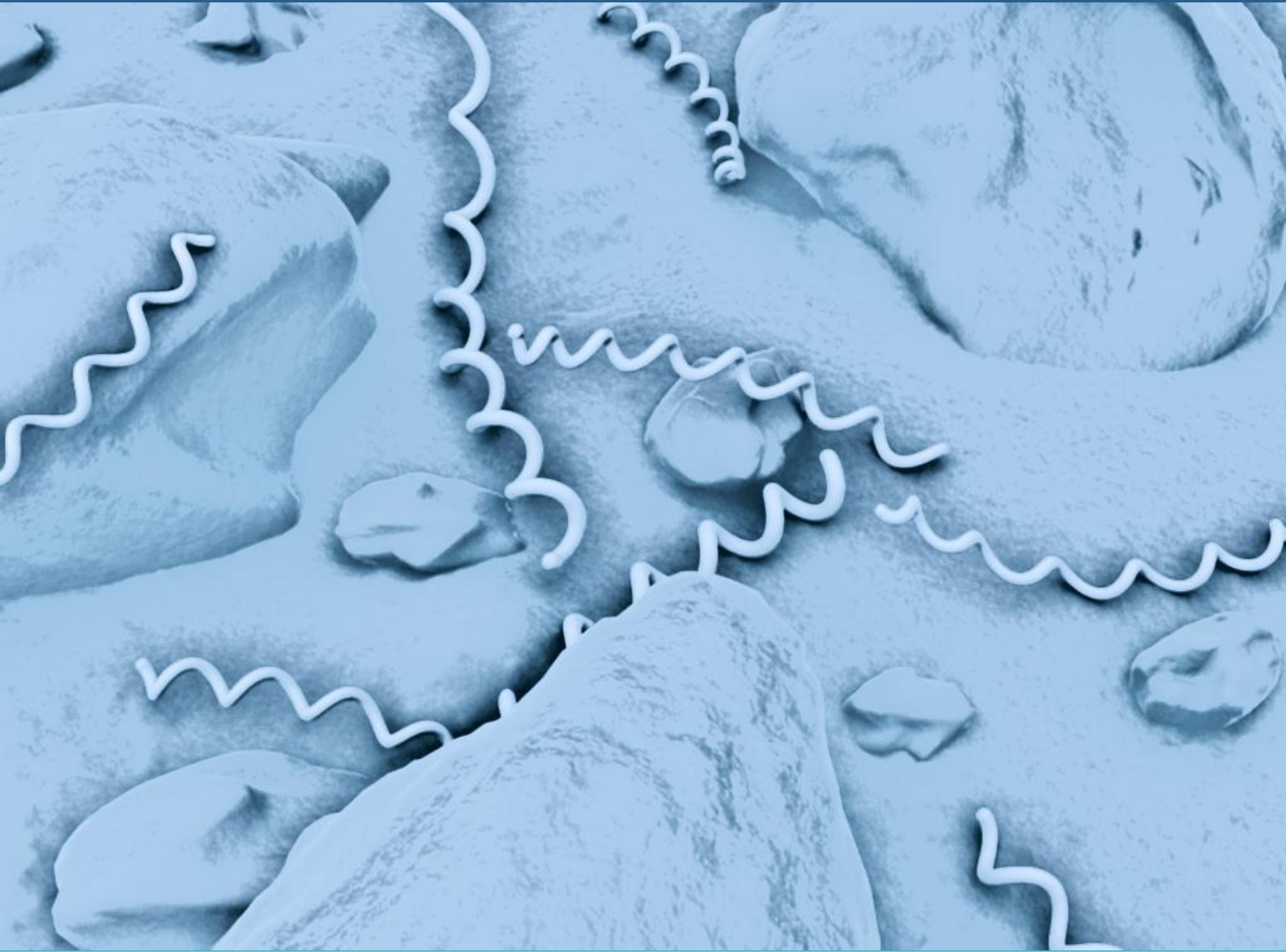


# Sexually Transmitted Infection surveillance in Northern Ireland 2012

An analysis of data for the calendar year 2011



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This report aims to provide an overview of STI epidemiology in Northern Ireland by collating and analysing information from a number of sources. Although it reflects epidemiological trends over time, its main focus will be on data collected in 2011.

Following recent ONS guidance on data disclosure, where the number of any category of episodes in any one year is between one and four, this is reported either within a cumulative figure, or as an asterix. In addition, where the anonymised figure can be deduced from the totals, the next smallest figure will also be anonymised.

# Summary points

## In Northern Ireland Genito-Urinary Medicine (GUM) clinics in 2011

- New STI diagnoses decreased by 2%; 7,661 in 2011 compared with 7,850 in 2010.
- New diagnoses of uncomplicated chlamydia remained similar; 1,830 diagnoses in 2011 compared with 1,832 in 2010.
- New diagnoses of uncomplicated gonorrhoea increased by 65%; 336 in 2011 compared with 204 in 2010.
- New diagnoses of genital herpes simplex (first episode) decreased by 6%; 386 in 2011 compared with 411 in 2010.
- New diagnoses of genital warts (first episode) increased by 8%; 2,305 in 2011 compared with 2,126 in 2010.
- New diagnoses of non-specific genital infection decreased by 19%; 2,242 in 2011 compared with 2,756 in 2010.
- New diagnoses of infectious syphilis decreased by 10%; 52 in 2011 compared with 58 in 2010.

# Surveillance arrangements and sources of data

## KC60 returns

The most comprehensive source of surveillance data for sexually transmitted infections (STIs) in Northern Ireland is the statutory KC60 return each quarter from GUM clinics. This return records the numbers of new diagnoses for a range of STIs. Individual patients may contribute more than one diagnosis. For selected conditions, additional age, gender and sexual orientation information are provided. Regularly updated summary statistics are presented at: [www.publichealthagency.org](http://www.publichealthagency.org)

There are two important limitations to KC60 data. Firstly, as data reflect only those diagnoses made in GUM clinics, it follows that accessibility of those services to the public, as measured by service capacity and geographic location of services, may influence the diagnostic rate of STIs. Thus, direct comparison of different regions, or indeed different time periods within the same region if service access should change, must be interpreted with caution.

Secondly, no residence-based data is collected. Given that the majority of new diagnoses originate from the GUM clinic at the Royal Victoria Hospital (the clinic that provides greatest access), the clinic location is not a useful proxy for patient residence.

## Laboratory reporting

Laboratory data represent an important complementary source to clinician-initiated surveillance arrangements. Laboratory reporting of *Chlamydia trachomatis* in Northern Ireland is provided for 2006–2011. Antibiotic susceptibility information for *Neisseria gonorrhoeae* isolates is provided for 2010–2011.

## Enhanced syphilis surveillance

Enhanced surveillance arrangements for infectious syphilis in Northern Ireland have been in place since the outbreak was first recognised in September 2001. Based on anonymised, confidential reporting by GUM clinicians to the Public Health Agency (PHA), a range of demographic, clinical and risk factor data are collected on cases of primary, secondary and early latent stage syphilis.

## Enhanced lymphogranuloma venereum (LGV) surveillance

Enhanced surveillance arrangements for cases of LGV in Northern Ireland have been in place since 2004. Based on anonymised, confidential reporting by GUM clinicians to the PHA, a range of demographic, clinical and risk factor data are collected.

