LETTERS TO THE EDITOR

Labial adhesions following severe primary genital herpes

EDITOR,—Labial adhesions following genital herpes infection have been described previously. 1 To prevent their development various suggestions such as the use of early aciclovir, 2 paraffin gauze, 3 and saline bathing 4 have been put forward. We believe nursing care is a significant factor in the prevention of this complication. Here we report two cases of severe genital herpes presenting at different sites, almost at the same time, both necessitating admission and developing labial adhesions.

CASE 1
A 25 year old woman was admitted to the medical ward with severe vulval ulceration, generalised skin rash, and difficulty in micturition of 4 days’ duration. Clinical examination revealed target lesions, swollen labia, bilaterally enlarged tender inguinal lymphadenopathy with extensive vulval ulcerations. A clinical diagnosis of erythema multiforme suggested admission and developing labial adhesions.

The bands were seen on palpation of the vulva, and new herpetic lesions (fig 1). She was prescribed oral valaciclovir, metronidazole, and lignocaine gel and advised to continue salt and water bathing at home. A follow up appointment was arranged for release of adhesions. Surprisingly, separation of adhesions was not needed.

COMMENT
These two cases illustrate that females with severe genital herpes can be admitted to different hospital departments other than genitourinary medicine, where the nursing staff may not be familiar with the management and complications of this infection. Patients should be encouraged to separate the labial folds; this can be facilitated by the liberal use of local anaesthetic agents with the assistance of the nursing staff. Frequent saline bathing of the genitalia should be encouraged to facilitate the removal of the fibrinous exudate, which is responsible for the formation of these adhesions.

GUM nurses and physicians should play an active part in the education and nursing care of such cases and lead the management especially when admitted to other specialties.

Contributors: EH managed case 1, JD managed case 2, while both authors wrote the manuscript.

E HERIEKA
Department of Genitourinary Medicine, Leicester Royal Infirmary

J DHAR
Department of Genitourinary Medicine, Derbyshire Royal Infirmary

Correspondence to: E Herieka, Department of GUM, Leicester Royal Infirmary, Leicester LE1 5WW, UK


Disseminated cryptococcal infection has a >80% mortality when associated with respiratory failure.1 Cutaneous lesions occur in 5–10% of cases. These include subcutaneous nodules, ulcers, and cellulitis. These may mimic pyoderma gangrenosum, Kaposi's sarcoma, and Molluscum contagiosum. Clinically, cryptococcal disease may be distinguished from Molluscum contagiosum by a more acute onset of numerous papules, which often have a central haemorrhagic crust.1

Our patient was unwell and had skin lesions that were too extensive for simple Molluscum contagiosum. While Pneumocystis carinii remains the commonest cause of severe respiratory disease in HIV infected individuals not on chemoprophylaxis, pleural effusions are rare in this condition. CMV would be unlikely to produce such acute systemic illness by itself. Hence, cryptococcal disease was a reasonable working diagnosis that required urgent treatment. A recent report has highlighted diagnostic delay as a major factor contributing to its high associated mortality. The CRAG test provides a rapid method of confirming the diagnosis of cryptococcosis.1 It will be positive in blood in infected individuals in up to 95% of cases. The result can then be verified on culture of infected blood samples.

We recommend early consideration of disseminated cryptococcosis in HIV positive patients with respiratory features suggestive of pneumonia or pleural effusion and atypical skin lesions. The use of rapid diagnostic tests may help to improve the poor outcome in this patient population.

PATIENT HISTORY

A 19 year old man presented with 2 day history of extensive painful pustular eruptions of the hands, forearms, and chest. He also felt unwell and had fever. Fingers were stiff and could not be fully extended. He was seen in the local accident and emergency department and prescribed flucloxacillin. On direct questioning he admitted that his illness started with painful penile ulcers followed 2 days later by a lacerated crops of blisters, which then became infected. Ten days before this he had unprotected sexual intercourse with a casual female friend in Ibiza. He had extensive atopic eczema during childhood, which is well controlled now but has been getting hay fever for the past few years.

