Correspondence

Letters should not exceed 400 words and should be typed double spaced (including the references) and be signed by all authors.

TO THE EDITOR Genitourinary Medicine
Chlamydial infections of the urethra in women

Sir,
While agreeing with Bradley et al (Genitourin Med 1985;61:371-5) in almost all respects, we disagree with their conclusion that "there seems to be no indication for taking routine urethral swabs to aid in the diagnosis of chlamydial infection in women" and present a simple inexpensive alternative protocol.

The mechanics of sexual activity mean that the infected urethra is always a potential reservoir for infection of the cervix. Our experience is based on two studies. In the first, specimens for culture for chlamydiae were collected from the urethra and cervix of 176 pregnant women at the time of their first antenatal visit. Twelve cultures were positive for Chlamydia trachomatis and 2/12 (17%) were positive only in the urethral specimen. In the second study specimens were similarly collected from 180 women attending a sexually transmitted diseases (STD) clinic. Eighteen cultures were positive for C trachomatis and 4/18 (22%) were positive in the urethral specimen alone. Though the percentage of patients yielding positive specimens from the urethra alone was high, the absolute number was small. It is therefore uneconomical to collect routinely separate cervical and urethral specimens for chlamydial culture.

The following protocol was devised in an attempt to contain costs while not missing patients who were harbouring chlamydiae in the urethra but not in the cervix. Using a cotton wool wire shafted swab, a specimen is first collected from the cleansed urethra and placed into a bottle of chlamydia transport medium (CTM). The cervix is then visualised and cleansed, and a further swab from the endocervix is placed in the same bottle of CTM. The eluate from these two swabs is then cultured on cycloheximide treated McCoy cells in the usual way, the result reported, and treatment instituted if necessary, irrespective of the specific site infected being known.

In this way, at the cost of an additional swab infection of both the urethra and cervix are detected and treated, which results in a corresponding increase in detection rates from female genital tracts and avoids possible sequelae.

Yours faithfully,
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References

TO THE EDITOR Genitourinary Medicine
Detecting chlamydiae in diagnosing and managing women with abdominal pain

Sir,
Munday et al (Genitourin Med 1986;62:15-6) detected cervical chlamydial infection in 42 of 232 (18%) women attending the Prad Street Clinic with abdominal pain not diagnosed as having pelvic inflammatory disease. Regrettably they did not include a matched control group of clinic patients who did not have abdominal pain to assess the prevalence of chlamydiae in them.

In Newcastle we are fortunate in being able to screen routinely all our female patients for chlamydial infection by cell culture. The table shows our results since 1983.

<table>
<thead>
<tr>
<th>Year</th>
<th>No tested</th>
<th>No (%) positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td>2364</td>
<td>452 (19.1)</td>
</tr>
<tr>
<td>1984</td>
<td>2609</td>
<td>402 (15.4)</td>
</tr>
<tr>
<td>1985</td>
<td>3063</td>
<td>534 (17.4)</td>
</tr>
</tbody>
</table>

Thus in the past three years we have screened 8036 women and detected chlamydiae in 1388 (17.3%). Though high risk groups (such as contacts of patients with non-gonococcal urethritis or gonorrhoea) were tested, a notable proportion (37%) of positive patients were from low risk groups (such as those attending with an episode of candidiasis or with warts).

Before advising that those with abdominal pain should preferentially be selected for a chlamydial diagnostic service, comparative data should be presented on clinic attenders without abdominal pain.

Yours faithfully,
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TO THE EDITOR Genitourinary Medicine
Minocycline in the treatment of genital chlamydial infection in women

Sir,
Tetracyclines or erythromycin are the recommended antimicrobials for the treatment of genital infection with Chlamydia trachomatis. The optimum therapeutic regimens of these agents still require investigation, as shown by two recent contributions on erythromycin to Genitourinary Medicine.3 4

Minocycline 50 mg twice daily for seven days has been shown to be as effective as longer regimens and higher doses of this tetracycline for treating urethral infection with C trachomatis in men.4 No similar study of the use of minocycline for treating genital chlamydial infection in women has been reported, and this antimicrobial is not listed in a recent summary of treatment regimens in women.4 We have recently evaluated minocycline 50 mg twice daily for seven days in the treatment of genital infection by C trachomatis in women.

From February to October 1983 we performed cervical culture for C trachomatis, using cycloheximide treated McCoy cells, on 603 patients; those who had taken antimicrobials during the preceding four weeks were excluded, but patients were otherwise unselected. C trachomatis was isolated from 222 women. Of these, 79 were contacts of men with non-gonococcal urethritis and the remainder had yielded C trachomatis after

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Routine examination.

