Po paddle and giant molluscum contagiosum

The letter by Kumar and Dawn1 on a case of solitary, giant penile molluscum contagiosum (MVC) merits further comment and clarification. We have observed a cardiac transplant recipient who was therapeutically immunosuppressed, with an recalcitrant facial MVC, some of which are "giant MVC". This clinical entity does exist in non-HIV patients contrary to Kumar and Dawn’s statement. We have just completed a clinical survey [that showed a positive correlation between CDC categories B and C HIV disease and facial MVC, compared with genital lesions in stage CDC A and non-HIV clinic attenders (p < 0.001 Fisher’s exact test) (tabl). The clinical and molecular study by Thompson et al6 also demonstrates the facial predilection of MVC in advanced HIV disease, but not to the exclusion of genital lesions as in Petersen’s study.7 This suggests that genital MVC occurs in HIV infected patients, as a sexually acquired infection early and once established may present in an opportunist form; however, the clinical site manifesting is determined by the degree of immunosuppression.

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Anatomical sites of MVC infection in patients at HIV and GUM clinics

<table>
<thead>
<tr>
<th>Site presentation</th>
<th>Total no. patients</th>
<th>HIV status with MVC</th>
<th>Face</th>
<th>Genital/vulval/limb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>HIV CDC C</td>
<td>12</td>
<td>1(100%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV CDC B</td>
<td>4</td>
<td>0 (0%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CDC A and GUM</td>
<td>3</td>
<td>0 (0%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Presumptive HIV neg</td>
<td>3</td>
<td>0(0%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GUM patients</td>
<td>70</td>
<td>69 (98.57%)</td>
</tr>
</tbody>
</table>

*Cardiac transplant recipient.

Ignored trichomonal infestation diagnosed by Papanicolaou smear

The retrospective study of Petersen et al1 on ignored trichomonal infestation diagnosed by Papanicolaou smear reiterates the value of routine wet-mount phase contrast microscopy as part of the diagnostic screening in the evaluation of women (and men with urethral discharge) who attend an STD clinic.8

A recent audit in our unit evaluating the efficacy of saline wet-mount phase contrast microscopy in the diagnosis of trichomoniais in the period 1992-1994 confirms its continued usefulness as part of the diagnostic triad in screening attenders at a genitourinary medicine (GUM) clinic. Our unit in the north east England region serves a catchment population of about 300,000 residing in the coastal city of Sunderland and its suburbs. As a routine, after obtaining relevant medical, sexual, contraceptive histories and a genital examination, a saline wet-mount smear from the posterior vaginal fornix in women and a urethral scrape from men with urethral discharge were examined by phase contrast microscopy. They were initially scanned at × 100 looking for motile trichomons and then at × 400 to confirm motility and morphology of trichomonads. Samples from the posterior vaginal fornix and urethral discharge were inoculated into commercially available Oxoid Trichomonas Medium (Basingstoke, UK), incubated at 37°C and examined after two days and seven days for motile trichomons. Gram-stained smears were done on vaginal, urethral and cervical sites including cultures for Nesseria gonorhoeae, Gardnerella vaginalis, Candida albicans and Chlamydia trachomatis (ELISA). Serological tests were done for syphilis and hepatitis B surface antigen routinely and for HIV (I and II) antibodies on individuals at high risk. Counseling are counselling. Cervical cytology was done according to the National Health Service Cervical Screening Programme guidelines. We modified the guidelines by screening opportunistically sexually active teenagers—those aged under 20 years, in particular sexual contact(s) of men infected with genital warts.

In the period 1992-1994, 45 cases of trichomoniais were identified (43 women and two men). Of the men; one was a single 24 year old who attended as an asymptomatic contact. Phase contrast microscopy of saline wet-mount urethral scrape showed motile trichomons confirmed by culture. The other was a married 34 year old who attended with a urethral discharge. Clinical examination and microscopic review of Gram-stained urethral smear and two glass urine test provided an initial diagnosis of non-gonococcal urethritis. He was commenced on a dose of 500 mg oxytetracycl on twice a day for two weeks while awaiting his cultural diagnosis. Phase contrast microscopy was not done. Trichomoniais was confirmed from culture. His contact seen elsewhere had confirmed trichomoniais.

The mean age of the 43 women was 22±5 years, range 14-43. Of these women 44±2% (19) were aged under 20 years; 95±3% (41) declared themselves single, separated or divorced, and were sexually active. Of those reported were; oral contraceptive pill 34±10% (23), depo-provera 4±6% (2), intra-uterine coil device 2±1% (1). No form of contraceptive use was reported by 53±4% (23) and 9±3% (4) were pregnant.

The source of referral was: 41±8% (18) were self referred, 30±2% (13) were referred by their GP, 16±7% (7) attended following a provider referral and 11±6% (5) were referred from the Antenatal Clinic or Gynaecology Department.

The reported reason for attendance was; vaginal discharge (43), genital wart infection 16±2% (7) and 9±3% (4) attended requesting only testing for HIV antibodies but agreed to infective screening after counselling. The rest attended for a check-up.

Other STDs identified in the women (sometimes in combination) were Neisseria gonorhoeae in 4±6% (2), Chlamydia trachomatis 18±6% (8), Candida albicans 18±6% (8), genital warts 16±2% (7), Gardnerella vaginalis 6±9% (3), Herpes simplex Type 1 in 2±1% (1). An incidental finding of septic vagina was noted in a 15 year old seen because of genital warts.

In this study, saline wet-mount phase contrast microscopy identified 88±3% (38) of the women and 50±1% (1) of the men in the first attendance, allowing prompt treatment. Subsequent culture identified 95±3% (41) of the women and 50±1% (1) of the men. Opportunistic cervical cytology was done in 14 of the women and trichomoniais was identified only in 75±3% (11) confirmed by culture. Various hypotheses for the decline in incidence of trichomoniais had been made,9 but we believe that routine phase contrast microscopic examination of saline wet-mount vaginal material from the posterior fornix and urethral discharge should remain an essential screening modality for trichomoniais in STD clinics, recognising the failure rate of various culture medium.10 However, direct immunofluorescence with monoclonal antibodies holds promise as a sensitive and specific diagnostic alternative culture system for the rapid detection of Trichomonas vaginalis in clinical specimens.11

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The value of colposcopy in genito-urinary medicine

In view of Griffith’s further comments on colposcopy in genitourinary medicine,1 it seems that a brief final observation may be justified.

The original paper1 was a retrospective report which looks as if it was written in 1966. The paper clearly identified that the colposcopy approach that was being explored was exactly that of the very wide use of the colposcope as practised throughout Germany, Spain, Italy and much of France and South America. Simply magnification of the cervix is considered to be a better way to detect a range of cervical diseases. This includes infectious and inflammatory conditions. Clearly this broad approach was
Polypoidal and giant molluscum contagiosum.

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