Labial adhesions following severe primary genital herpes

EDITOR,—Labial adhesions following genital herpes infection have been described previously. To prevent their development various suggestions such as the use of early aciclovir, paraffin gauze, and saline bathing 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 secondary to herpes simplex virus (HSV) was made. However, swabs taken at admission for HSV culture were negative. The patient was commenced on oral aciclovir and metronidazole and advised to use topical lignocaine gel, she admitted, however, to being afraid to touch her genitalia. The patient made a slow recovery and was allowed home following 8 days in hospital. At follow up (GUM) 2 weeks later, she presented with a history of her abnormal urinary stream “urine splashing all over the place.” Examination of the external genitalia revealed two bands of adhesions between the labia minora. The bands were separated using a knife after infiltration with saline. The bands were cut and 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.

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

LETTERS TO THE EDITOR

Figure 1: Thick band of adhesions between the middle halves of labia minora.
Disseminated cryptococcal infection has a >80% mortality when associated with respiratory failure. Recurrent 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.

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. 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 individuals in up to 95% of cases. The testing of a representative number of respiratory specimens to screen for other STIs and herpes simplex infections has been suggested by the World Health Organization as a primary prevention strategy.1

Eczema herpeticum is classically a disseminated herpes simplex infection of the skin occurring in patients with pre-existing active dermatitis. The immune system response to infec-

CASE REPORT

A 19 year old man presented with 2 day his-
tory 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 flucloxicillin. On direct questioning he admitted that his illness started with painful penile ulcers followed 2 days later by tender localised 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, wrist, 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 and prescribed flucloxicillin. On direct questioning the patient admitted that his illness started with a more acute episode that required urgent treatment. 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 immune system response to infection is responsible for the development of recurrent eczema herpeticum. Atopic dermatitis typically begins in early infancy, and individuals with this disease frequently develop other atopic manifestations in later life such as hay fever, allergic rhinitis, and bronchial asthma. Eczema herpeticum has also been associated with seborrheic dermatitis, neurodermatitis, Darier’s disease, pemphigus, mycosis fungoides, Wiskott– Aldrich disease, congenital ichthyosiform erythroderma,3 and second degree burns.4 The presentation in our patient is fairly typical, lesions appearing in crops initially as tiny vesicles passing through pustular and crusted phases associated with systemic symptoms. This condition is often missed, because the lesions are usually scratched and blistering is lost leaving raw punched out areas often with secondary infection. Diagnosis is based on patient history of atopic disease, presence of vesicular lesion, the striking tendency for the lesions to return to the same areas of the skin, and a positive result of viral culture for herpes simplex.

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 HARINDRA
MAURICE C PAFFRETT
Department of General Practice, St Mary’s Hospital, Milton Road, Portsmouth PO3 6DJ, UK
Correspondence to: Dr Harindra


Accepted for publication 14 November 2000

Pooling urine samples for PCR screening of C trachomatis urogenital infection in women

Michael Lipman, FCOG, FACOG, FRCOG, FANZCOG
Department of Reproductive Medicine, Royal Free Hospital, London NW3 2QG, UK

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 make 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 very encouraging results.1 2 As the pooling strategies need individual retesting of each component of a positive pool, in order to identify the positive samples the cost saving inherent to these strategies is 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 subsequently tested using the Amplicor PCR test, according to the manufacturer’s
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 Argentina, distributed throughout the country, routinely sent their isolates to the NRC for typing, susceptibility testing, and plasmid characterisation.

The NRC was incorporated into the WHO Gonococcal Antimicrobial Susceptibility Profiling Programmes (GASP) in 1993 and since then the methodology has been standardised.

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 0.04 µg/ml, and azithromycin 0.25 µg/ml. The auxotype/serogroup class² was prone 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.

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 had admitted to having sexual intercourse with a commercial sex worker, 4 days before the onset of the symptoms. He presented with a purulent acute urethritis 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 0.04 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.

There was no relation between the PGFE patterns of the two strains and neither showed genomic similarities to four other ciprofloxacin susceptible NG isolates belonging to the auxotype/serogroup class Pr0/WII-III isolated in Buenos Aires at the same time.