# 1: Diagnoses provided in Northern Ireland GUM clinics in 2011

During 2011:

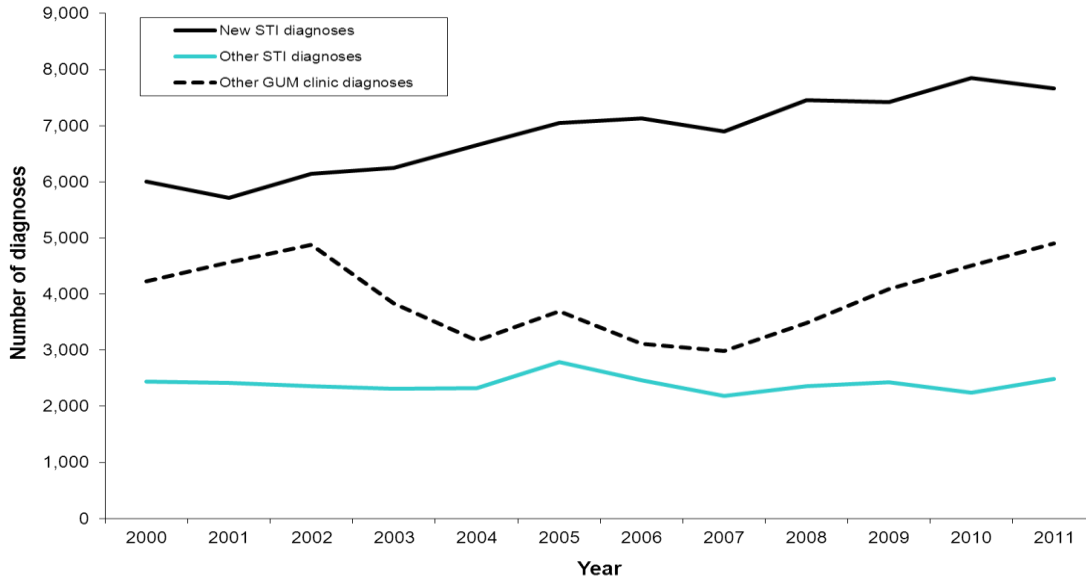
- 7,661 **new STI diagnoses** were made, compared with 7,850 in 2010, a decrease of 2%;
- males accounted for 66% (5,054/7,661) of **new STI diagnoses**;
- three types of infection accounted for 84% of **new STI diagnoses** – genital warts (first infections) (30%), non-specific genital infection (29%), and chlamydia (25%);
- 2,485 **other STI diagnoses** were made;
- there were 4,900 **other diagnoses made at GUM clinics**.

<b>New STI diagnoses</b>
Chlamydial infection (uncomplicated and complicated)
Gonorrhoea (uncomplicated and complicated)
Infectious and early latent syphilis
Genital herpes simplex (first episode)
Genital warts (first episode)
New HIV diagnosis
Non-specific genital infection (uncomplicated and complicated)
Chancroid/lymphogranuloma venereum (LGV)/donovanosis
Molluscum contagiosum
Trichomoniasis
Scabies
Pediculus pubis
<b>Other STI diagnoses</b>
Congenital and other acquired syphilis
Recurrent genital herpes simplex
Recurrent and re-registered genital warts
Subsequent HIV presentations (including AIDS)
Ophthalmia neonatorum (chlamydial or gonococcal)
Epidemiological treatment of suspected STIs (syphilis, chlamydia, gonorrhoea, non-specific genital infection)
<b>Other diagnoses made at GUM clinics</b>
Viral hepatitis B and C
Vaginosis and balanitis (including epidemiological treatment)
Anogenital candidiasis (including epidemiological treatment)
Urinary tract infection
Cervical abnormalities
Other conditions requiring treatment at a GUM clinic

## Trends: 2000–2011

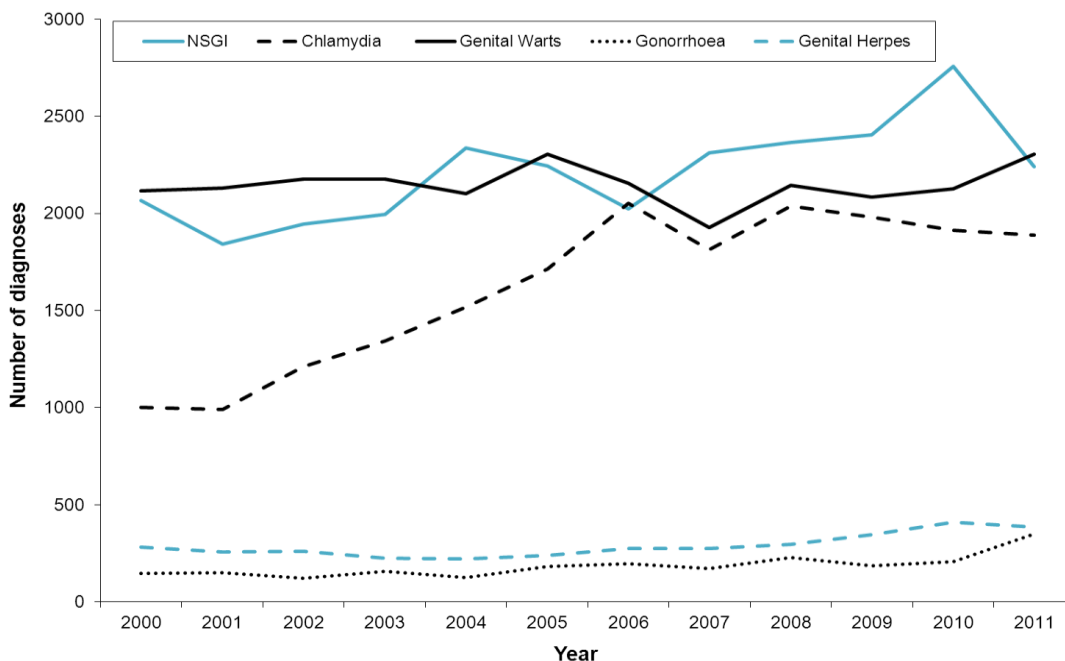
Between 2000 and 2011, the number of **new STI diagnoses** increased by 28%, the number of **other STI diagnoses** increased by 2% and **other GUM clinic diagnoses** increased by 16% (Figure 1.1).

**Figure 1.1: Trends in diagnoses made in Northern Ireland GUM clinics, 2000–2011**



During 2000–2011, chlamydia infection, non-specific genital infection (NSGI) and genital warts (first infections) accounted for the highest proportion of new STI diagnoses (87%) made in Northern Ireland GUM clinics (Figure 1.2). Specific disease trends will be examined in chapters 2 to 8.

**Figure 1.2: Trends in new diagnoses of STIs in Northern Ireland GUM clinics, 2000–2011**



## 2: Chlamydia

Genital chlamydia is a bacterial infection caused by *Chlamydia trachomatis*. The infection is asymptomatic in at least 50% of men and 70% of women. In women, untreated infection can cause chronic pelvic pain and lead to pelvic inflammatory disease (PID), ectopic pregnancy and infertility. An infected pregnant woman may also pass the infection to her baby during delivery. Complications in men include urethritis, epididymitis and Reiter's Syndrome.

Consistent with elsewhere in the UK, chlamydia is the most common bacterial STI diagnosed in Northern Ireland GUM clinics.

Although there is currently no organised regional chlamydia testing programme in Northern Ireland, symptomatic testing is undertaken within primary care and sexual health services.

### Diagnoses made in GUM clinics during 2011

Chlamydial infection accounted for 25% (1,888/7,661) of all new STI diagnoses made in Northern Ireland GUM clinics during 2011.

#### Uncomplicated chlamydial infection

- There were 1,830 new episodes of uncomplicated chlamydial infection diagnosed in Northern Ireland GUM clinics in 2011, compared with 1,832 in 2010.
- 1,036 (57%) of these were diagnosed in males.
- The highest rates of infection in both males and females were in the 20–24 years age group, accounting for 41% of male and 47% of female diagnoses.
- The rate of diagnoses in the 16–19 years age group is nearly twice as high in females as in males.
- 15% (152/1,036) of the total male diagnoses occurred in men who have sex with men (MSM).

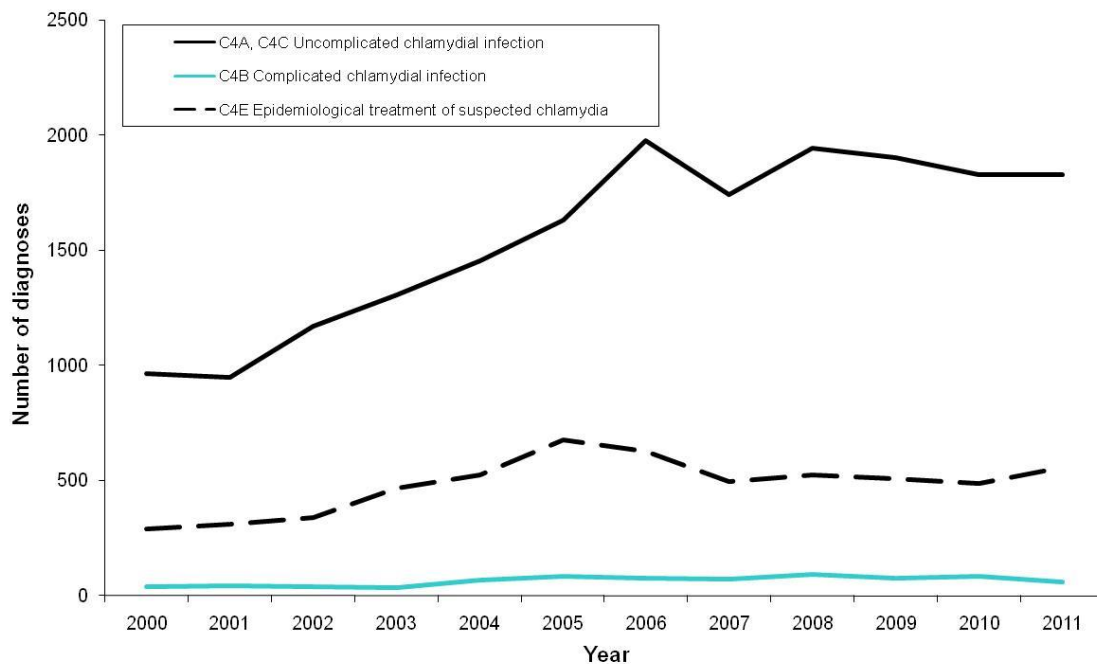
#### Complicated chlamydial infection

- There were 58 new episodes of complicated chlamydial infection diagnosed in Northern Ireland GUM clinics in 2011.
- 45 (78%) of these were diagnosed in females.

