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LETTER

Lymphogranuloma venereum among men having sex with men: what have we learned so far?

Recently, French et al reported the first cases of lymphogranuloma venereum (LVG) in the United Kingdom.1 One year later, the LVG outbreak first noticed in 2003 among men having sex with men (MSM) has spread beyond the first countries affected (Netherlands, Belgium, Germany, France, the United Kingdom, Sweden, and the United States) to other European countries like Spain, Italy, Switzerland, Poland, and outside the continent to Australia, United States, and Canada. Moreover, some of the questions raised in the publication of French et al can now be partially answered.

A retrospective study performed on anal swabs from STI clinic visitors in Amsterdam and San Francisco has taught us that the LVG strain which seems to be responsible for the current outbreak (L2b), can be traced back to at least 1981 in the United States and to 2000 in Europe.2,3 So it seems more appropriate to speak of a slow epidemic rather than an outbreak of LVG. What has caused LVG to spread unnoticed within the MSM community worldwide for many years? In part, this can be attributed to the routine chlamydia test procedures for MSM before 2003. Anal swabs positive for chlamydia were recorded as chlamydia proctitis. Since the occurrence of LVG outside the traditionally epidemic countries was unknown, additional testing of LVG outside the traditionally epidemic countries would have been more easily with a recently developed fast molecular biological diagnostic test (real time polymerase chain reaction) by our group, designed specifically for LVG Chlamydia trachomatis strains.4 This test can be performed under routine microbiological laboratory conditions and will hopefully facilitate the propagation of LVG screening programmes.

During the last International Society for Sexual Transmitted Disease Research meeting in July 2005 in Amsterdam, Netherlands, an LVG satellite workshop was organised under the supervision of the European Surveillance of Sexually Transmitted Infections (ESSTI) network in order to tackle urgent LVG related research questions in a multilateral joint effort (www.isstdr.nl/sat_meet.htm). Supranational collaborations will have to prove their benefit to increase our understanding of this LVG epidemic.

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References

CORRECTION

There were several errors in the article by Accijas C, Friedman, SR, Cooper HLF, et al. Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution. Sex Transm Infect 2006;82(Suppl III):i10–i17.

In the abstract, the values of Q1 and Q3 for the Middle East and Africa should have been: Q1 0.14% and Q3 1.47% respectively. They should have been deleted. The last sentence of the results section (“Greater dispersion...Caribbean”) should also have been deleted.

Also in the abstract, the values of Q1 and Q3 for Eastern Europe and Central Asia are incorrect. They should have been as follows: Q1 0.39%; Q3 1.32%. The values of Q1 and Q3 for Asia and the Pacific should have been: Q1 0.14% and Q3 1.47%. The values of Q1 and Q3 for the Middle East and Africa should have been: Q1 0.11%; Q3 0.23%, and the values of the median and maximum Q1 and Q3 in Latin America and the Caribbean should have been: 0.11%, 0.69%, 0.04% and 0.13%, respectively.

In the results section, the values of Q1 and Q3 for Eastern Europe and Central Asia are incorrect and should have been <0.39% and 1.32%. The values of Q1 and Q3 for Asia and the Pacific should have been <0.14% and <1.47%. The values of Q1 and Q3 for the Middle East and Africa should have been 0.11% and 0.23%, and the values of the median, maximum, Q1 and Q3 in Latin America and the Caribbean should have been <0.11%, 0.69%, <0.04% and <0.13%, respectively.