The epidemiological data and laboratory characteristics 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.*

S FIORRITO
P GALARZA
C OVIDO
National Reference Center for STI, National Institute of Infectious Diseases, Buenos Aires, Argentina

A LANZA
J SHAYEKI
Center for Medical Investigation (CEMIC), Buenos Aires, Argentina

G WELTMAN
Bioclinic Laboratories, Buenos Aires, Argentina

L BUSCEMI
Dr F J Musich Hospital, Buenos Aires, Argentina

E SANFAN
San Luis Medical Center, Buenos Aires, Argentina

Correspondence to: Susana Fioritto, MD, National Reference Center for STI, National Institute of Infectious Diseases, Av Velez Sarsfield 563 (CP 1281) Buenos Aires, Argentina

smfiorito@yahoo.com.ar


Correspondence to: João Paulo Gomes, Centro de Bacteriologia, Instituto Nacional de Saúde, Av Padre Cruz, 1649-016, Lisboa, Portugal

Table 1 Distribution of positive samples

<table>
<thead>
<tr>
<th></th>
<th>“+” Pools</th>
<th>Equivocal (12) pools (4)</th>
<th>“−” Pools</th>
</tr>
</thead>
<tbody>
<tr>
<td>a “+” Samples</td>
<td>13</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>b (17)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Confirmed as positive pools.


Accepted for publication 14 November 2000

Dorsal perforation of prepuce due to locally erosive condylomata acuminata

EDITOR,—We recently reported five patients with sexually/non-sexually transmitted ulcerative diseases complicated by perforation on the dorsal surface of the prepuce. We could find reports of only three similar cases in the indexed literature. During screening of our STD clinic files we found record of another patient with dorsal perforation of the prepuce; however, it was not due to genital ulcer disease, but to condylomata acuminata. This patient, a 22 year old man had unprotected sexual intercourse with a commercial sex worker about 6 months before reporting to our STD clinic in January 1994. About 1 month after sexual contact, he...
Warty lesions were visible (fig 1). Warty through which multiple papulonodular, lar defect on the dorsal aspect of the prepuce forated. Examination revealed a large, circu-
eroding the undersurface of the prepuce. Developed small papular lesions on the glans lesions are visible.

Preputial perforation had ulcerative diseases. Warty lesions showed features consistent with eration on the dorsal surface of the prepuce as site is more susceptible to this complication. Glans, but perforation took place only on the clinical disease in women ranges from asymptomatic to severe vaginitis, and has been associated with preterm delivery and an increased rate of HIV-1 transmission. The magnitude of T vaginalis associated morbidity, including risk of HIV-1 transmis-
tion, makes simple accurate diagnosis impor-
tant especially in at-risk populations. Micro-
scopic examination of a wet mount vaginal specimen is easy to perform but only identifies 40–60% of infections in compari-
son to culture. The In-pouch culture system (Biomed Inc, San Jose, CA, USA) is reported to be equally sensitive yet more practical than traditional culture methods. It is a proved sensi-
tive, culturing of urine from female patients for T vaginalis might prove useful in popula-
tion based screening programmes, field inves-
tigations, or individual circumstances when a patient might not want a genital examination. Therefore, we set out to determine the sensi-
tivity of culturing urine from women in com-
parison with a self collected vaginal swab for identification of T vaginalis.

We recruited subjects from a randomised community study that investigated the preva-
lence of sexually transmitted infections in women with and without access to female condoms. 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 told not to clean the genital area before providing both speci-
mens. Immediately after collection the vagi-
nal swab was inoculated into the In-pouch and urine sample was kept at 37°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 instruc-
tions. 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 673 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 trichomons 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 vagi-
nalis 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.

It is 6 years since the first edition of this book and the expansion in knowledge about lower genital tract precancer reflected in this 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 interrupted. 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 condylomata 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 added to very good effect. The overabundant book critic might mention the data left on some colposcopic photographs, the venerable laser machine shown 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


I liked this book. An alternative title could be “An evidence based guide to prevention, diagnosis, and treatment of congenital and perinatal infection.” The editors, both recognised experts in perinatal infection, persuaded an international panel to provide up to date reviews of particular perinatal infections with key references up to 1999/2000. Despite clearly a short production time an inevitable weakness is that new data have become available after going to press. To keep costs down there are few illustrations and a lot of text. However, tables are widely used and the text is well broken up. One third of the book is devoted to references so all the text is strongly evidence based, and statements are not based on authors’ opinion but on published literature.