## Trends: 2000–2011

Between 2000 and 2011, diagnoses of uncomplicated chlamydial infection increased by 90%, from 963 diagnoses in 2000 to 1,830 in 2011. Diagnoses in males increased by 116%, while in females, there was a 64% increase. Diagnoses of complicated chlamydial infection increased from 40 in 2000 to 58 in 2011, but remained at a relatively low level (Figure 2.1).

**Figure 2.1: Diagnoses of chlamydia in Northern Ireland, 2000–2011**



### Age and gender trends: uncomplicated chlamydia

From 2000–2011, diagnostic rates in females were consistently highest in the 16–24 years age group, peaking between 20 and 24 years (Figure 2.2). In males, the highest rates were in the 20–34 years age group, again peaking between 20 and 24 years.

Diagnostic rates in those under 25 years of age were consistently higher in females, with rates in those aged 25 years and over consistently higher in males. Diagnostic rates in females aged over 24 years decrease due to changes in sexual behaviour, as well as decreased susceptibility.

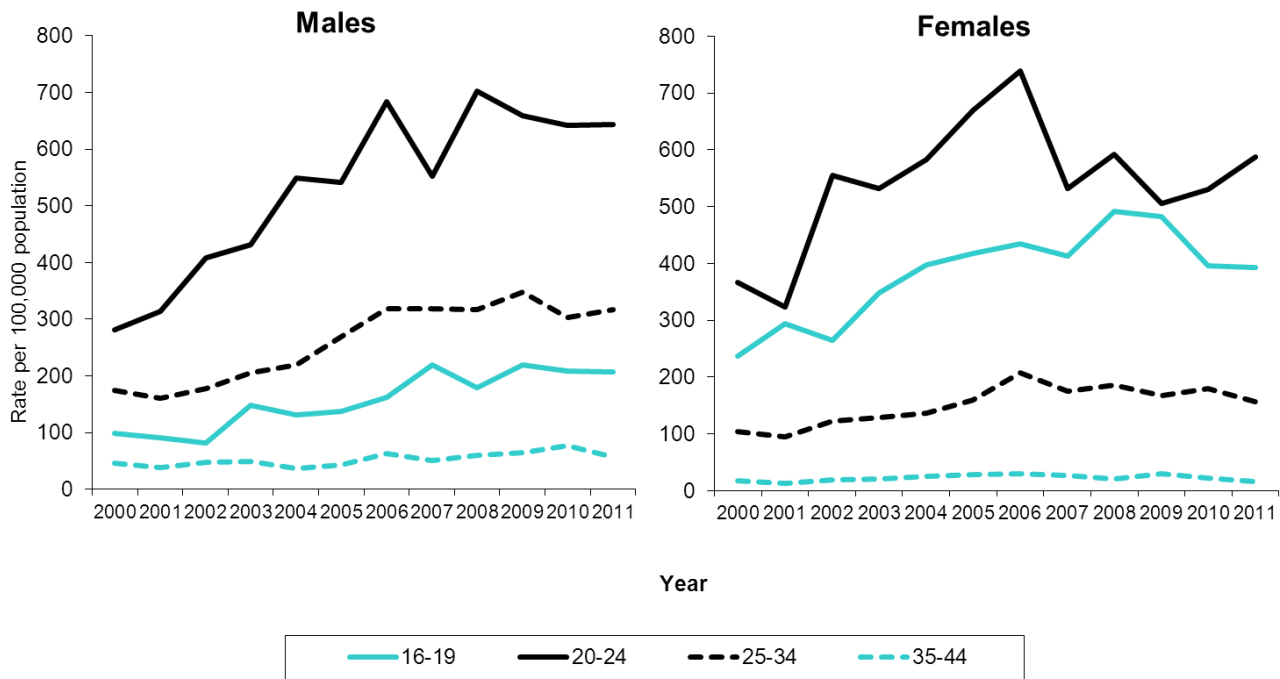
Diagnoses in those under 16 years of age accounted for 1% (122/18,708) of all diagnoses made during the period 2000–2011.

Diagnoses in the 45+ years age group accounted for 2% (347/18,708) of all diagnoses made during the period 2000–2011.

The proportion of male chlamydia diagnoses attributed to MSM has ranged from 2% in 2000 and 2002 to 15% in 2011.



**Figure 2.2: Rates of uncomplicated chlamydial infection in Northern Ireland, by gender and age group, 2000–2011**



### Genital *Chlamydia trachomatis* laboratory reporting, 2006–2011

During 2011, 3,200 laboratory confirmed cases of genital *Chlamydia trachomatis* were reported, a decrease of 5% compared to the number reported in 2010. GP specimens accounted for 34% (1,096/3,200) of cases reported during 2011 (Table 2.1). Between 2006 and 2011, confirmations from GP specimens increased by 52%.

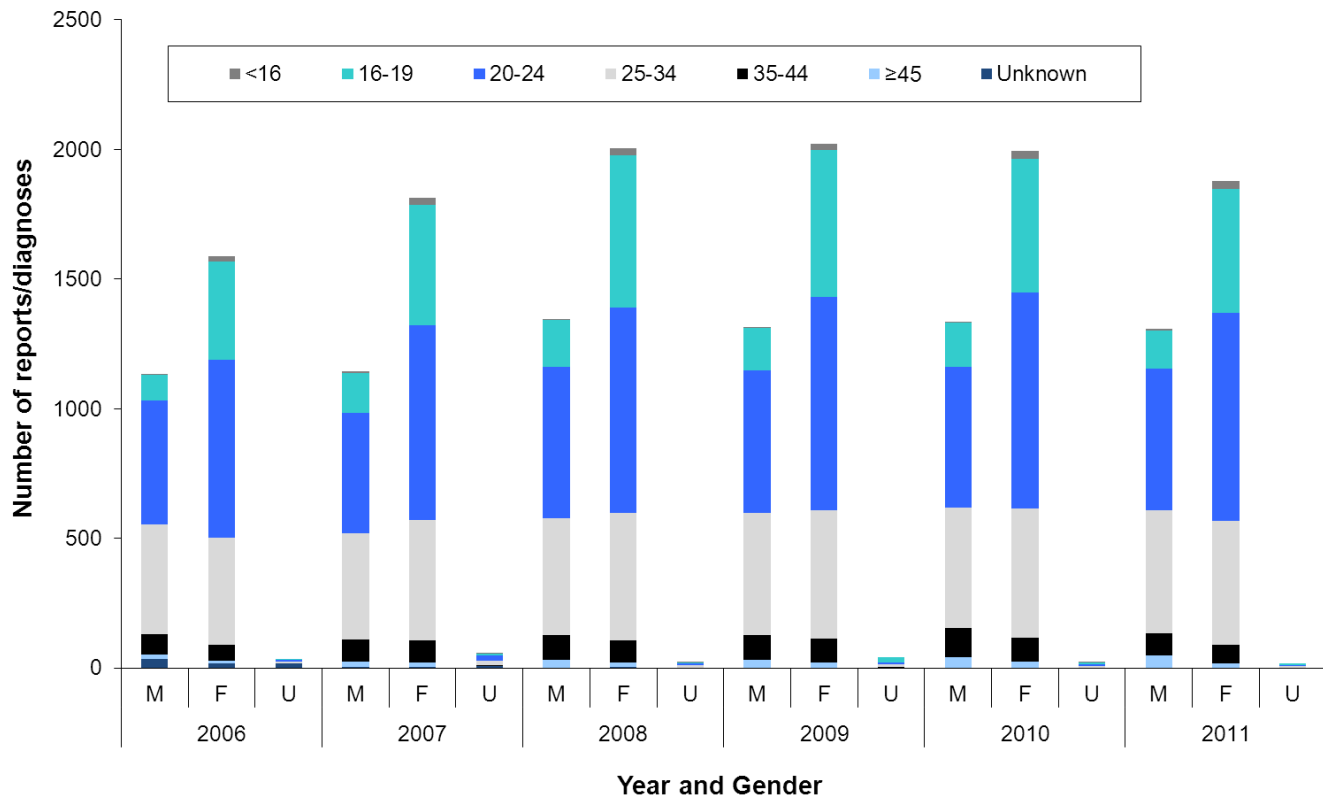
**Table 2.1: Referral source of genital *Chlamydia trachomatis* specimens, 2006–2011**

