TO THE EDITOR, Genitourinary Medicine

Treating chancreid: summary of studies in South Africa

Sir,

We were interested to read the article by Ballard et al.1 which summarised the effective treatments for chancreid with particular reference to single dose therapies. Guidelines on the general management of genital ulcer disease in Southern Africa were also given. However, patients who are HIV Ab positive are not immune to genital ulcer disease and this article failed to consider the effects of concomitant HIV infection on both natural history and treatment efficacy.

Cameron et al.2 concluded that treatment failure in chancreid using single doses of trimethoprim-sulphonamide or a quinolone was significantly associated with HIV Ab positivity. Treatment failure appeared to be a good clinical indicator of such positivity. Furthermore, the article suggested the use of benzathine penicillin together with single dose anti-chancreid therapy in genital ulcer disease where diagnostic facilities are limited.

It has been shown that benzathine penicillin fails to reach treponemacidal levels in CSF.3 Reports on the development of neurosyphilis after treatment with benzathine penicillin4 strongly suggest it is not optimal therapy even in the immunocompetent. Neurological relapse after treatment of early syphilis with benzathine penicillin in HIV Ab+ patients has now been reported.5,6 Moreover, the natural history of syphilis in HIV infection is not yet fully understood but reports suggest that there may be an accelerated progression of late complications in such patients who receive treatment.

Thus, the management of genital ulcer disease along the lines suggested without taking into account HIV status would appear to leave a susceptible population open to the possibility of ineffective chancreid treatment and the late complications of syphilis.

Yours faithfully,
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References

TO THE EDITOR, Genitourinary Medicine

Evaluation of abnormal cervical cytology results in a genitourinary clinic

Sir,

Drs Coker et al in their letter to this journal1 expose the tendency for female genitourinary patients to possess abnormal cytology necessitating colposcopy. In our colposcopy clinic we have attempted to answer the corollary: do colposcopy patients have STDs we are failing to diagnose?

Modern theory holds that CIN is a sexually transmissible disease.2 Long established thought in genitourinary medicine makes it necessary, in the presence of an STD, to search for others. It may be expected therefore that STD will be found in colposcopy clinic patients.

The cost effectiveness of identifying and treating all such STDs at one consultation appears attractive. In the Jessop Hospital, the facilities are ideal to perform this function since the clinic is co-managed by two consultants; one gynaecologist (VAB) and one genitourinary physician (DAH). Genitourinary patients with abnormal cytology are managed “in-house” and if necessary are then referred for appropriate treatment to Jessop Hospital.

Seventy five consecutive patients referred directly to the Jessop Hospital for colposcopy were screened. These were females with abnormal cytology from sources other than genitourinary medicine.

A sexual and medical history noting age, marital status, age at first intercourse and number of sexual partners was solicited. Patients with a recent (one month) history of antibiotic ingestion were excluded.

Tests comprised urethral swab for Gram staining and culture, high vaginal specimens for dark ground illumination, Gram staining and culture, and cervical samples for Gram staining and viral culture. Endo-cervical testing for Chlamydia trachomatis was performed with a monoclonal antibody labelled with fluorescein (Microtrak, Syva). Samples were obtained after cytology had been performed, but before formal colposcopic procedures.

Positive findings are shown in the table. If organisms of low potential risk or commensal status are excluded, then carriage of pathogens in this group of patients is seen to be low. Only one patient had C trachomatis with 11 other patients having ureaplasma and/or mycoplasma. Eleven patients had mixed infections, and 13 others were only candida (7) or gardenerella (6).

Review of sexual, contraceptive, smoking and obstetric history failed to reveal any useful risk factors. These findings would appear to agree with other similar studies3 and may be concluded that microbiological screening of all new colposcopy patients is not effective or economic.

However, our colposcopy clinic may not be representative in that patients found to have abnormal smear tests in genitourinary medicine clinics have already been screened prior to attendance for treatment at this hospital. Where this system does not operate the risk of STD may be consequently higher.

