Among primary care workers, 65% (11) of those questioned were willing to discuss HPV vaccination with both parents and children, with a further 18% (14 in total) prepared to talk to parents but not children. This group identified the same limiting factors as the teachers, again with no objections on religious grounds.

Concerns raised by teachers and health-care professionals included insufficient knowledge about long-term efficacy of vaccination and a potential reduction in precautions taken to prevent STIs.

All participants were asked what they felt was the best way to prevent STIs. Sexual health education emphasizing the use of barrier methods of contraception was considered most effective, but 60% (27) of patients, 71% (12) of primary care workers and 78% (10) of teachers recommended the addition of vaccination strategies to education programmes.

Our results indicate that while knowledge about the vaccines among health-care professionals appears good, the other groups we surveyed are poorly informed, despite recent media coverage. This situation must be further assessed, as we have demonstrated that explanation about the risks of HPV infection and the benefits of immunization assessed, as we have demonstrated that explanation about efficacy of vaccination and a potential reduction in

Facilitating lymphogranuloma venereum surveillance with the use of real time polymerase chain reaction

In their article, Lymphogranuloma venereum: an emerging cause of proctitis in men who have sex with men, Richardson and Goldmeier discuss the recent increase in reporting of lymphogranuloma venereum (LGV) in Greece. The authors comment, 'It is important to be aware of the recent increase in reporting of LGV in Greece and to consider this in the differential diagnosis of proctitis in men who have sex with men. It is important to be aware of the recent increase in reporting of LGV in Greece and to consider this in the differential diagnosis of proctitis in men who have sex with men.'

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the presence of a unique gap in the polymorphic membrane protein (pmpH gene) in the L-type serovars. The assay requires about two hours from sample processing to completion, and is capable of testing approximately 30 specimens simultaneously.

Out of 86 specimens tested, none (0.0%, 95% confidence interval [CI] 0.0–4.2%) showed presence of the L-type serovars of C. trachomatis. There are a handful of potential causes for our null finding. The two most likely causes are the absence of LGV and the use of urogenital specimens. Though there has been a case report of urethritis associated with LGV serotypes,† large surveillance trials in Europe have not found LGV among chlamydia-positive urogenital specimens.‡ Unfortunately, rectal specimens were not collected as part of this study. However, an important finding of our study is that surveillance for LGV by molecular methods is a feasible exercise in settings where realtime PCR is available. The addition of this technique, applied to known chlamydia-positive rectal specimens, could vastly enhance LGV surveillance.

Better estimates of LGV prevalence in Latin America and elsewhere in the developing world are crucial for the public health response to the disease. Such information is indicated to identify risk factors, classify high-risk populations and direct proper treatment of proctitis. Historically, LGV surveillance has relied on genotypic sequencing, an expensive and timely enterprise.†† However, the use of molecular methods to help differentiate between chlamydia serotypes makes such estimates possible in a wider range of settings and should be incorporated into surveillance programmes.

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The metabolic syndrome in HIV-seropositive patients

Sir: The article by Palacios et al.1 stresses the important issue of the metabolic syndrome in HIV-seropositive patients. This syndrome is characterized by insulin resistance, dyslipidaemia, central fat accumulation and hypertension.

While they mention several potential causative factors, it is disappointing that the authors have seemingly ignored another association that may be causal. Hypogonadism has long been known to occur in both men and women with HIV disease.2,3 There is now good evidence to suggest that hypogonadism is an important regulator of insulin sensitivity in men. Observational studies have shown that testosterone levels are low in men with diabetes, visceral obesity, insulin resistance, coronary artery disease and metabolic syndrome. Indeed some authors have suggested that hypogonadism can be an early marker for the development of the metabolic syndrome.

This has always been thought to be due to aromatization of testosterone in peripheral adipose tissue. However, this dogma must be questioned in the light of recent short-term observational studies,4 which have shown that testosterone

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