Referral Source	2006	2007	2008	2009	2010	2011	TOTAL
GP Number (% of total specimens)	720 (26.1)	894 (29.7)	979 (29.0)	1025 (30.3)	1124 (33.5)	1096 (34.3)	<b>5838 (30.6)</b>
Other	2,036	2,121	2,396	2,353	2,231	2,104	<b>13,241</b>
<b>Total</b>	<b>2,756</b>	<b>3,015</b>	<b>3,375</b>	<b>3,378</b>	<b>3,355</b>	<b>3,200</b>	<b>19,079</b>

Higher numbers of diagnoses are consistently reported in females, accounting for 59% (1,877/3,200) of all cases reported by laboratories during 2011. The majority (68%; 7,677/11,303) of female cases reported in the period 2006–2011 were aged between 16 and 24 years. Males accounted for between 38% and 41% of cases reported annually since 2006. The majority of male cases reported since 2006

were in the 20–34 years age group (Figure 2.3). Information on gender was missing for 1% of cases reported during the period 2006–2011.

**Figure 2.3: Laboratory reports of genital *Chlamydia trachomatis*, by age and gender, 2006–2011**



## 3: Gonorrhoea

Gonorrhoea is a bacterial STI caused by *Neisseria gonorrhoeae*. Untreated, gonorrhoea can enter the bloodstream or spread to the joints, and in women it can cause pelvic inflammatory disease, ectopic pregnancy and infertility. An infected pregnant woman may pass the infection to her baby during delivery.

### Diagnoses made in GUM clinics during 2011

Gonorrhoea accounted for 5% (350/7,661) of all new STI diagnoses made in Northern Ireland GUM clinics during 2011.

#### Uncomplicated gonococcal infection

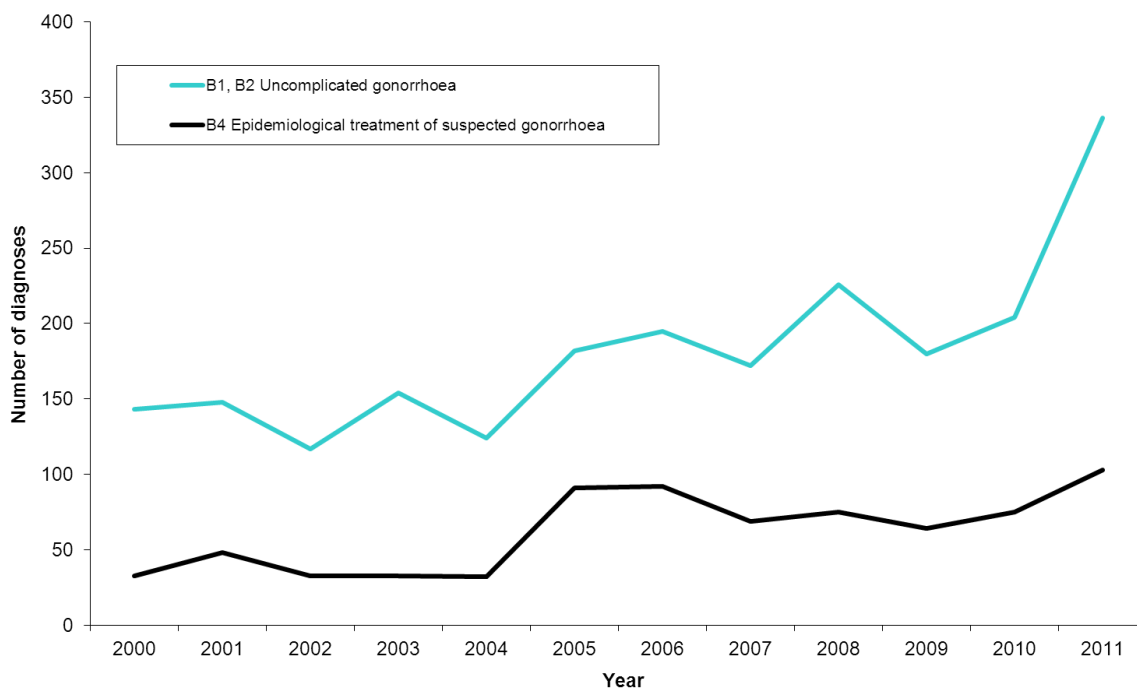
- There were 336 new episodes of uncomplicated gonorrhoea diagnosed in Northern Ireland GUM clinics in 2011, compared with 204 in 2010, an increase of 65%.
- 259 (77%) of these were diagnosed in males.
- The highest diagnostic rates in both men and women were in the 20–24 years age group.
- 69% of female diagnoses were in the 16–24 years age group and 25% were in the 25–34 years age group.
- 40% of male diagnoses were in the 16–24 years age group and 36% were in the 25–34 years age group.
- 56% (145/259) of male diagnoses were attributed to MSM.

#### Trends: 2000–2011

Although numbers have been variable, diagnoses of uncomplicated gonorrhoea have shown a general increased trend since 2000 (Figure 3.1). The number of diagnoses in 2011 (336) have been the highest ever recorded in Northern Ireland. This is likely to be due at least in part to the introduction of more sensitive nucleic acid amplification tests (NAATs) which are being used across laboratories in Northern Ireland<sup>1</sup>. The proportion of male diagnoses attributed to MSM ranged from 9% in 2000 to 56% in 2011.

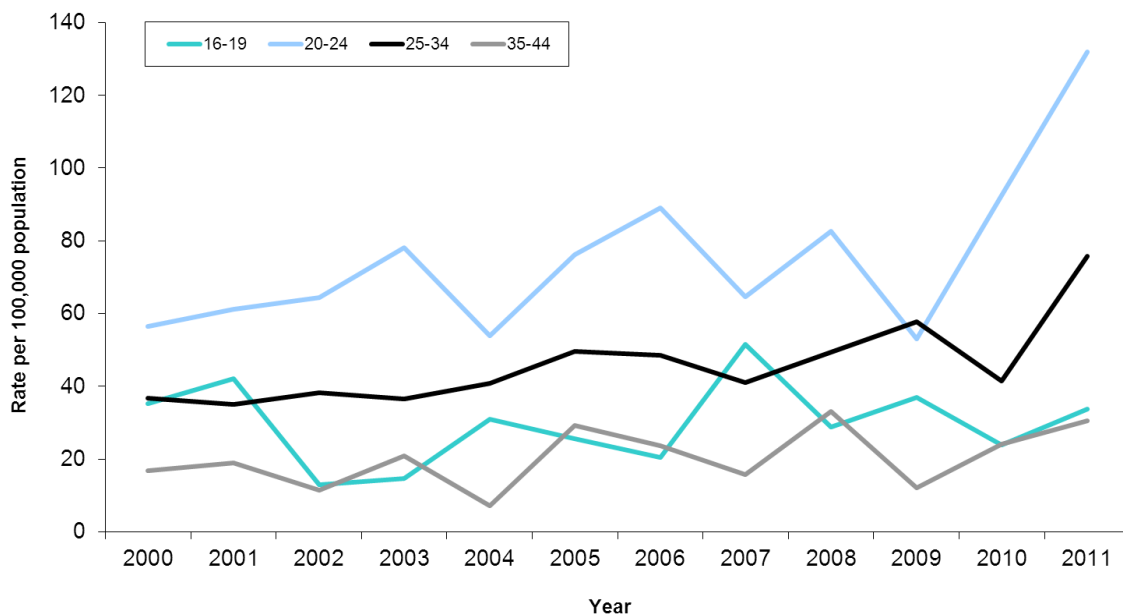
The number of diagnoses of complicated gonorrhoea have ranged from 1 in 2007 to 14 in 2011.

