced an increase in the number of patients seen over that time.

A new appointment based system was introduced at the John Hunter genitourinary medicine clinic at the Chelsea and Westminster Hospital in October 2001. This comprised 80% of appointments which were prebooked with a further 20% allocated on the day following triage by a nurse. All patients with symptoms were seen on the day of presentation.

We have analysed the results from two 9 month periods, taken immediately before the change and 3 months after the introduction of an appointment based system. The total number of patients and sex ratio seen

Table 1 Total number of STI diagnoses

	No (%)		
	Jan–Sept 2001	Jan–Sept 2002	Relative drop (%) (95% CI)
Total no of patients attending	11714	11345	3.2 (2.8 to 3.5)
Patients new to clinic	5191 (44.3)	4669 (41.2)	

Table 2 Details of STIs diagnosed in men and women

	Male			Female		
	Jan–Sept 2001 (n = 6920)	Jan–Sept 2002 (n = 6659)		Jan–Sept 2001 (n = 4794)	Jan–Sept 2002 (n = 4690)	
	No (prevalence per 100 patient)		p Value using χ^2 test	No (prevalence per 100 patient)		p Value using χ^2 test
A1	37 (0.5)	53 (0.8)	0.061	0 (0.0)	3 (0.1)	0.121*
B1	262 (3.8)	190 (2.9)	0.002	41 (0.9)	35 (0.7)	0.552
C4a/C4c	244 (3.5)	179 (2.7)	0.005	187 (3.9)	199 (4.2)	0.399
C4h	683 (9.9)	479 (7.2)	<0.001	–	–	–
C10a	89 (1.3)	55 (0.8)	0.009	111 (2.3)	80 (1.7)	0.035
C11a	264 (3.8)	254 (3.8)	0.998	147 (3.1)	164 (3.5)	0.239
Total diagnosed with an STI at this episode	1579 (22.8)	1210 (18.2)	<0.001	486 (10.1)	481(10.3)	0.849

*p Value using χ^2 test with Yates's correction.
(A1) Primary diagnosis of syphilis; (B1) gonorrhoea; (C4a, C4c) uncomplicated chlamydia; (C4h) non-gonococcal urethritis; (C10a) first attack of genital herpes; (C11a) anogenital warts.

over this period did not change. We have shown however a dramatic change in the number of STI diagnoses made over these two periods.

Tables 1 and 2 highlight a significant fall in the total number of STI diagnoses for gonorrhoea (B1), uncomplicated chlamydia (C4a, C4c), non-gonococcal urethritis (C4h), and first attack of genital herpes (C10a) in our male patients. The only significant fall for women was seen in the diagnosis of a first attack of genital herpes. There was no significant change for both sexes in the diagnosis of anogenital warts (C11a) between the two systems. The rise in primary diagnosis of syphilis (A1) reflects the beginning of the current epidemic in London, boosted further by a proactive approach to diagnosis in our HIV positive population.[2]

This fall in acute STI diagnoses in men was approximately twice as marked for men who have sex with men (data not shown).

Our aim in planning the change to a primarily appointment based system was to improve patient experience, by reducing waiting times, and enhance access for symptomatic patients into reserved appointment slots. These data show evidence for an opposite effect which we believe has resulted from asymptomatic individuals requiring sexual health screening booking the majority of clinic appointments well ahead of their appointment, thereby reducing access at convenient times for symptomatic individuals who telephone.

To respond to this we have adjusted the ratio of prebooked versus emergency appointments and significantly amended our approach to triage of symptomatic patients, in an attempt to reverse these trends. Particular attention is now being given to our telephone booking protocol to facilitate symptomatic patients to achieve prompt, immediate appointments. We are publishing these findings to inform others who are implementing changes in clinic appointment schedules, designed to enhance access, to better tailor the booking and triage systems to achieve this goal. We will continue to audit our system to examine the effect of the revised system and to further examine why the change to our appointment system disproportionately affected those men who have sex with men.

A S Menon-Johansson, D A Hawkins, S Mandalia, S E Barton, F C Boag
Chelsea and Westminster Healthcare NHS Trust, London, UK

Correspondence to: Dr A S Menon-Johansson, Chelsea and Westminster Healthcare NHS Trust, London, UK; anatole.menon-johansson@chelwest.nhs.uk

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Prevalence of HSV-1/HSV-2 antibodies in HIV seropositive patients in Coventry, United Kingdom

The seroprevalence of herpes simplex virus (HSV) antibody among HIV patients within the United Kingdom is unknown. We therefore conducted a HSV seroprevalence study in HIV patients attending our genitourinary medicine clinic from January 2000 to December 2001. Our previous study[1] revealed an overall prevalence of HSV-1 (60%), HSV-2 (20%), and both HSV-1 and HSV-2 (12%) among male and female genitourinary medicine clinic attendees who were either HIV negative or whose HIV status was unknown.

Serum samples from 96 consecutive ethnically diverse HIV patients were collected during routine investigations, and tested for HSV type specific antibodies by monoclonal antibody blocking enzyme linked immunoassay.[2] Out of 96 patients, two HSV-1 and three HSV-2 antibody test results were equivocal in four individuals. These were excluded from the analysis and results are presented here for 92 patients.

There were 56 men and 36 women in the study: 46 (50%) were white, 43 (47%) black African, and three were from other ethnic groups. All the black Africans were heterosexuals and 71% of men were homosexuals. The median age was 35 years (range 21–80).

HSV-1 seroprevalence was 86% among men and 97% among women ($p = 0.14$). HSV-2 seroprevalence was 50% among men whereas it was 94% among women ($p = 0.0001$). There was no statistically significant difference between the seroprevalence of HSV-1 between white and black people. However, seroprevalence of HSV-2 and both serotypes was significantly higher among black than among white people.

This study shows very high seroprevalence of HSV-1 (90%), HSV-2 (67%), and both HSV-1 and HSV-2 (64%) among our HIV positive cohort in Coventry. The high prevalence of HSV-2 in women is possibly because most of them were black African and acquired HIV through sex. These findings may have important public health implications as the high rate of HSV-2 is therefore likely to act as a cofactor in HIV transmission.

P S Allan, S Das
Department of GU Medicine, Coventry and Warwickshire Hospital, Coventry CV1 4FH, UK; srisallen@yahoo.co.uk

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BOOK REVIEW

Effective Sexual Health Interventions: Issues In Experimental Evaluation

Ed Judith M Stephenson, John Imrie, and Chris Bonell. Pp 232; £55. Oxford: Oxford University Press, 2003. ISBN 0-19-850849-2.

HIV spreads more every day and there are epidemics of other STIs in both the developed and developing world at least in part because the fear of HIV appears to be receding in the population. Our current strategies to contain these problems are meeting with limited success and treatment of people who are already infected, important though that is in controlling bacterial infections, is much less effective with continuing viral infections. There is an urgent need to develop and to test better