

## Editorial

### Partner notification: where are we now?

The epidemiological investigation of infectious disease has been deep-rooted in the field of medical epidemiology and microbiology. Initially, contact tracing was a term coined to describe the process in identifying and evaluating sexual partners of patients infected with sexually transmitted diseases. Later, the term partner notification has gained popularity over the old term as it embraces a broader concept of finding and managing the contacts. In this issue, Chan KHN et al described the local scenario of partner notification of gonorrhoea in public sexually transmitted disease clinics.

Two separate approaches are employed in partner notification. Patient referral refers to the direct notification of partners by patient themselves; whereas provider referral refers to the involvement of healthcare workers in notifying partners. Provider referral is costly and is only permissible with relevant legal provision and logistics support whereas patient referral is a softer approach that is currently employed in the public sectors in Hong Kong. The basic aims of partner notification are direct evaluation of the at risk group, prevention of reinfection of index cases and disease control. However, even for the group of gonorrhoea patients with traceable partners, 39.6% of patients in study by Chan KHN et al refused partner notification. Although no concrete reasons are provided in the study, refusal of partner notification may at least be partly attributable to the concern about breach of confidentiality, stigmatisation and quarrel among couples.

To overcome some of the problems in traditional partner notification, patient delivered partner therapy or expedited partner therapy has been introduced. Patient delivered partner therapy has been shown, in large randomised controlled trials mainly from USA, to reduce persistent or repeated infection in index cases as compared with standard partner referral. It has been included as a possible partner treatment options in heterosexual patients affected by gonococcal or chlamydial infections in the 2006 CDC sexually transmitted disease guideline.<sup>1</sup> However, drug prescription to people whom a doctor has not seen potentially violates the local code of practice. Up to November 2007, patient delivered partner therapy was permissible, potentially allowable and prohibited in 11, 28 and 13 states in US respectively.<sup>2</sup> Traditionally, in HK public sectors, patient delivered partner therapy is often used in the management of trichomoniasis detected incidentally on Pap smear (personal observation). Although patient delivered partner therapy has the advantages of maintaining confidentiality and timeliness of epidemiological treatment, it has the disadvantages of potential poor drug compliance, missing an opportunity of health education and screening partners with other sexually transmitted diseases, and potential medicolegal risk should adverse drug reactions develop. The National Institute for Health and Clinical Excellence (NICE) in UK also published guidelines in 2007 that emphasized the importance of testing and treating partners at risk but patient delivered partner therapy was not mentioned as a possible option.<sup>3</sup>

The article by Chan KHN et al gives us some data on the acceptance of partner notification in Hong Kong public sexually transmitted disease clinics. Nonetheless, it does not touch upon the basic question on the efficacy of partner notification, i.e. can partner notification reduce persistent infection or reinfection in index cases? To compare the reinfection/persistent infection rates in patients with or without partner notification in a prospective study is not ethical nowadays. Instead, studies in partner notification would compare improved methods with standard simple patient referral. Trelle S et al has published a meta-analysis of randomised trials that examine the effectiveness of various methods to improve partner notification through patient referral.<sup>4</sup> Many studies are criticised for their methodological weakness. Although reduction in incidence and prevalence of sexually transmitted disease in index patient is the primary goal of partner notification, some studies report outcomes like number of partner treated, number of partner tested, number of partner tested positive or number of partner notified/treated. But these outcomes cannot be directly extrapolated to the reduction of persistent or recurrent infection in index patients and are best viewed as secondary outcomes. The meta-analysis concluded that patient delivered partner therapy would reduce the risk of persistent/recurrent infection in patients suffering from gonococcal or chlamydial infection. For unknown reasons, similar efficacy was absent in women with trichomoniasis. Supplementing patient referral with booklets with tear-out cards and treatment guidelines was as effective as patient delivered partner therapy. Despite the development of these new strategies, none of them could be used in the subgroup of patients with untraceable partners (up to 53%

in the study by Chan KHN et al). Moreover in developing countries where syndromic approach is used, lack of diagnostic specificity may lead to unnecessary notification and potential domestic quarrel or violence.

In conclusion, the article by Chan KHN et al provides us with a brief picture on how well partner notification is being performed in patients with gonorrhoea in Hong Kong public sexually transmitted disease clinics. As much as 39.6% of patients with traceable partners refuse partner notification, therefore, future effort should be directed to finding the reasons of their refusal and helping them to accept partner notification, like improved counseling advice to deal with the difficulties of disclosure of their diseases to partners. Moreover, it would be interesting to study partner notification in the private sectors, where most of the sexually transmitted diseases are dealt with in Hong Kong.

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## References

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