**Figure 3.1: Diagnoses of gonorrhoea in Northern Ireland, 2000–2011**



**Age and gender trends: uncomplicated gonorrhoea**

**Figure 3.2: Rates of diagnosis of uncomplicated gonorrhoea in males in Northern Ireland, by age group, 2000–2011**



In males, the highest diagnostic rates were in the 20–34 years age groups (Figure 3.2).

From 2000–2011, fewer than five diagnoses were made annually in males aged under 16 years. Males aged 45 years and over accounted for 7% (128/1,837) of all male diagnoses during the period 2000–2011. There was no clear trend in females due to the small numbers involved.

### ***Neisseria gonorrhoeae* laboratory reporting, 2010–2011**

Effective treatment of gonorrhoea has been compromised by the ability of *Neisseria gonorrhoeae* to develop resistance to antimicrobial agents.<sup>2</sup> Ongoing monitoring of antimicrobial resistance in Northern Ireland is important to ensure that first line treatments for gonorrhoea remain effective, as patterns of resistance can change rapidly. During 2011, laboratories reported antibiotic susceptibility data for 169 isolates.

Current guidelines recommend the use of third generation cephalosporins to treat gonorrhoea. During 2011, only 1 isolate was reported as resistant to third generation cephalosporins (Ceftriaxone) (Table 3.2).

**Table 3.2: *Neisseria gonorrhoeae* antibiotic susceptibility reported activity for antibiotics, 2010–2011**

Antibiotics	Susceptible		Resistant (%)		Indeterminate		Total specimens Reported	
	2010	2011	2010	2011	2010	2011	2010	2011
Azithromycin	0	4	0 (0%)	0 (0%)	0	0	0	4
Cefixime	21	23	0 (0%)	0 (0%)	0	0	21	23
Cefotaxime	105	27	0 (0%)	0 (0%)	0	0	105	27
Ceftriaxone	8	109	0 (0%)	1 (1%)	0	0	8	110
Ceftizoxime	0	0	0 (0%)	0 (0%)	0	0	0	0
Cefuroxime	21	12	3 (13%)	2 (14%)	0	0	24	14
Cephalexin	0	1	0 (0%)	0 (0%)	0	0	0	1
Ciprofloxacin	99	122	49 (33%)	43 (26%)	0	2	148	167
Doxycycline	0	88	0 (0%)	10 (10%)	0	0	0	98
Nalidixic Acid	17	23	8 (32%)	7 (23%)	0	0	25	30
Penicillin	89	127	57 (39%)	37 (23%)	0	0	146	164
Spectinomycin	8	11	1 (11%)	0 (0%)	0	0	9	11
Tetracycline	93	44	25 (21%)	4 (8%)	0	0	118	48

## 4: Genital herpes

Genital herpes is caused by the herpes simplex virus (HSV), of which there are two distinct subtypes. HSV2 is almost exclusively associated with genital infection. Historically, HSV1 has mainly been associated with oral infection, but the proportion of genital herpes attributed to HSV1 in the UK is increasing. Genital herpes infection may facilitate HIV transmission, can cause severe systemic disease in those with impaired immunity, and can be potentially fatal to neonates.

### Diagnoses made in GUM clinics during 2011

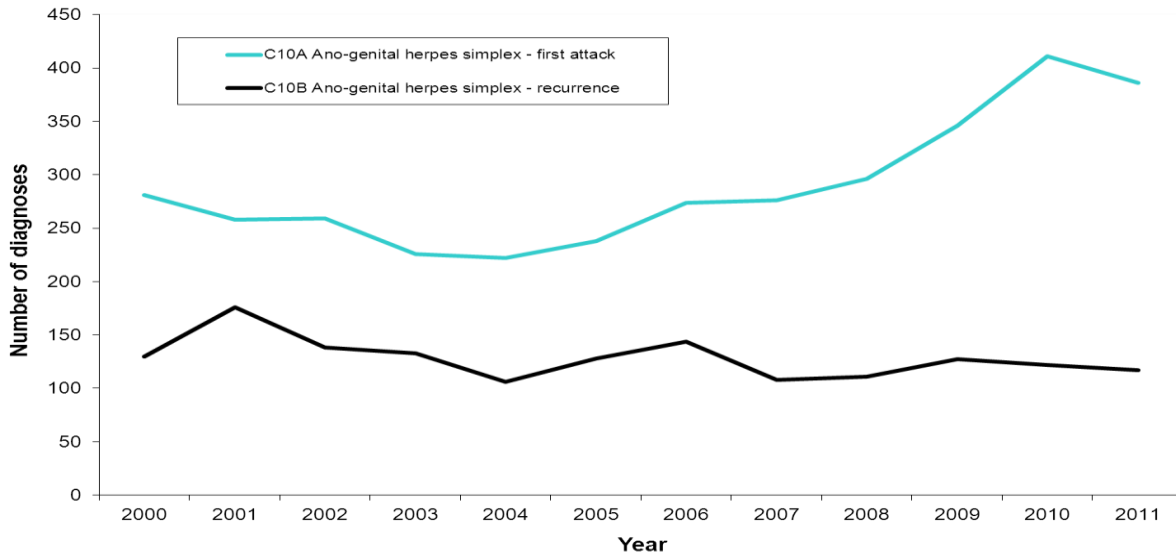
Genital herpes (first episodes) accounted for 5% (386/7,661) of all new STI diagnoses made in Northern Ireland GUM clinics during 2011.

- There were 503 episodes (first infections and recurrent infections) of genital herpes diagnosed in Northern Ireland GUM clinics in 2011.
- 335 (67%) of these were diagnosed in females.
- 386 (77%) of the total attendances for herpes in 2011 were for treatment of first infection and 117 (23%) were for treatment of recurrent infection.
- 23% of male diagnoses (39/168) and 23% (78/335) of female diagnoses were recurrent infections.
- The highest diagnostic rates of first infection in men were in the 20-34 years age group and in women were in the 16-19 years age group.
- Diagnostic rates of first infection in most age groups were higher in females. The diagnostic rate in 16–19 year old females was nearly 15 times higher than in males of the same age.
- 11% (14/129) of male first diagnoses occurred in MSM.

### Trends: 2000–2011

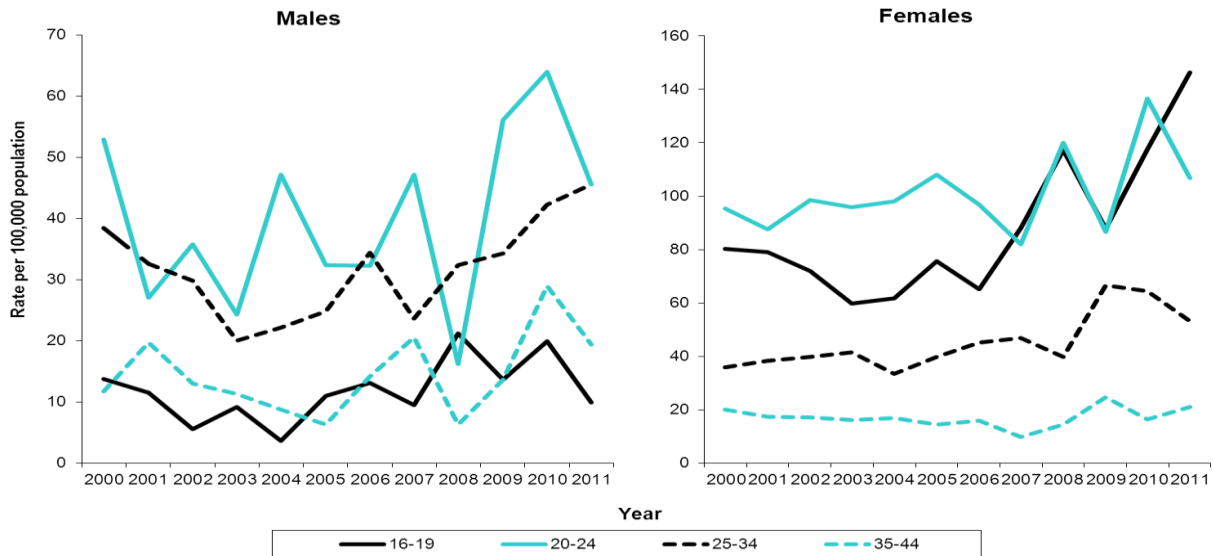
Annual numbers of first diagnoses of genital herpes increased each year from 2004-2010 with 2011 showing a slight decrease. (Figure 4.1).