Women with concomitant infections, such as trichomonia and gonorrhoea, were excluded and the remaining 195 women with chlamydia infection were treated with minocycline 50 mg twice daily for seven days and followed for up to six months after completing treatment, cervical culture for C trachomatis being repeated on each occasion. Of the 195 patients entered into the study, 18 failed to keep their first follow up appointment and four did not complete the course of treatment; thus 173 patients were available for evaluation. The results of treatment are shown in the table.

**TABLE Results of cultures of cervical material for Chlamydia trachomatis after treatment for one week with minocycline 50 mg twice daily (number of possible reinfections in parentheses)**

<table>
<thead>
<tr>
<th>Time after completion of treatment</th>
<th>No examined</th>
<th>No yielding C trachomatis</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7 days</td>
<td>162</td>
<td>0</td>
</tr>
<tr>
<td>8-14 days</td>
<td>112</td>
<td>1</td>
</tr>
<tr>
<td>15-21 days</td>
<td>42</td>
<td>2 (2)</td>
</tr>
<tr>
<td>22-28 days</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>1-2 months</td>
<td>31</td>
<td>1 (1)</td>
</tr>
<tr>
<td>2-4 months</td>
<td>18</td>
<td>1 (1)</td>
</tr>
<tr>
<td>4-6 months</td>
<td>14</td>
<td>2 (2)</td>
</tr>
</tbody>
</table>

Early reisolation of C trachomatis, 8-14 days after completion of treatment, was noted in only one of 112 patients. Late reisolation was rare and was confined to those who had resumed intercourse, making reinfection a possibility. Side effects occurred in nine patients. Gastrointestinal symptoms were reported in five patients and central nervous system symptoms (headache, dizziness, or depression) in four; treatment had to be discontinued for side effects in three women. We conclude from this study that minocycline in the dosage used is an effective and well tolerated treatment for infection of the lower genital tract with C trachomatis in women, and the simple regimen is attractive.

Yours faithfully,

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References


TO THE EDITOR Genitourinary Medicine

Colposcopy in genitourinary medicine clinics

Sir,

We write to inform colleagues of the results of our recent questionnaire regarding colposcopy service in genitourinary medicine in this country.

All consultants on the “Department of Health List of Genitourinary Clinics, 1985” were circulated. There were 105 consultants who replied who worked at 142 clinics. Of this number 35 had trained or were experienced in colposcopy, and 33 other members of clinic staff (13 senior registrars, 6 registrars, 3 senior house officers, 10 clinical assistants, and 1 associate specialist) were training in the use of the instrument. Sixty other consultants expressed an interest in training. There seem to be 42 colposcopes in use in these clinics, all but three of which are used regularly. The range of clinical investigation for which these instruments were used was extremely wide and included examination of the rectum, vagina, and cervix and most forms of pathology therein. Fifteen consultants used colposcopically directed biopsy of the cervix or vagina, or both. Three practitioners regularly use a laser for the treatment of cervical warts or cervical intraepithelial neoplasia, or both, and most of the rest use either cryosurgery or podophyllin, and a few use trichloracetic acid for warts on the cervix. Fourteen respondents regarded colposcopy as not being useful in departments of genitourinary medicine, but 12 of these regarded the length of time taken for examination as being incompatible with the most economic use of their time (six of them were content to leave abnormal cytology to their gynaecological colleagues). Only two of these 14 replied that colposcopy was contraindicated in departments because of the risk of cervical bleeding associated with biopsy. Fourteen consultants were members of the British Society of Colposcopy and Cervical Pathology (BSCCP), with 40 expressing interest in becoming members and all these have since been circulated with details. Eighty respondents felt that joint scientific meetings between the BSCCP and the Medical Society for the Study of Venereal Diseases (MSSVD) would be valuable.

It seems, therefore, that colposcopy is enjoying a healthy prospect in genitourinary medicine, and junior staff are training to develop their skills.

We would like to see formal requirements for training in this skill recognised by our Specialist Advisory Committee for accreditation.

The provision of resources to continue developing colposcopy services in our speciality should be given a clear priority so that “routine” genitourinary patients are not denied access to clinics where colposcopy is performed. Where better to begin the investigation and treatment of abnormal cytology than in the clinics to which “at risk” patients present themselves and where such cytology is disproportionately to be found?

As the relations between wart virus subtypes, other possible infections, and non-infectious cofactors, and the progression of dysplasia are far from clear, where better to investigate these than in departments of genitourinary medicine? Moreover, the colposcope’s potential in visualising non-dysplastic conditions and lesions at other sites is only beginning to be developed.

A harmonious relationship seems to be present between individual experienced genitourinary physicians and gynaecological colleagues, which is reflected in the common interest in the instrument and patient sharing. We understand that this co-operation is evident in more formal terms, as the BSCCP has approached the MSSVD to further detailed discussions and develop training courses designed for genitourinary staff.

We would value the comments of our colleagues.

Yours faithfully,

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Minocycline in the treatment of genital chlamydial infection in women.
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