Examination revealed symmetrical pustular eruptions on the hands, wrists, forearms, lower legs and chest, and a few vesicular eruptions on the hands typical of herpes. He also had multiple superficial penile ulcers. Axillary and inguinal lymph nodes were enlarged. There was also evidence of generalised eczema. Herpes simplex was isolated from the penile ulcers. Screening for other STIs and HIV was negative. He was treated with aciclovir 200 mg five times a day for 5 days with very good response. Two months later he presented to us with a similar episode that required treatment with aciclovir. Since then he has been seen on two occasions with recurrence in the past year, but the attacks were more localised to his hands and external genitalia (fig 1).

Eczema herpeticum is classically a disseminated herpes simplex infection of the skin occurring in patients with pre-existing active dermatitis. The infection may arise from minor transient to a fulminating fatal disorder involving the visceral organs.1,2 The severity appears to be unrelated to the extent of cutaneous lesions. Active dermatitis is not necessary for the development of recurrent eczema herpeticum.

Atopic dermatitis typically begins in early infancy, and individuals with this disease frequently develop other atopic manifestations later in life such as hay fever, allergic rhinitis, and bronchial asthma.3 Eczema herpeticum has also been associated with seborrhoeic dermatitis, neurodermatitis, Darier's disease, pemphigus, molluscum contagiosum, lichen planus, and kerato-acanthoma.3,4 Eczema herpeticum is now being seen with increasing frequency in adults and herpes simplex infection should be considered in the differential diagnosis of vesicular skin lesions occurring in atopic patients.

V HARIINDRA
Department of Genitourinary Medicine, St Mary's Hospital, Milton Road, Portsmouth PO3 4AD, UK

Correspondence to: Dr Harindra


Accepted for publication 14 November 2000

Pooling urine samples for PCR screening of Chlamydia trachomatis infection in women

EDITOR,—Selective or universal screening for Chlamydia trachomatis infections has been suggested by the World Health Organization as a primary prevention strategy.1 The improved sensitivity of the nucleic acid amplification assays for the detection of C trachomatis allows the use of urine samples, suitable for screening programmes. However, these commercial assays are expensive, which makes them disadvantageous for this purpose.

Therefore, some authors have recently evaluated the accuracy and cost saving of different urine pooling strategies using polymerase chain reaction (PCR) and ligase chain reaction (LCR) tests for the screening for genital C trachomatis infections, reporting encouraging results.2,3 As the pooling strategies need individual testing of each component of a positive pool, in order to identify the positive samples the cost saving inherent to these strategies and pool size dependent. For this reason, pooling may be particularly suitable when applied to low prevalence populations. On the other hand, a high number of urine samples per pool may yield a decreased sensitivity because of the dilution effect associated with pooling. Peeling et al and Kacena et al have put forward a mathematical formula to estimate the number of pools that are likely to be positive given a selected pool size and population disease prevalence.3,4 Thus, it is possible to estimate the reduction on the number of tests required for a pooling strategy compared with individual testing. The objective of this study was to evaluate a pooling urine samples strategy for screening urogenital chlamydial infection by PCR testing.

In all, 330 processed first catch urine samples (FCU) from women attending general practice clinics in Lisbon (from August 1999 to February 2000) were pooled by five into 66 pools. Pools and individual specimens were simultaneously tested using the Amplicor PCR test, according to the manufacturer's

Accepted for publication 14 November 2000

Emergence of high level ciprofloxacin resistant Neisseria gonorrhoeae strain in Buenos Aires, Argentina

Editor,—The surveillance programme of Neisseria gonorrhoeae (NG) antimicrobial susceptibility patterns was implemented in 1980 in the National Reference Centre for STI (NRC). Twenty nine peripheral STI laboratories belonging to the National Network of Argentinia, distributed throughout the country, routinely send isolates to the NRC for typing, susceptibility testing, and plasmid characterisation.