There is an excellent introduction on the interaction between pregnancy and infection and a thorough discussion on maternal infections and their consequences. This section ends with a review of the pitfalls and benefits of screening for antenatal infections including an excellent summary of potential biases involved in setting up and evaluating screening programmes.

The second section is a traditional whizz through the standard common infections in pregnancy. Highlights include Malm’s excellent chapter on herpes simplex infection, and Mandelbrot and Newell’s thorough review of vertical transmission of hepatitis viruses. I was disappointed to see no detailed discussion of HIV+ infection or more detailed review of the role of perinatal infections in cerebral palsy.

Two other criticisms could be a relative lack of assessments of cost effectiveness of screening programmes already in place and for the future. The introduction of new screening programmes and the retention of existing screening programmes—for example, syphilis and rubella, need to be increasingly driven by cost-benefit analysis. It would also be interesting to have had some speculation about why different infections have such different vertical transmission rates and have their impact at different stages of pregnancy.

Overall, the strength of this book lies in its literature reviews. It is an extremely good summary of where we are at with perinatal infections in the year 2000. Who will find it useful? It is a postgraduate text, too detailed for undergraduates. It should be compulsory reading for obstetricians in training. I would recommend it to perinatologists, obstetricians and genitourinary medicine physicians. It is a practical text with dosages, immunisation schedules, and treatment algorithms. It is reasonably priced. There are larger textbooks on perinatal infections costing £200, so this fills a gap in the market. Buy it and you won’t be disappointed.

M SHARLAND
Department of Paediatrics, St George’s Hospital, London SW17


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-
gent quality control and legal standards, has become a life saving device. The chapter on latex condom manufacture was fascinating and gives almost enough detail to allow you to try it at home!

Each year 8–10 billion condoms are used worldwide although an estimated 15 billion are required to protect adequately against HIV/STDs. The chapter outlining the effectiveness of condoms in preventing STIs was clearly set out with an excellent summary table outlining data and references. There was a fascinating chapter on how the commercial sector has risen to the challenge of global condom distribution through social marketing. By using pre-existing infrastructure, supplies to Africa have increased from 45.8 million in 1987 to 264.5 million in 1990. In Thailand by targeting commercial sex workers through “the 100% condom programme” usage rates have increased from 14% in 1982–9 to 93% in 1993 with STI cases in government clinics dropping from 237,000 to 39,000. In the chapter on condoms and commercial sex there was a fabulous table summarising different condom usage rates by CSWs in developing countries.

The condom should probably receive more credit as a contraceptive device. Failure rates diminish with increasing experience and it may be a suitable long term option for some women who combined with knowledge of fertile days and progesterone only emergency contraception. There were interesting discussions on the use of condoms for anal sex, the pros and cons of non-latex condoms, female condoms (becoming increasingly popular, especially in Zimbabwe), and recent developments in spermicides and viricides.

In summary, condoms are highly effective, cheap, and largely free of side effects. This book left me with a renewed belief that they should be promoted at every opportunity and given almost enough detail to allow you to try it at home!

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.

TheJoachim Kuhlmann AIDS Foundation, Essen, Germany, is awarding the abovementioned 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.


Further details: ECEAR 2001 Conference Secretary, Division of Retrovirology, NBISC, 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 Behcet’s Disease will be held in Berlin 27–29 June 2001

Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de).

20th World Congress of Dermatology, Paris, 1–5 July 2002

Further details: P Fournier, 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: p.fournier@colloquium.fr; website: www.derm-wcd-2002.com).
Sexually transmitted infections and risk behaviours in women who have sex with women
L Semple

*Sex Transm Infect* 2001 77: 79
doi: 10.1136/sti.77.1.79-a

Updated information and services can be found at:
http://sti.bmj.com/content/77/1/79.2

These include:

**References**
This article cites 1 articles, 1 of which you can access for free at:
http://sti.bmj.com/content/77/1/79.2#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/