**Figure 4.1: Diagnoses of genital herpes in Northern Ireland, 2000–2011**



**Age and gender trends: genital herpes (first episode)**

**Figure 4.2: Rates of diagnosis of genital herpes (first episode) in Northern Ireland, by age and gender, 2000–2011**



Diagnostic rates in females were consistently highest in the 16–24 years age group. In males, the highest diagnostic rates were in the 20–34 years age group (Figure 4.2).

Males under 20 years of age accounted for 7% (75/1,150) of all male diagnoses of genital herpes (first episode) made during the period 2000–2011, with diagnoses in the 45+ years age group accounting for 9% (109/1,150).

Females under 16 years of age accounted for 1% (30/2,323) of all female diagnoses made during the period 2000–2011, with diagnoses in the 45+ years age group accounting for 5% (124/2,323).

## 5: Genital warts

Genital warts are caused by human papillomavirus (HPV). More than 90 HPV types have been identified, of which approximately one third are sexually acquired. Although around 20 different types of HPV have been linked to cervical cancer, these particular types are less frequently linked to genital warts.

HPV vaccine was introduced as a school-based programme in Northern Ireland in 2008/09. Until September 2012 the vaccine used protected against the oncogenic types 16 and 18, but not those types causing genital warts.<sup>3</sup> From September 2012 onwards, the vaccine used will protect against types 6 and 11, accounting for 90% of genital warts<sup>4</sup>.

### Diagnoses made in GUM clinics during 2011

Genital warts (first episodes) accounted for 30% (2,305/7,661) of all new STI diagnoses made in Northern Ireland GUM clinics during 2011.

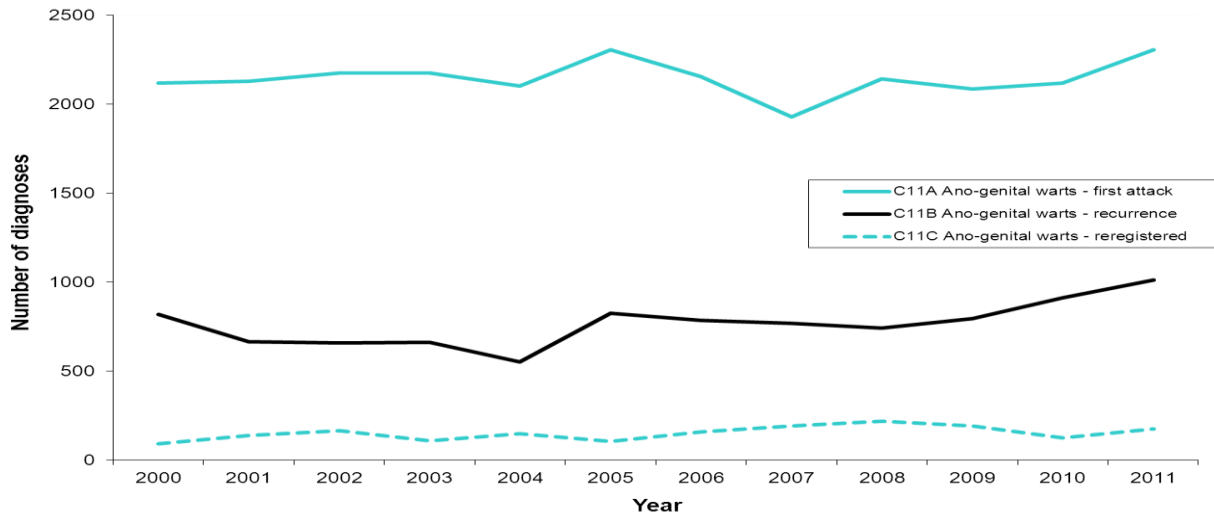
- There were 3,316 episodes (first infections and recurrent infections) of genital warts diagnosed in Northern Ireland GUM clinics in 2011.
- 1,886 (57%) of these were diagnosed in males.
- 2,305 (70%) of the total attendances for genital warts in 2011 were for treatment of first infection and 1,011 (30%) were for treatment of recurrent infection.
- 34% of male diagnoses (649/1,886) were recurrent infections, compared with 25% (362/1,430) of female diagnoses.
- The highest diagnostic rates of first infection in both men and women were in the 20–24 years age group.
- 38% of male diagnoses and 37% of female diagnoses of first infection were in the 20–24 years age group.
- The diagnostic rate in females aged 16–19 years (505/100,000) was more than twice that of males the same age. However, diagnostic rates in those aged over 19 years were higher in males.
- 8% (93/1,237) of male first diagnoses occurred in MSM.

### Trends: 2000–2011

Diagnoses of first infections of genital warts have shown little variation since 2000 (Figure 5.1). Diagnostic rates tend to be higher overall in males (Figure 5.2).

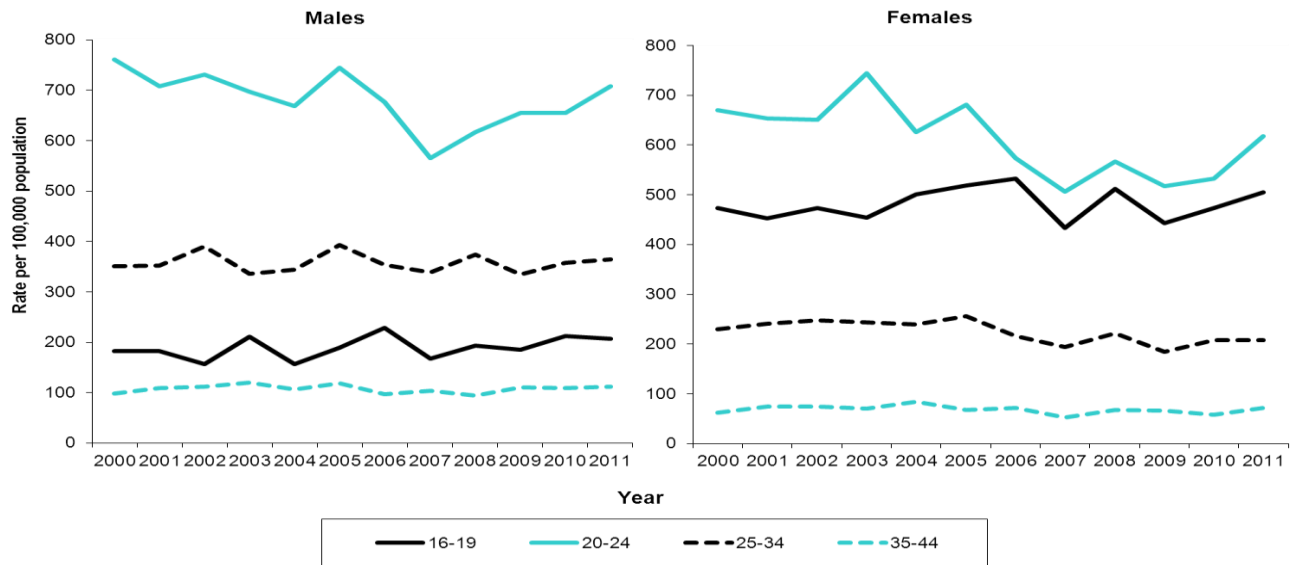


**Figure 5.1: Diagnoses of genital warts in Northern Ireland, 2000–2011**



**Age and gender trends: genital warts (first episode)**

**Figure 5.2: Rates of diagnosis of genital warts (first episode) in Northern Ireland, by age and gender, 2000–2011**



Diagnostic rates in females were highest in the 16–24 years age group, peaking between 20 and 24 years. In males, the highest diagnostic rates were in the 20–34 years age group, also peaking between 20 and 24 years. Rates in those under 20 years of age were consistently higher in females, whereas rates in those over 20 years of age were higher in males (Figure 5.2).

Those under 16 years of age accounted for 0.5% (116/25,751) of all diagnoses (first episode) made during the period 2000–2011, while the 45+ years age group accounted for 5% (1,187/25,751).

During 2000–2010, the proportion of male diagnoses attributed to MSM ranged from 2% in 2000 and 2002 to a peak of 8% in 2010 and 2011.

## 6: Syphilis

Syphilis is a bacterial infection caused by the spirochete *Treponema pallidum*. Its importance lies in its ability to promote both the acquisition and transmission of HIV, and in the potential for serious or even fatal consequences if left untreated. Late syphilis can cause complications of the cardiovascular, central nervous and mucocutaneous systems. Infectious syphilis in pregnant women can cause miscarriage, stillbirth or congenital infection.