The NRC was incorporated into the WHO Gonococcal Antimicrobial Susceptibility Program in Buenos Aires city and was the Caribbean in 1993 and since then the methodology has been standardised.

From January 1993 to June 2000, the NRC determined the MICs of 1194 NG strains by the agar dilution method with the media, conditions, and controls as recommended by the NCCLS.1 Ciprofloxaxin range, MIC<sub>50</sub>, and MIC<sub>90</sub> were 0.002–0.004, and 0.016 µg/ml, respectively. 

Only one NG strain, detected in 1996, showed a decrease susceptibility to ciprofloxacin. The isolate was submitted by a public hospital from Buenos Aires city. The strain was β lactamase negative by nitrocefin discs and the MICs were penicillin 0.5 µg/ml, tetracycline 4 µg/ml, ciprofloxacin 0.125 µg/ml, spectinomycin 32 µg/ml, ceftriaxone 0.004 µg/ml, and azithromycin 0.25 µg/ml. The auxotype/serogroup class was proline requiring/WII-III.

In May 2000 the first NG strain with high level quinolone resistance (QRNG) was isolated. This strain was isolated in a private medical centre in Buenos Aires city and was submitted to the NRC; no inhibition zone was observed with a 5 µg ciprofloxacin disc.

CASE REPORT

The patient was a heterosexual man, aged 34 years, married, not a drug user, and he hadn’t travelled abroad during the past year. However, he admitted to having had sexual intercourse with a commercial sex worker, 4 days before the onset of the symptoms. He presented with a purulent acute urethritis with dysuria and was treated with a parenteral dose of ceftriaxone 500 mg and a week’s course of doxycycline. The patient became asymptomatic 36 hours after the start of the treatment. Serological tests for VDRL, HIV, and hepatitis B and C were negative.

The strain was β lactamase negative and exhibited high level ciprofloxacin resistance (MIC 16 µg/ml) and low level tetracycline resistance (MIC 4 µg/ml) and was susceptible to the other antibiotics assayed. The MICs were penicillin 1 µg/ml, spectinomycin 32 µg/ml, ceftriaxone 0.004 µg/ml, and azithromycin 0.25 µg/ml. Phenotyping demonstrated a proline requiring auxotype and a WII/III serotype.

Both NG strains mentioned above displayed the same phenotypic characteristics: MICs (except for ciprofloxacin), auxotype, and serogroup. 

Pulse gel field electrophoresis (PFGE) was performed with Nhel and SpeI. There was no relation between the PFGE patterns of the two strains and neither showed genomic similarities to four other ciprofloxacin resistant NG isolates belonging to the auxotype/serogroup class Pro/WII-III isolated in Buenos Aires at the same time. 

The epidemiological data and laboratory characterisation of this high level quinolone resistant strain suggest it might have a foreign origin.

According to the literature reviewed no QRNG strain with high level quinolone resistance was reported in Latin-American countries. We report here what we believe to be the first isolation of a strain with high level resistance to ciprofloxacin in Argentina. Owing to the large scale use of quinolones in our country, where antibiotic use is difficult to control, a substantial increase of QRNG might be expected in the near future. If dissemination occurs, current first line therapy, a single 500 mg dose of ciprofloxacin, should be reviewed.*
developed small papular lesions on the glans penis. Lesions enlarged rapidly and started eroding the undersurface of the prepuce. Finally, 3 months later, the prepuce was perforated. Examination revealed a large, circular defect on the dorsal aspect of the prepuce through which multiple papulonodular, warty lesions were visible (fig 1). Warty lesions were also visible all around the prepuce: a common end point of severe ulcerative disease.

