

severe pain on movement. The trial of opioid itself needs success and failure criteria, encapsulated in the common clinical question "What is an adequate dose?" The dose needs to be increased until analgesia or adverse effects result, and sometimes this needs doses that raise eyebrows. The balance between effect and adverse effect may be fine, and active management may be needed to produce, in that coy phrase, tolerable and manageable adverse effects.

There is a complicated practical and research agenda, which requires coherent multicentre working and innovative research design. There is no evidence base on which we can rely other than common sense, our own experience, and that of others. Patients' wishes are simple but can be hard to fulfil. They want good pain relief, but not at the expense of adverse effects, particularly those affecting the central nervous system. Even when we resolve these puzzles the professional's unease will remain. Few would be uncomfortable with opioid use that allows an elderly patient with rheumatoid disease to sit without pain, but few would be comfortable prescribing strong opioids long term for a young person with a vague diagnosis of back pain.

The trial by Allan et al reported this week compares two opioids, each in a different formulation—oral or transdermal (p 1154).¹ This is a welcome trial in a difficult area. The focus is which drug (or formulation) gives the fewest problems, or is preferred by patients, at the same level of pain relief. Unfortunately the design of

the trial means that we have to question the results. Rule one of drug trials that compare different formulations and use subjective outcomes such as patient preference is that the comparison should be done double blind. This may be awkward and it will be more expensive, but breaking the rule means that the conclusions may not be correct. Yet here we are with a trial which compared different formulations and used subjective outcomes and was not done double blind. The problem we are left with is whether any difference between formulations is credible, and whether any credible difference is worthwhile. Given the high prevalence of chronic pain and its major impact on quality of life it is time that we had a better grip on what works in clinical practice and when.

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HJM has worked with a variety of companies which market analgesics.

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Sexually transmitted infections: control strategies

There's a new emphasis on reducing the period of infectiousness

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Sexually transmitted infections, including HIV and hepatitis B, remain one of the greatest global public health challenges. Over the past five years notable rises have been observed in the United Kingdom in the incidence of genital chlamydial infection (76%), gonorrhoea (55%), and infectious syphilis (54%)¹; such sustained rises have not been seen since the late 1960s and 1970s.² Similar increases have also been seen in other countries in Western³ and Eastern⁴ Europe and the United States.⁵ The highest rates of sexually transmitted infections occur among 16-24 year olds, particularly older teenagers.¹ Ethnic and socioeconomic inequalities in sexually transmitted infection rates exist in the US⁵ and the UK,⁶ with higher rates among black ethnic groups and lower socioeconomic groups. If we are to reverse these trends and reduce inequalities we need to understand their underlying determinants.

Some rises may reflect improved detection, particularly for genital chlamydial infection (with new diagnostic technologies), and deteriorating healthcare infrastructure (in the former states of the USSR). However, the major factor behind the recent rises in Western Europe is probably changing sexual behaviour. The median age of sexual debut continues to decline and the period of experimentation and changing partners has lengthened; similarly, the likelihood that sexual intercourse with a new partner will be unprotected is highest for those aged over 16.⁷ In the

UK levels of awareness and fear of HIV and AIDS among young people have declined,² and the major fear is of unintended pregnancy, not sexually transmitted infection.⁸ Recent increases in the incidence of gonorrhoea among men who have sex with men have also been seen in association with increasing antimicrobial resistance.⁹

Sexually transmitted infections can be prevented and controlled through three basic strategies: reducing the risk of transmission in any sexual encounter (such as condom use); reducing the rate of sexual partner change; and reducing the period of infectiousness in individuals. Over the later part of the 20th century, particularly since the advent of the AIDS epidemic, control programmes have emphasised the first two strategies. Good evidence on the effectiveness of health education is limited,¹⁰ although clearly it will continue to have a place, as all strategies against sexually transmitted infections will benefit from improved population awareness and openness about sexual health. Health education on sexually transmitted infections must be integrated into broader messages on sexual health if conflicting messages—for example, on the roles of hormonal and barrier contraception—are not to be given. Equally messages must be culturally appropriate to their audience, prominent within which are adolescents and ethnic groups at higher risk.

New opportunities for controlling sexually transmitted infections come from strategies that will reduce

the period of infectiousness of individuals, through screening and partner notification, monodose and simplified therapies to improve compliance, and more accessible services. Evidence already exists that screening is effective in controlling genital chlamydial infection.^{11 12} The results of the UK pilot of screening for genital chlamydial infection will be published later this year, and preliminary analysis suggests that an opportunistic approach to screening for this infection is acceptable to professionals and the public and can achieve high population coverage (M Catchpole et al, European Society for Chlamydia Research, August 2000, Helsinki). Nevertheless, important questions remain, including who to screen (men and women or women only), how often, which test to use, and how the costs will be met. The period of infectiousness, and so transmission of sexually transmitted infections, may also be reduced by antimicrobial treatments, with the possibility that long term antiviral therapy may reduce the incidence of genital herpes simplex and even HIV.¹³

The greatest potential for communicable disease control rests with vaccination. As Gilson and Mindel outline in their Recent Advances article in this week's issue (p 1160), trials of vaccines against herpes simplex and human papillomavirus are under way.¹⁴ An effective vaccine against the oncogenic papillomavirus types could offer important health gains in developing countries, where cervical cancer is one of the commonest causes of cancer related death in women. Proof of efficacy alone, however, is unlikely to be enough to ensure that these vaccines are adopted in the fight against sexually transmitted infections. Public acceptance of such vaccines, particularly their administration in childhood, may prove difficult, though it is being achieved for hepatitis B in many countries. Also, though genital herpes infection significantly affects the quality of life of some of those infected, the economic case for mass vaccination is unclear.

Any major developments in screening or vaccination will shift the balance of responsibility for delivering control measures from specialist to general healthcare services. Such a shift will require close collaboration between generalists and specialists to ensure appropriate management of patients with infections and their partners, but it should provide a

greater opportunity for integrating the control of sexually transmitted infections with fertility control and the management of other sexual health problems.

Recent technological advances provide new opportunities for control. What remains to be seen is where they will fit into political priorities, when the British government's sexual health strategy is finally published and implemented. Moreover, though the burden of sexually transmitted infections in industrialised countries is growing, it is greatly exceeded by that in poorer countries. The final challenge is to make sure advances in industrialised countries translate to the developing world, where they are even more needed.

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Career advice for doctors with a chronic illness

The Career Focus matching scheme may help fill the gap

I have scleroderma. Eighteen months ago I was advised by an occupational health physician to retire from the NHS on grounds of ill health. I was 30. Determined not to let my medical skills go to waste, I was left on my own to find a niche for myself which matched my health needs and allowed me to carry on working. My situation is not unique, and in this week's Career Focus (*BMJ Classified* p 2) some doctors who have chronic illnesses summarise their experiences and give advice to other doctors who may find themselves in a similar position. This week also sees the launch of Career Focus's mentoring scheme for doctors with chronic illness.

Doctors who have a chronic illness have a rough deal. As well as having to come to terms with their illness, they also face problems in their career. Inflexible working patterns, poor contingency cover, and colleagues who are "sympathetic until it affects them" often add guilt to an already difficult situation and leave ill doctors wondering whether they can continue working in a position that makes little allowances for their health needs.

If they were classified as having a disability the Disability Discrimination Act would make it illegal to discriminate against them in this way, and employers would be forced to accommodate them. The BMA has

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