LETTERS TO THE EDITOR

Methicillin resistant Staphylococcus aureus (MRSA) balanoposthitis in an insulin dependent diabetic male

EDITOR,—Balanoposthitis is a common condition affecting 11% of the male attendees at GUM clinics.1 It is an inflammation of the glans penis and the prepuce, and its causes include bacterial and yeast infections, parasitic infestations, trauma, and irritants.2 However, to our knowledge, no case has been reported to be caused by MRSA.

A 49 year old insulin dependent diabetic man who was an inpatient for repair of a upper jaw fracture developed a penile itch with swollen foreskin, which was difficult to retract, together with longitudinal fissures on the prepuce and subpreputial discharge. In his recent past he had had two incidents of unprotected sexual intercourse with two known females. He was clinically diagnosed as having candida balanitis and was commenced on clotrimazole cream, which did not produce a clinical response over the course of a week. The swabs taken before the commencement of clotrimazole cream failed to grow candida; however, MRSA resistant to erythromycin, penicillin, and flucloxacillin but sensitive to mupirocin was isolated.

Screening tests for chlamydia, gonorrhoea, and trichomonas were negative. A 10 day course of mupirocin 2% ointment completely resolved his symptoms.

Subpreputial swab after treatment was negative.

MRSA has been a well recognised cause of hospital acquired infections worldwide since it was first detected in Europe in the 1960s.3 The organism can survive for long periods in both the hospital and the home environment and can colonise the skin, nose, or throat of both the hospital and the home environment completely resolved his symptoms.

Contributors: Both authors managed the patient and wrote the manuscript.

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Chlamydia trachomatis reinfection rate: a forgotten aspect of female genital chlamydial management

EDITOR,—Hillis et al1 reported that repeated episodes of infection of female genital tract with Chlamydia trachomatis increase the risk of hospital admission for pelvic inflammatory disease and ectopic pregnancy. The first diagnosed attack of genital infection with chlamydia presents the clinician with a unique opportunity to implement measures to minimise the risk of reinfection—that is, health promotion and contact tracing.

During April-June 1998 we reviewed the case notes of female patients who were diagnosed with genital chlamydia at Leicester Royal Infirmary and Derbyshire Royal Infirmary GUM clinics in the year 1996 for evidence of repeat episode of genital chlamydia. We also noted the following data: age at presentation with the first episode of infection, time for presentation with reinfection, test of cure if performed, co-infection with gonorrhoea, review by health adviser, contact tracing, and analysed the data.

We believe it is time to evaluate outcome measures in terms of reinfection rates. Large prospective studies need to be done to elucidate this aspect of chlamydial infection management.

Contributions: PS had the original idea; EH collected and analysed the data and wrote the manuscript.

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Accepted for publication 8 March 2001

The Society of Apothecaries Diploma examination in Genitourinary Medicine: death of the viva voce?

EDITOR,—The London Apothecaries Diploma in Genitourinary Medicine is likely to become even more important in the near future as all specialist registrars and probably
A pilot study was conducted to compare the sensitivity of LCR testing for genital chlamydial infection in men, taken from the meatus itself against the standard technique. All male patients attending the GUM clinic over a 3 month period were included in the study if they had symptoms or signs compatible with chlamydia, or if a contact of a known case of chlamydia. A swab was taken from the urethra in the standard fashion. A second swab was taken from the meatus. After the sixth week of the study the order of the first and second swabs was changed, in order to evaluate any bias related to the order of the swabs. Specimens were processed using Abbott Laboratories LCx Chlamydia and handled according to the manufacturer’s guidelines.

Twenty five patients were asked to evaluate the swabs and to state which swab caused least discomfort or if there was no difference between them. A total of 208 men were recruited to the study. The overall prevalence of genital chlamydia infection in our population was 25% (52/208). A confirmed diagnosis was made by at least one sample performed from the same man were positive for chlamydia, or if one sample was positive together with an equivocal result. There were no false positive tests using these criteria giving all methods a specificity of 100%.

There was no significant difference in detection rates between the subgroups where the order of swabs was changed.