Out of the 10 patients reported/published, 5 had perforation of the dorsal surface of prepuce: a common end point of severe ulcerative disease involving genitalia. Maite and Hay 3 earlier reported a patient with genital warts treated with podophyllin, who presented later with perforation of the dorsal surface of prepuce. They considered it as delayed podophyllin damage. Our patient had not been treated before with podophyllin. The identical presentation in our and the reported patient suggests that warts themselves and not podophyllin are responsible for perforation. Condylomas particularly in immunocompromised individuals may attain a very large size and rarely become locally invasive and destructive. 4 In our patient, however, condylomas were not very large and there was no evidence of immunosuppression.

Our patient had condylomas all over the glans, but perforation took place only on the dorsum of the prepuce, confirming that this site is more susceptible to this complication.

Incidentally, two more patients with perforation on the dorsal surface of the prepuce as a complication of chancroid and genital herpes have been depicted in A colour atlas of AIDS in the tropics. 5 Both patients were HIV seropositive. This suggests that this complication is not uncommon (though underreported), more so in tropics. HIV infection by altering the course and severity of genital lesions of sexually transmitted diseases probably makes this complication more frequent. Out of the 10 patients reported/published, half were HIV seropositive.

Urine proves a poor specimen for culture of Trichomonas vaginalis in women

EDITOR,—Trichomonas vaginalis infection occurs worldwide with an incidence of over 200 million infections. Clinical disease in women ranges from asymptomatic to severe vaginitis, and has been associated with preterm delivery 1 and an increased rate of HIV-1 transmission. 2 The magnitudes of T vaginalis associated morbidity, including risk of HIV-1 transmission, makes simple accurate diagnosis important especially in at-risk populations. Microscopic examination of a wet mount vaginal specimen is easy to perform but only identifies 40–60% of infections in comparison with culture. The In-pouch culture system (Biomed Inc, San Jose, CA, USA) is reported to be equally sensitive yet more practical than traditional culturing methods. 6 We have described a proved sensitive, culturing of urine from female patients for T vaginalis might prove useful in population based screening programmes, field investigations, or individual circumstances when a patient might not want a genital examination. Therefore, we set out to determine the sensitivity of culturing urine from women in comparison with a self collected vaginal swab for identification of T vaginalis.

We recruited subjects from a randomised community study that investigated the prevalence of sexually transmitted infections in women with and without access to female condoms. 7 In this particular substudy we obtained specimens from participants in two study sites. Participants were instructed by one of the study nurses how to obtain a self collected vaginal swab and at the same time collect urine. Women were asked not to clean the genital area before providing both specimens. Immediately after collection the vaginal swab was inoculated into the In-pouch and urine was stored at 4°C for up to 10 minutes. After the supernatant was discarded, the sediment was agitated and pipetted directly into the In-pouch. Specimens were shipped at room temperature to the University of Nairobi and incubated at 37°C for up to 5 days according to manufacturer's instructions. Daily microscopic examination was performed for identification of T vaginalis. Random specimen coding ensured that laboratory staff remained blind to specimen source and pairing.

We recruited 675 women for this substudy. T vaginalis was detected by culture in 121 (17.9%) women per self collected swab and 23 (3.4%) women per centrifuged urine. In comparison with culture of self collected swab, culture of centrifuged urine yielded a sensitivity of only 17% and a specificity of 99.6% (table 1). We originally intended to recruit over 2000 women into the study, but discontinued recruitment when preliminary results clearly demonstrated the inadequacy of urine for culturing T vaginalis in women.

In this large scale community study we found culture of centrifuged urine very insensitive for identification of trichomonads in women. Since only 5–10 organisms in a sample are necessary for a positive culture, these findings were unexpected. We cannot fully explain why culture of urine for T vaginalis in women proved so poor. Because of contamination of the external genitalia with vaginal fluid, a first void urine specimen might have proved a better sample.
BOOK REVIEWS


It is 6 years since the first edition of this book and the expansion in knowledge about lower genital tract precancer has been reflected in the addition of an assistant and a contributing author, as well as an increase in the number of pages (from 254 in the first edition to 323 in the present one).