Table Positive findings in 75 consecutive colposcopy patients

<table>
<thead>
<tr>
<th>Organism</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia trachomatis</td>
<td>1</td>
</tr>
<tr>
<td>Ureaplasma urealyticum</td>
<td>2</td>
</tr>
<tr>
<td>Candida albicans</td>
<td>7</td>
</tr>
<tr>
<td>Gardenerella vaginalis</td>
<td>6</td>
</tr>
<tr>
<td>Ureaplasma + Gardenerella</td>
<td>2</td>
</tr>
<tr>
<td>Ureaplasma + Candida</td>
<td>5</td>
</tr>
<tr>
<td>Anaerobes + Gardenerella</td>
<td>1</td>
</tr>
<tr>
<td>Mycoplasma, Gardenerella +</td>
<td>1</td>
</tr>
<tr>
<td>Mycoplasma, Gardenerella +</td>
<td>1</td>
</tr>
<tr>
<td>Group B Streps. + Candida</td>
<td>1</td>
</tr>
</tbody>
</table>

Total 27


correspondence
Correspondence

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References

TO THE EDITOR, Genitourinary Medicine

Labial adhesions after genital herpes infection

Sir,
It was interesting to note from the case reported by Walzman and Wade1 that this was thought to be a rare complication. In our experience, severe primary attacks of herpes in the young can very easily lead to labial adhesions, especially under the clitoral hood, and often along the labia minora and labia majora. If left untreated, this same process during healing could lead to fusion across the midline. On most occasions, this is avoidable by early diagnosis, treatment with acyclovir and frequent follow up.

To illustrate this point, we have seen two females aged 19 and 21 years in the past 18 months with florid primary herpes. Since they both followed similar courses, only one will be detailed.

The initial attack involved both labia introitus, perineum and mons pubis, with bilateral tender inguinal lymphadenopathy. On their first visit, HSV cultures were obtained from the lesions, further examination proving to be too painful. Treatment was started with oral acyclovir 200 mg five times daily for 5 days, and cotrimoxazole 960 mg twice daily for 5 days. The patient was advised to have frequent saline washes.

When reviewed 5 days later, most symptoms had abated, but she still complained of dysuria. On examination, the ulcers were clean, but had a serous exudate, which was already causing some adhesions under the clitoral hood and between the labia. These adhesions were gently separated, and the patient advised to separate the labia when in the bath. Further STD screening was still not possible. During her third visit an STD screen including cervical smear was done: all were negative. However, now the upper one-third of the labia minora and majora had fused. This adhesion was gently separated and vaseline gauze was applied. She was given vaseline gauze to take home and told to change the gauze between the labia at frequent intervals to prevent further adhesions. On this treatment the area healed well and there were no further problems with adhesions. Since then, both patients have attended the clinic with recurrences of herpes infection, which were not severe. These cases illustrate that labial adhesions can occur very easily in florid primary herpes, and are most common at the healing stage, probably due to the formation of a fibrous exudate. Early diagnosis, close vigilance and good counselling help prevent permanent damage.

Yours faithfully,
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Reference

Matters arising

Trichomonal vaginitis refractory to conventional treatment

Dr Seligman states in his letter to Genitourinary Medicine1 that vaccination has proved useful in the prophylaxis of recurrent trichomonia, although not for the treatment of resistant organisms. We have recently reported the case histories of two patients who failed to respond to oral metronidazole (400 mg twice daily for 7 days) and oral nimorazole (one gram 12 hourly for 3 days). The minimum inhibitory concentration of metronidazole for these organisms under aerobic conditions was 125 mg/l and 32 mg/l (control strain 1 mg/l). Following failure to respond to conventional treatments, both patients received vaccination with Gynatren, a lyophilisate of inactivated selected strains of Lactobacillus acidophilus, as a course of three intramuscular injections of 0·5 ml at two weekly intervals. Within one month of the final injection both patients became free of their symptoms of an altered vaginal discharge with vulval discomfort for the first time for six months and four years respectively. Unfortunately, only one woman was able to attend for tests of cure which confirmed that her infection had been eradicated.

This response is in accordance with other reports demonstrating a cure rate of 84%–100% following the third injection.3 Although unable to explain its mechanism our experience leads us to believe that Gynatren has a role in the treatment of trichomoniasis caused by resistant organisms and not solely as a prophylactic measure.

References
2 Pattman RS, Sprott MS, Kearns AM, Earnshaw M. Failure of mebendazole to cure metronidazole-resistant trichomonal vaginitis. Genitourin Med. (In press.)
Evaluation of abnormal cervical cytology results in a genitourinary clinic.

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