A meatal swab for the detection of chlamydia is more sensitive than taking a swab from the urethra itself against the standard technique. Urine samples, although non-invasive, are less likely to yield a positive diagnosis compared to urethral/meatal swabs and require extra processing by laboratories. In a high prevalence setting (such as a sexual health clinic), the meatal technique provides a specific, highly sensitive, and well tolerated sampling method for the detection of chlamydia infection in men.

Further studies to confirm our findings in symptomatic, and asymptomatic, chlamydia infection are needed before introducing this technique as routine clinical practice.


detection of chlamydia on meatal swabs

Editor,—The advent of ligase chain reaction (LCR) and other DNA technologies and their greater sensitivity has allowed the possibility of taking samples other than from the urethra in men, including urine samples. Although urine samples have the advantage of being collected non-invasively, the sensitivity of LCR testing on such samples is less than that of being collected non-invasively, the sensitivity on urine samples may be unacceptably low. This may be due to the presence of inhibitors in urine. The reduced sensitivity on urine samples may be unacceptable, particularly if testing populations with a high prevalence of chlamydia infection. Furthermore, processing of urine samples is more laborious.

It is currently recommended that specimens for the detection of genital Chlamydia trachomatis infection by LCR are taken 2–4 cm from the urethral orifice and the swab rotated for 3.5 seconds. Many men are unable to tolerate this. It is often painful and may discourage patients from seeking medical attention.
Table 1 Unprotected anal intercourse (UAI) in the previous 3 months

<table>
<thead>
<tr>
<th>Type of partner for UAI</th>
<th>HIV negative men (n=477*)</th>
<th>HIV positive men (n=126)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Main only</td>
<td>Casual†</td>
</tr>
<tr>
<td>Men in a relationship reporting</td>
<td>27.1 (75)</td>
<td>1.5 (4)</td>
</tr>
<tr>
<td>Non-concordant UAI</td>
<td>35.1 (97)</td>
<td>8.0 (22)</td>
</tr>
<tr>
<td>Men not in a relationship reporting</td>
<td>2.5 (5)</td>
<td>2.5 (5)</td>
</tr>
<tr>
<td>Non-concordant UAI</td>
<td>4.0 (8)</td>
<td>18.6 (37)</td>
</tr>
</tbody>
</table>

*Data on UAI or relationship status missing for two HIV negative men.
†Men reporting casual partners only or main and casual partners. Most men reported casual partners only.
‡Men reporting UAI with a partner of unknown or discordant HIV status. Non-concordant UAI was more likely to report concordant UAI with a casual partner. HIV prevention programmes need to reinforce risk reduction strategies, tailored to a person’s HIV status, while simultaneously addressing high risk sexual behaviour.

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Chaperoning male patients

Editor,—I was delighted to see the letter by Fisk et al in the journal.1 My staff and I were becoming alarmed at the suggestion that male patients should have a chaperone when they are being examined by a male doctor. Was common sense finally leaving the specialty? There are thousands of consultations taking place throughout the country, in both primary and secondary care, where sexual issues are discussed. These often include a genital examination, and just because there is a problem found with one or two individual patients or doctors it doesn’t mean the whole national service has to be turned upside down. Surely, the last thing an overworked, under pressure, genitourinary medicine service needs is to have another section of its already stretched resources being seen, there were no polymorphs on microscopy, swabs for gonorrhoea, chlamydia, and trichomoniasis were all clear. He was treated with a 5 day course of metronidazole as per MSVVSD guidelines.

If this patient had turned up without a contact slip, epidemiological treatment of trichomoniasis is unlikely to have been instituted and contact tracing would have been impossible. Thanks to the use of text messaging on this man’s mobile phone, appropriate treatment was initiated. Certainly patients and health advisers appreciate the security offered by mobile phones (no other family members can take the calls), the instant access, and it avoids additional paper work. The use of text messaging and mobile phones for contact tracing may be considered as an adjunct to contact slips in GU clinics.