The extra input and space has been used to maximal effect with the book losing none of its attractions of appearance, content, and even texture by its use of high quality paper.

The addition of a chapter on the role of human papilloma virus in lower genital tract neoplasia makes the book more rounded. This chapter is comprehensive as well as excellently presented and very up to date. I appreciated the section on the role of oncogenic HPV detection in the prevention of lower genital tract precancer, although this naturally concerned CIN rather than VIN or VaIN.

I would have preferred chapter 5 (Cytology and screening for cervical precancer) to follow chapter 2 (HPV in the pathogenesis of lower genital tract neoplasia) and then the more practical aspects of colposcopy itself would not be interposed. This is a small criticism of an otherwise comprehensive and logical content.

The chapter on the management of cervical precancer is a delight to read and see, with the section devoted to HIV positive women reflecting most shades of reliable opinion in this developing field. HIV is again included in the chapter on VIN.

GU colposcopy will be particularly interested in the final chapters on infective conditions causing confusion in diagnosis of lower genital tract precancer. It is easy to quibble with some of the statements of management of the infections noted (cervical warts do not even merit a mention of treatment) but that is not the remit of the book.

The illustrations are gorgeous throughout and the line drawings are used to very good effect. The overabundance book critic might mention the data left on some colposcopic photographs, the venerable laser machine showed on page 171 and whether the speculum is correctly placed on page 36, but not me.

This is a “must buy.” It’s a big book (in size, content, and price) which should form the nucleus of the colposcopist’s library.

D A HICKS
Royal Hallamshire Hospital, Department of Genitourinary Medicine, Glossop Road, Sheffield S10 2JF


Considering we inquire about or promote the use of condoms with each and every patient we see in GU/HIV clinics, it’s extraordinary how little we know about them. “Penis protectors” have come a long way since they were used in battle, cast to size, and made from goat bladder, although “natural” condoms can still be obtained today from the caeca of New Zealand lambs. Thanks to Charles Goodyear, the birth control movement, and the HIV epidemic the condom has enjoyed a renaissance and with more strin-
 Topics in International Health: HIV/AIDS. £30 for individuals, £20 or £45 for institutions in developing countries, and £120 for “first world” institutions, post inclusive with a 30 day money back guarantee. CD-Roms are not Apple Mac compatible. Oxon: CABI Publishing, 2000.

So the clinic’s not going well—you’ve too many patients and four students have all rolled up at once. Trouble is, they are all beginners at condom forms, and hanging around the corridor is not going to be great for departmental kudos in the medical school teaching stashes. CD-Roms are now the standard fall back for a loose half hour—and this one is definitely the way to get top ratings. It is superbly designed with a host of easy features. Technically there were no problems with installation, and the package ran happily on a Pentium 100 with limited memory, which is welcome when the latest PCs remain out of reach to most in the NHS or in resource-poor countries.

The CD-Rom covers the whole of HIV/AIDS from testing through opportunistic disease to the psychosocial and community impact of the unfolding epidemic. The well crafted material is grouped into 11 tutorials with 50-odd pages each, broken up with well designed interactive quizzes to aid factual recall, such as matching HIV prevalence to world region by dragging numbers across a map. In the best educational fashion, wrong answers are met with a gentle reminder of the right answer and an offer to review the section again. A glossary is just a click away should a word be unclear, and a full reference list is hidden on each page for those wanting to explore more. A separate section allows incredibly flexible searching of a rich international collection of over 700 images by keyword or text. These can then be viewed as thumbnails for rapid tag, tagged for later printing, or saved in a personalised teaching set. Snatching the illustrations on my own 35 mm slides proved beyond my hacking ability, but I wanted to shows just how good the pictures are.