Northern Ireland has, in common with elsewhere in the UK and Europe, experienced a marked increase in infectious syphilis since 2000. In the decade prior to 2000, on average only one case of infectious syphilis per year was reported.

### Reports from enhanced syphilis surveillance arrangements

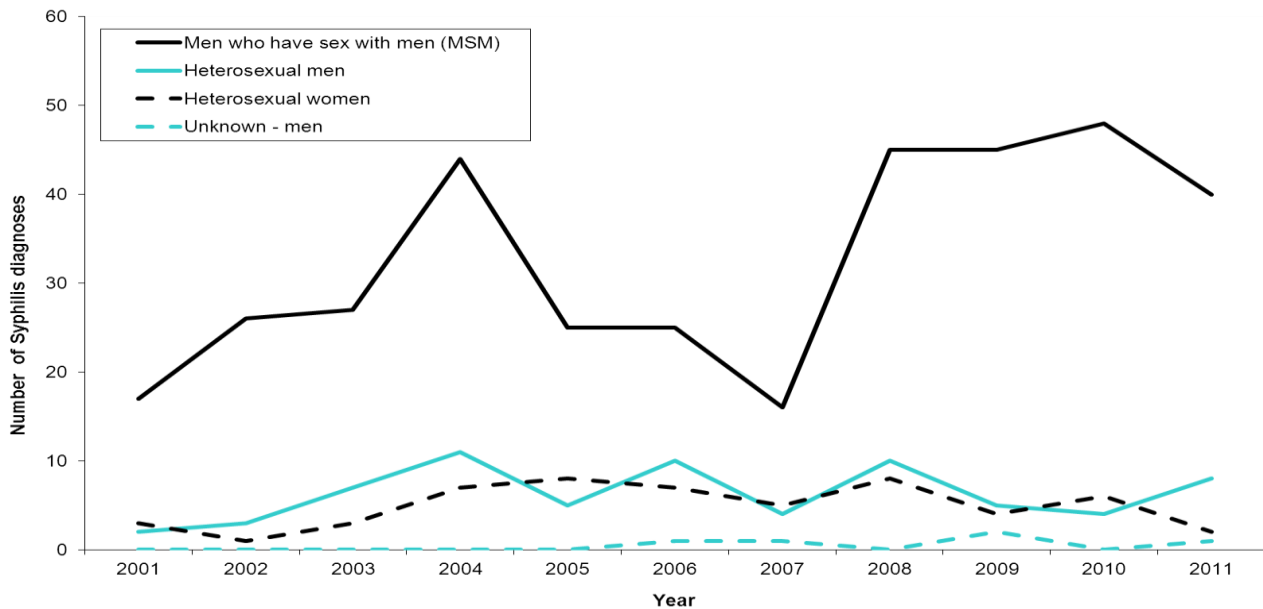
During 2011:

- 52 new episodes of infectious syphilis, representing 51 individuals, were diagnosed;
- 23 presented as primary syphilis, 15 as secondary syphilis and 10 as early latent syphilis, for four episodes the stage of illness was not known;
- 77% (40/52) of episodes were diagnosed in MSM;
- 34 episodes occurred in Northern Ireland residents and, in 27 episodes, syphilis was likely to have been acquired through exposure within Northern Ireland;
- diagnosed co-infections included HIV, chlamydia, gonorrhoea, genital warts and non-specific genital infection (NSGI);
- 29% (15/52) reported one sexual partner in the three months preceding diagnosis;
- the highest number of reported sexual partners of any one individual in the preceding three months was 30;

### Trend information

While there has been no overall annual trend since the outbreak began in 2000, it is clear that infectious syphilis is now endemic within Northern Ireland. One individual presented with infectious syphilis to the GUM clinic in 2000 (this episode has been excluded from the analysis below). Overall, there have been 487 new episodes of infectious syphilis since 2001: 22 in 2001, 30 in 2002, 37 in 2003, 62 in 2004, 38 in 2005, 43 in 2006, 26 in 2007, 63 in 2008, 56 in 2009, 58 in 2010 and 52 in 2011. The outbreak continues to involve predominantly MSM, who accounted for 74% (358/487) of diagnoses to the end of 2011. Episodes in heterosexual males and females accounted for between 13% and 40% of annual totals. Fifty six percent of heterosexually acquired episodes were in males (Figure 6.1).

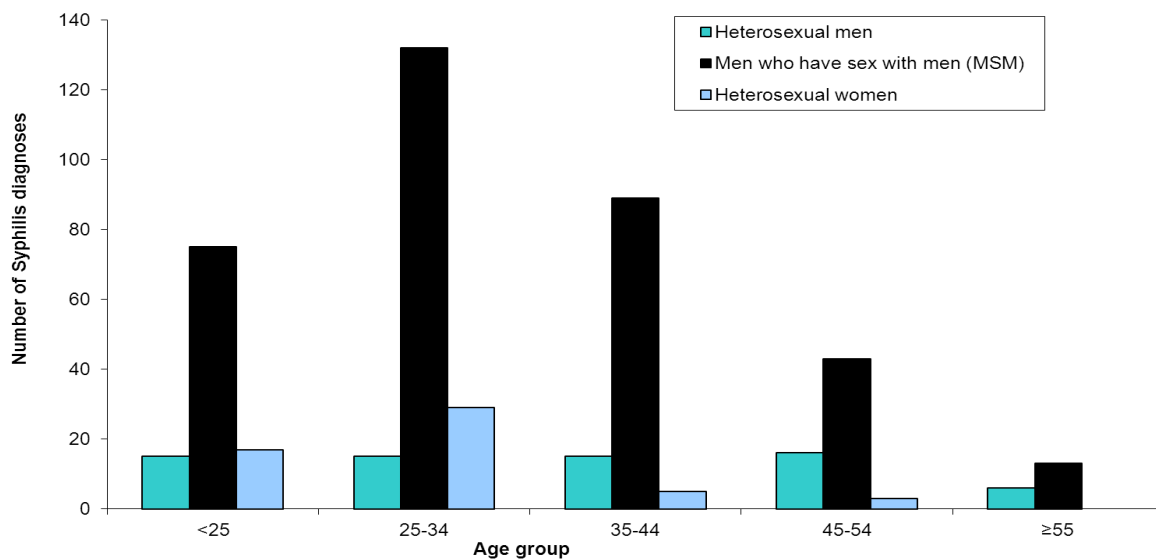
**Figure 6.1: Number of syphilis diagnoses in Northern Ireland, by gender and sexual orientation, 2001-2011**



**Age and sexual orientation**

Analysis of cumulative data by age and sexual orientation shows the highest number of episodes in heterosexual females was in the 25–34 years age group (54%; 29/54). In MSM, the highest number of episodes was in the 25–44 years age group (62%; 221/358). In heterosexual males, diagnoses were more evenly spread across the age bands, with those aged 25+ years accounting for 75% (52/69) of diagnoses. Information on age was missing for eight episodes (Figure 6.2).

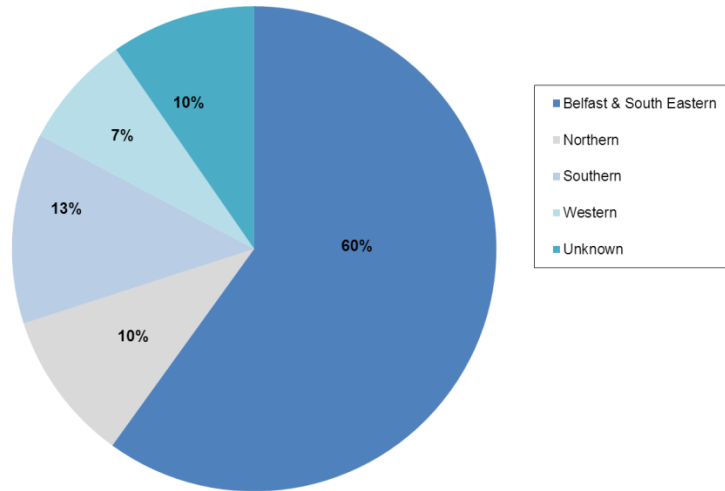
**Figure 6.2: Age distribution of syphilis diagnoses in Northern Ireland, by gender and sexual orientation, 2001–2011**



### LCG area of residence

Of the 487 new episodes reported since 2001, 292 (60%) were resident in the Belfast and South Eastern Local Commissioning Group (LCG) areas, 49 (10%) in the Northern LCG area, 62 (13%) in the Southern LCG area, 37 (7%) in the Western LCG area, and for 10% (47), the area of residence was unknown (Figure 6.3).

