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Absence of lymphogranuloma venereum infection among high-risk men who have sex with men in Lima, Peru

Sir: Greene *et al.*[1] describes a case of rectal lymphogranuloma venereum (LGV) infection diagnosed from 2003. Following the initial 2003 report of a cluster of rectal LGV infections among men who have sex with men (MSM) in Amsterdam, LGV was identified as an important public health issue in the USA and the Western Europe.[2] Initially, discussion referred to a pathogen newly reintroduced from endemic tropical areas but questions arose as to whether rectal LGV infection had been consistently present, but undiagnosed, in developed countries.[3–6] Yet the epidemiology of LGV in endemic tropical regions, including parts of Asia, the Caribbean and South America, is poorly defined.[7] Screening studies of supposedly endemic areas have not been conducted, and the syndromic management strategy for STDs used in many low-income countries precludes definitive diagnosis of chlamydia infections or LGV subtyping. A previous analysis of urogenital specimens collected from men and women at high-risk for HIV and STD transmission in the coastal region of Peru found no evidence of LGV in the population.[8] However, rectal samples were not collected in the study and the presence of rectal LGV could not be assessed.

To determine the prevalence of LGV infection among MSM in Peru, we screened a convenience sample of 559 MSM attending the Alberto Barton STD clinic in Lima/Callao from May to December 2007. All participants underwent swab collection from urethral, pharyngeal and rectal sites for STD screening. All specimens with chlamydia identified by nucleic acid testing (Roche Cobas Amplicor, Roche Diagnostics, Indianapolis, IN, USA) underwent additional realtime polymerase chain reaction (RT-PCR) testing (LightCycler, Roche Diagnostics) to identify the characteristic polymorphic membrane protein gene (PmpH) observed in LGV subtypes of chlamydia (serovars L1–L3). A total of 28 chlamydia-positive samples (8 pharyngeal, 13 urethral and 7 rectal) were collected from 27 MSM, indicating an overall chlamydia prevalence of 5.0% (95% confidence interval [CI] = 3.4–7.0%). None (0/28) of the chlamydia strains were positive by RT-PCR for LGV infection (0%, 95% CI = 0–9.8%). Confirmation of assay validity was provided by the inclusion of positive and negative control samples.

Although LGV is thought to be common in tropical areas, no cases of LGV infection from any anatomic site were identified during screening of a high-risk MSM population in Lima, Peru. The absence of observed infection in this population could be due to the limited number of samples available for testing or may reflect the vaguely defined global epidemiology of LGV infection in developing areas. Peru is composed of three different geographic regions (coast, mountains and rainforest), each with distinct cultures and epidemiological patterns of infection. As participants were recruited from the urban, coastal region of the country, it is still possible that LGV infection could be endemic in high-risk populations of Peru's tropical Amazon River basin region. Additional epidemiological surveys are necessary to determine the prevalence of LGV strains in diverse regions of Latin America and to accurately define the global epidemiology of LGV infection.

Disclaimer: The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, nor the US Government.

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Difficulties in accessing psychosexual services in London, UK

Sir: In order to assess access and location of existing psychosexual services with Greater London Hospital Trusts, we sent a 12-point questionnaire to 40 London Hospital Trusts simply addressed to 'The Psychosexual Clinic' in June 2005. The questionnaire asked about the provision of a psychosexual clinic, the type of service offered and the respondent's knowledge of other psychosexual services within the same trust.

The response rate to the 40 letters was 55% (22/40). Seventeen trusts had a psychosexual clinic and five did not. Eight of these 17 psychosexual clinics were within Sexual Health Departments (47%) with the others in family planning (23%), urology (12%), gynaecology (6%), psychiatry (6%) and psychology (6%). Seven respondents knew of other psychosexual clinics within the same trusts, eight thought that there were no other psychosexual clinics and two did not know.

Fifteen (88%) of the 17 psychosexual clinics saw both men and women, all saw couples, and 10 (59%) dealt with both psychosexual and physical aspects of sexual problems. Medics, nurses, psychologists and some psychotherapists worked in the clinics. The total number of half-day sessions per week dedicated to the psychosexual clinics ranged from one to 13.

The survey showed that some Trusts have no psychosexual clinic while in others there is more than one clinic operating with a vast range of dedicated half-day sessions in a variety of specialities. Two respondents stated that there was no psychosexual clinic in their trust when, in fact, clinics known to the authors existed and three other respondents stated that there was no other psychosexual clinic apart from their own when, in fact, clinics known to the authors existed within the same trust.

Sexual Health Departments provided many of the psychosexual clinics found in this survey. A survey in 2007 of all UK genitourinary (GU) medicine clinics showed that 25% provided at least one dedicated sexual dysfunction clinic per week although, within the Thames area this was higher at 46%.[1] This has decreased from a similar survey of all UK GU medicine clinics in 1997 when 42% of respondents said they provided a sexual dysfunction service.[2] It can be argued that GU medicine is ideally placed to look after people with sexual dysfunction.[3] However, psychosexual medicine is not part of the core curriculum for higher medical training in GU medicine.

We conclude that the variable provision of psychosexual clinics within different specialities and the lack of knowledge even within trusts inevitably make access for patients and referrers difficult. Access would be made easier if a single field of medicine, such as GU medicine, embraced psychosexual medicine.

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Respecting patient choice on access

Sir: We strongly support the suggestions by Carlin *et al.*[1] and by Rooney *et al.*[2] A significant proportion of would-be attendees to genitourinary (GU) medicine departments prefer to select an appointment time that suits their social, domestic and working lives than to have their access restricted by compulsory 48-hour attendance targets.

In Rotherham, we have effectively redesigned our GU medicine service to enable us to offer 100% 48-hour access. In addition, we have increased our new attendances by 42% from 4571 (2004) to 6501 (2007) and increased our new to follow-up ratio from 0.5 to 1.6. Despite the ease of access to our service, only 76.5% choose to be seen within 48 hours (March 2008).

We conducted a survey of all new clinic attendees from 28 August to 11 October 2007 to determine factors influencing patients' choice regarding attendance and to explore possible options for improving the percentage seen within this timeframe. The survey was conducted by face-to-face discussion between patient and clinician. In this period, 469 forms were completed. Of the total patients, 150 (32%) declined the 48-hour appointment they had been offered.

Our findings were very similar to those in Nottinghamshire. Most patients cited personal convenience, child-care and work as reasons for preferring appointments outside the 48-hour period. When asked whether provision of additional evening clinics would have facilitated earlier attendance, only 10% said it would have helped.

Rapid access to diagnostic and treatment sexual health services is clearly important to relieve symptoms, reduce complications and prevent transmission. There are public health as