Improvements for the next edition might include creating the references with Medline abstracts (for example, offering searches for other works on the subject of interest or finding works which cite the article in question), and including more video material such as interviews with key players in the field.

On a deeper level, such an international approach to teaching HIV/AIDS fits well with the emphasis of the recent international AIDS conference on the whole HIV epidemic, not just the treatment options open to those affected by HIV in resource-rich countries. The sections on treatment reflecting mainly resource rich practices sit uneasily with the pictures of AIDS orphans and underfunded African hospitals. That this CD-Rom left me feeling uncomfortable about the structural inequity of the world is testament to the vision of its creators.

GILL DEAN
The Lawson Unit, Royal Sussex County Hospital, Eastern Road, Brighton BN2 5BE

NOTICES

International Herpes Alliance and International Herpes Management Forum
The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, regional office of the World Health Organization
A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@asp.sheridan.com).

International Symposium on Disorders of the Prostate, 21–23 March 2001, Castres, France
Further details: Dr Mike Briley, Scientific Director, Pierre Fabre Medicament, Parc Industriel de la Chartreuse, F-81106 Castres Cedex, France (tel: +33 563 714 501; fax: +33 563 725; email: briley@pierre-fabre.imagenet.fr).

Call for papers—6th European Forum on Quality Improvement in Health Care, 29–31 March 2001, Bologna, Italy
Further details: BMA/BMJ Conference Unit, BMA House, Tavistock Square, London WC1H 9JP, UK (tel: +44 (0) 20 7383 6409; fax: +44 (0) 20 7383 6666; email: quality@bma.org.uk; website: www.quality.bmj.com).

Joachim Kuhlmann AIDS award 2001
The Joachim Kuhlmann AIDS Foundation, Essen, Germany, is awarding the above mentioned prize to investigators in the field of clinical and scientific HIV work. The prize is valued at 50 000 DM. Papers that have been published in 2000 or are accepted for publication can be submitted to the foundation for anonymous review. The submitted papers must be received by 31 March 2001. The award will be presented to the winner as part of the 8th German AIDS Congress in Berlin.

Submissions should contain seven copies of the paper and should be send to: Joachim Kuhlmann AIDS Foundation, Birkenstrasse 55, 45128 Essen, Germany.

Each of the submitted papers should contain a running title and may not indicate the names of the authors. An additional envelope should contain the running title on the outside and information in the inside as follows: first name, last name, date of birth, address, professional position, as well as the running title and the complete title of the submitted paper.

Further details: ECEAR 2001 Conference Secretary, Division of Retrovirology, NIBSC, Blanche Lane, South Mimms, Potters Bar, Herts, EN6 3QG, UK.

International Congress of Sexually Transmitted Infections, 24–27 June 2001, Berlin, Germany
Further details: Congress Partner GmbH, Krausenstrasse 63, D-10117, Berlin, Germany (tel: +49-30-204 500 41; fax: +49-30-204 500 42; email: berlin@cpb.de).

10th International Congress on Behçet’s Disease will be held in Berlin 27–29 June 2002
Further details: Professor Ch Zoubbous (email: zoubbous@zedat.fu-berlin.de).

20th World Congress of Dermatology, Paris, 1–5 July 2002
Further details: F Pournier, Colloquium, 12 rue de la Croix St Faubin, 75011 Paris, France (tel: +33 1 44 64 15 15; fax: +33 1 44 64 15 16; email: f.pournier@colloquium.fr; website: www.derm-wcd-2002.com).
Labial adhesions following severe primary genital herpes: Sex Transm Inf 2001;77:75–80

E Herieka and J Dhar

Sex Transm Infect 2001 77: 75
doi: 10.1136/sti.77.1.75

Updated information and services can be found at:
http://sti.bmj.com/content/77/1/75.1

These include:

References
This article cites 3 articles, 0 of which you can access for free at:
http://sti.bmj.com/content/77/1/75.1#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/