


Chlamydia and gonorrhea screening in the ED setting: increasing evidence of utility and need for further research

I applaud the work of Garlock et al. in investigating the utility of chlamydia (CT) and gonorrhea (GC) screening in emergency departments (ED). In the time of record levels of these infections and the specter of antimicrobial resistant gonorrhea (AMR GC) on the horizon, new means to identify and treat those at risk are sorely needed [1-3].

I would like to point out that somewhat similar work has been done before, and complements to a large extent the findings presented by this study. Two of our previous studies of prospective screening of emergency department patients found both relatively high rates of infection and individual-level factors suitable to refine screening criteria. The first study of universal urine-based screening of females aged 15–35 years for CT/GC found a disease prevalence of 9.1% (CT only 5.7%; GC only 2.5%; CT and GC 0.9%) [4]. Further, restricting screening to only those “…reporting 2+ male partners in the past year or those who thought their sex partner had other partners resulted in a 52% decrease in the number of tests administered and a 73% increase in screened patient prevalence.” Our second universal screening study, including males and oropharyngeal swabs in additional to urine specimens, found an overall prevalence of 7.7% with similar risk between males and females [5]. Further, 26.3% of infected individuals had an oral infection, and the majority of oral GC infections would not be identified with urine-based screening. Both of these studies were pilots at a single hospital site and require further exploration.

The clinical setting (primary and emergency) has been and will likely continue to be a critical aspect of addressing sexually transmitted disease screening and treatment [6,7]. Still, universal screening in relatively low prevalence settings is not generally considered cost-effective [8].

As Hull et al. describe in their review, there are multiple factors impacting both cost-effectiveness and even full implementation of current guidelines [8]. Of particular concern for emergency department-based screenings is the potential loss to follow up, leading to presumptive treatment as a frequently-preferred paradigm. While efficient from an operations perspective, it is unattractive in terms of waste, potential for inadequate treatment (for those truly infected), and adverse personal and social outcomes (for those not infected). Whereas the primary care setting has an established framework for long-term patient engagement and follow up, none such exists in the emergency setting. Models of linkages between ED-based screening and other agency follow up and treatment have been explored, and I would suggest that further study in this regard is warranted [9,10]. While truly new strategies for addressing increasing rates of STDs and AMR GC are needed, expanding and refining evidence-based practices in existing clinical sites may be comparably low cost and easily generalized.

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References


Red cell distribution width and mean platelet volume in carbon monoxide poisoning

Dear Editor,

We read the article “Predicting of neuropsychosis in carbon monoxide poisoning according to the plasma troponin, carboxyhemoglobin (COHb), red cell distribution width (RDW) and mean platelet volume (MPV) levels” by Coskun et al. [1] They aimed to determine the predictivity of neuro psychosis in carbon monoxide poisoning by the admission levels of RDW, MPV and troponin I levels which can be measured quickly and easily in the emergency department (ED). They

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