asymptomatic and microscopy of an early morning urine specimen from him was negative for *T. vaginalis*.

When *T. vaginalis* has been isolated in children, the mode of transmission usually thought of has been sexual abuse. Charles (1991) showed the presence of *T. vaginalis* in 33 children below the age of 12 years among 115 juvenile and adolescent patients with leucorrhoea. He concluded that there was the possibility of transmission of this infestation through the communal use of water tanks, ponds, and rivers. Burch et al concluded that *T. vaginalis* can be transmitted by fomites, among individuals with a poor concept of hygiene and sanitation after isolating *T. vaginalis* from wet wash cloths of infected women. It is commonplace to have whole families in developing countries use the same bathing apparel. It is not unlikely that *T. vaginalis* can be transmitted within the family this way.

In the case report above, it is believed the three children contracted *T. vaginalis* from their mother, even though the protozoan could not be identified by microscopy in one of them, the vehicle of transmission being either the bathing sponge or towel shared by the family. While it can be presumed that the wife was infected through sexual intercourse by the husband or vice versa, it was impossible to prove that there had been any genital contact between the man and his daughters. Nevertheless, there was absolutely no evidence of sexual abuse and transmission through shared bathing equipment seems the most likely explanation.

Since the presence of a STD in a child has medico-legal implications, when *T. vaginalis* or any other pathogen known to be transmitted sexually is isolated from the vagina of children, the possibility of non sexual transmission through communal use of fomites as above, should be considered.

Y ADU-SARKodie
STD/AIDS Clinic,
Komfo Anokye Teaching Hospital,
Kumasi,
Ghana

Address correspondence: Department of Clinical Sciences, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK.


Accepted for publication 5 September 1994

Asthma in an AIDS patient with Norwegian scabies induced by bathing

Scabies is common among the HIV infected population.1 Patients with advanced HIV disease are at risk of developing the atypical crusted, or Norwegian form of scabies in which the mite burden is extremely high.1 Successful treatment of such patients involves bathing to remove crustated areas in addition to repeated applications of topical scabicides.2

We recently treated a patient with widespread Norwegian scabies and HIV encephalopathy who developed an anaphylactoid reaction to getting into a hot bath on two successive occasions. During the second episode, he became distressed, tachypnoeic and developed expiratory wheezing. He had an oxygen saturation of 79% on air. His systolic blood pressure fell from 110 mm Hg to 70 mm Hg with a heart rate of 140/min. All of the abnormal findings resolved within 30 minutes of his being removed from the bath and being given a salbutamol nebuliser. From then on he was bathed in tepid water until his skin had recovered. He required no further asthma treatment, and was not given corticosteroids at any time. He was not able to use a peak flow meter. There was no personal or family history of previous asthma or atopy.

During the period of his infection, our patient had a marked eosinophilia, peaking at 6×10⁶ ml. His total IgE was markedly raised. Two weeks after successful scabies treatment his eosinophil count had fallen to 0×10⁶ ml and he was able to tolerate hot baths without wheezing or hypotension.

Typical scabies infestation in immunocompetent individuals frequently provokes a TH2 type immune response, with production of IgE and an eosinophilia; such responses are reported to be relatively well preserved, or exaggerated, in HIV infected individuals.4 IgE directed against scabies mite antigens cross reacts with house dust mite antigens.3 Asthma resulting from parasitic infections is well described,5 but has not previously been associated with scabies. Increased antigen absorption following cutaneous vasodilation in response to immersion in hot water may have precipitated our patient’s asthmatic attacks. Scabies infestation may be a predisposing factor for the development of IgE mediated hypersensitivity reactions in patients with AIDS.

E L CORBETT
J CROSSLEY
K M DE COCK
HIV and AIDS unit,
Camden and Islington community health services NHS trust,
The Middlesex Hospital site,
Mortimer Street, WIN 44A, UK


Accepted for publication 23 February 1995. Address correspondence to Dr Corbett

Diagnosis of gonorrhoea by microscopy

Microscopy of Gram stained specimens remains the initial screening test for gonorrhoea, and facilitates early treatment. A recent audit of microscopy has suggested that the sensitivity of this technique is falling,
Letters to the Editor

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The

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limbs,

lymph

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herpes

simplex

virus

were

all

negative.

Gram

stain

of

a

urethral

smear

was

unremarkable.

An

ultrasound

of

the

abdomen

showed

normal

liver

and

pancreas,

and

there

was

no

intra-abdominal

lymphadenopathy.

An

ultrasound

of

the

scrotum

showed

normal

testes

and

epididymis.

On

19 April 1994

biopsy

was

performed,

which

revealed

T

immunoblastic

(high

grade)

lymphoma.

This

case

highlights

the

importance

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keeping

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open

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about

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SM A EL-GADI

G SINGH

R A SPARKS

Department of Genitourinary Medicine,

Cardiff Royal Infirmary,

Newport Road,

Cardiff CF3 1SZ, UK

Accepted for publication 26 January 1995

It could be more serious than you think!

A 25 year old patient presented to this department

on 5 April 1994 with a small lump in the

left inguinal region since December 1993. He

had no other associated symptoms, no history of

trauma to the lower limbs, and no history of

sex abroad.

On examination he had an enlarged (about 2 cm)

very firm, non-tender lymph node in the

left inguinal region. There was no other

associated lymphadenopathy or hepato-

splenomegaly. The rest of the examination

was unremarkable; in particular there were no

lesions found on the lower limbs. Syphilis

serology was negative and cultures for

Neisseria gonorrhoea, Chlamydia trachomatis

and herpes simplex virus were all negative.

Gram stain of a urethral smear was unremarkable.

An ultrasound of the abdomen showed

normal liver and pancreas, and there was no

intra-abdominal lymphadenopathy. An ultra-

sound of the scrotum showed normal testes

and epididymis.

On 19 April 1994 biopsy was performed,

which revealed T immunoblastic (high grade)

lymphoma.

This case highlights the importance of

keeping an open mind about the differential

diagnosis, and considering an urgent biopsy in

an enlarged inguinal lymph node which

cannot be explained by a local identifiable cause.

SARAH EDWARDS

GORDON DOCKERTY

Department of Genitourinary Medicine,

Addenbrooke's NHS Trust, Cambridge CB2 2QQ, UK

1 Evans JK, Mersey DE, French PD, Prince MV. Audit of
diagnosis of gonorrhoea at first visit to a London

genitourinary medicine clinic. Genitourinary Med

Diagnosis of gonorrhoea by microscopy.

S Edwards and G Dockerty

*Genitourin Med* 1995 71: 200-201
doi: 10.1136/sti.71.3.200-a

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