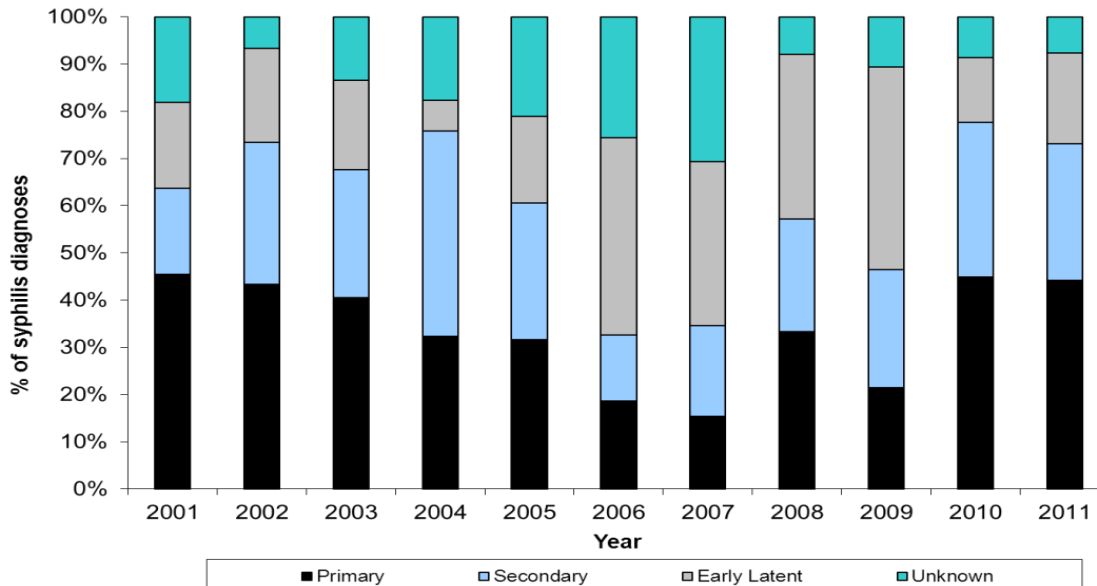
**Figure 6.3: Syphilis diagnoses by LCG area of residence, 2001–2011**



### Stage of disease

From 2001 to 2005, there was little variation in the stage of disease at which diagnosis was made, with primary and secondary stages accounting for 82% (131/159) of episodes for which this information was available. During 2006 and 2007, this fell to 46% (23/50), with the proportion of early latent episodes increasing to 54% (27/50), representing diagnosis of syphilis at a later stage. However, 2008 and 2009 saw an increase in primary and secondary stage diagnoses to 62% (36/58) and 52% (26/50) respectively. A further increase was noted in 2010 and 2011, with 85% and 79% of episodes in the primary and secondary stage, representing early diagnosis of syphilis. The number of episodes at an unknown stage has decreased to 8%, compared with 31% in 2007 (Figure 6.4).

**Figure 6.4: Stage of disease, by year of diagnosis**



## Location of exposure

Although initial episodes were linked to an outbreak among MSM in Dublin, the majority of episodes in both MSM and heterosexuals were acquired in Northern Ireland (Table 6.1).

**Table 6.1: Location of acquisition of syphilis infection diagnosed in Northern Ireland, 2001–2011**

Year	Dublin	Northern Ireland	Elsewhere in the UK	Outside UK/ROI	ROI (excluding Dublin)	Unknown
2001	9	*	*	*	0	*
2002	*	18	*	*	*	*
2003	*	23	*	*	*	5
2004	*	43	7	*	0	5
2005	*	24	*	5	*	*
2006	*	21	5	11	0	*
2007	0	14	0	5	0	7
2008	*	38	*	9	*	9
2009	*	41	*	*	0	8
2010	*	46	*	*	0	*
2011	*	27	*	*	*	16

## Partner change

Cumulative data from 2001–2011 show that the majority of cases reported between zero and two partners (67%: 327/487) in the three months prior to diagnosis. Three percent (14/487) reported 20 or more partners during this period.

## Co-infections

Of the 487 new episodes of syphilis reported since 2001, 52 (11%) were HIV positive. In addition to HIV and syphilis, nine of these cases had another STI co-infection. A further 115 episodes had one of the following STI co-infections: chlamydia, gonorrhoea, genital herpes, genital warts, non-specific genital infection (NSGI), balanitis, bacterial vaginosis, scabies, anogenital candidosis, hepatitis A, hepatitis B or trichomoniasis. Six episodes had two STI co-infections.

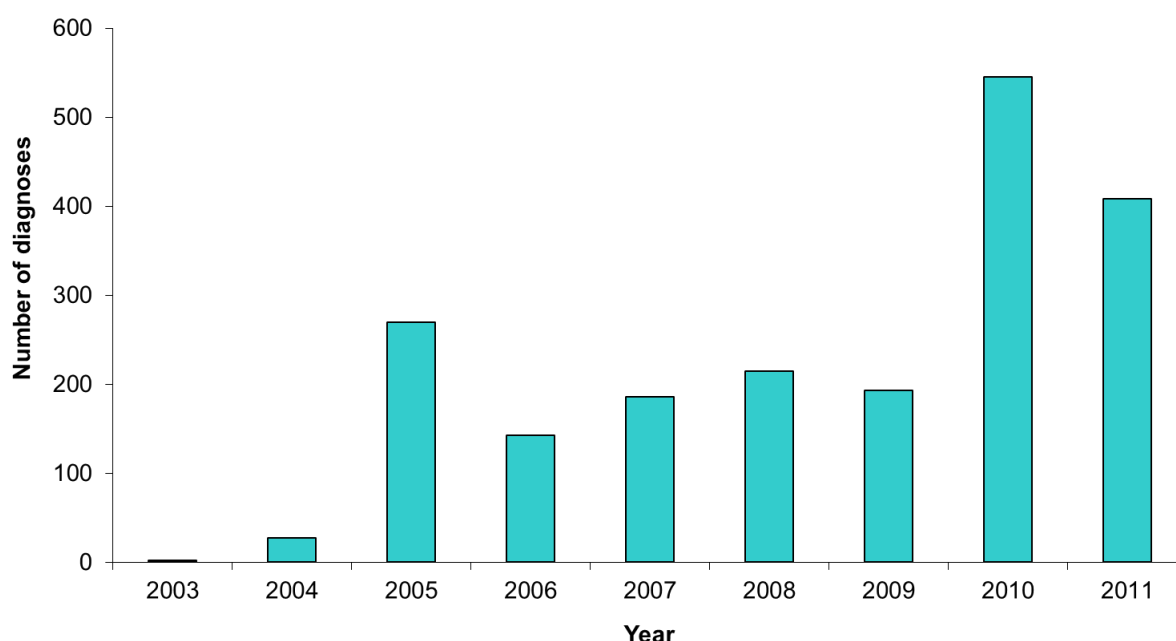
# 7: Lymphogranuloma venereum (LGV)

Lymphogranuloma venereum (LGV) is a bacterial infection caused by a specific type of *Chlamydia trachomatis* (serovars L1, L2 and L3). LGV is highly prevalent in parts of Africa, Asia, and Central and South America. For many years, LGV was rare in Western Europe, with the majority of cases being imported. However, since 2003 a series of outbreaks have emerged across different countries in Europe. The majority of cases seen in the UK have been HIV positive white MSM. The most common presentation is proctitis.<sup>4</sup>

## Reports from enhanced LGV surveillance arrangements

### Trends: 2003–2011

Figure 7.1: United Kingdom LGV diagnoses, by year of diagnosis



Compared with the rest of the UK, Northern Ireland has had very few cases of LGV, with only 11 cases reported since 2008. Seven of these were reported in 2009. The majority of Northern Ireland cases were white MSM. The median age of cases was 28 years, range 19–54 years. Six of the 11 cases were HIV positive.

## 8: Summary and conclusions

2011 saw a slight decrease in annual numbers of new STI diagnoses made in Northern Ireland GUM clinics.

Together, chlamydia, non-specific genital infection and genital warts accounted for 84% of all new STI diagnoses made in Northern Ireland GUM clinics in 2011.

MSM is the group most at risk of acquiring gonorrhoea, infectious syphilis and LGV.

During 2011, 55% of new STI diagnoses for which age group information was available occurred in young people under the age of 25 years.

Safer sex messages should continue to be promoted to the general population, young people and MSM. The risks of unprotected casual sex, both within and outside Northern Ireland, need to be reinforced.

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