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A mobile phone text message and Trichomonas vaginalis

Editor,—Over the past decade vast numbers of the general population have accepted the internet, email, and mobile phones. Among new patients attending our centre 70.3% (90/128) of men and 73.7% (93/133) of women provide mobile telephone numbers for contact. However, the use of mobile phones as a mechanism for contact tracing as far as I am aware has not been reported previously. A 26 year old Afro-Caribbean man presented to our clinic and informed us that his girlfriend had attended a GUM clinic but unfortunately he did not know why. However, he informed us that he had texted on his mobile. He duly brought up the message, which gave the woman’s clinic number and the KC60 diagnosis of C6A.

On examination there were no abnormalities seen, there were no polymorphs on microscopy, swabs for gonorrhoea, chlamydia, and trichomoniasis were all clear. He was treated with a 5 day course of metronidazole as per MSVVSD guidelines.

If this patient had turned up without a contact slip, epidemiological treatment of trichomoniasis is unlikely to have been instituted and contact tracing would have been impossible. Thanks to the use of text messaging on this man’s mobile phone, appropriate treatment was initiated. Certainly patients and health advisers appreciate the security offered by mobile phones (no other family members can take the calls), the instant access, and it avoids additional paper work. The use of text messaging and mobile phones for contact tracing may be considered as an adjunct to contact slips in GU clinics.

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kind of interference, and that basic common sense should prevail.

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Lichen sclerosus of the glans is significantly associated with penile carcinoma

EDITOR,—We read with interest the article by Riddell et al on 66 men with penile lichen sclerosus (PLS) attending a department of genitourinary medicine.1 In this study, the authors found no cases of malignancy.

We have previously reported a retrospective study on the incidence of cancer on 66 cases of PLS retrieved from our histopathological files over a 10 year period (1987–97).2 In that study, five cases showed malignant transformation—namely, squamous cell carcinoma (SCC) (three cases), in situ carcinoma (one case), and verrucous carcinoma (one case).

Since that report, we decided to interview all PLS patients in order to rule out any further malignancy that occurred over time. Of 86 patients identified, 60 were evaluated at our clinic. Among these, we found three additional patients treated with partial penectomy and laboratory information for these patients.

In this current study, eight (9.3%) out of 86 patients with PLS developed an epithelial cancer, with historical perspective. Implications for chronic inflammation and sclerosis in neoplastic progression. Hum Pathol 1998;29:932–48.

Accepted for publication 22 March 2001

Table 1 Clinical and histopathological features of eight cases of carcinoma on penile lichen sclerosus

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Age of onset of PLS (years)</th>
<th>Age of onset of Ca (years)</th>
<th>Lag time (years)</th>
<th>Site</th>
<th>Clinical aspect of malignancy on PLS</th>
<th>Histopathology</th>
<th>PCR testing for HPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>41</td>
<td>62</td>
<td>21</td>
<td>glans</td>
<td>fungating keratotic nodule with a white-yellowish hue and slightly infiltrated plaque</td>
<td>SCC</td>
<td>well differentiated</td>
</tr>
<tr>
<td>2*</td>
<td>36</td>
<td>59</td>
<td>23</td>
<td>glans</td>
<td>multiple erythematous, indurated, and ulcerated plaques sharply circumscribed, erythematous, and slightly infiltrated plaque</td>
<td>SCC</td>
<td>well differentiated</td>
</tr>
<tr>
<td>3*</td>
<td>41</td>
<td>55</td>
<td>14</td>
<td>glans</td>
<td>moderately differentiated, and ulcerated plaques sharply circumscribed, erythematous, and slightly infiltrated plaque</td>
<td>SCC</td>
<td>well differentiated</td>
</tr>
<tr>
<td>4*</td>
<td>39</td>
<td>49</td>
<td>10</td>
<td>glans</td>
<td>exophytic verrucous whitish nodule sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>VC</td>
<td>well differentiated</td>
</tr>
<tr>
<td>5*</td>
<td>29</td>
<td>47</td>
<td>18</td>
<td>glans</td>
<td>exophytic verrucous whitish nodule sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>SCC</td>
<td>well differentiated</td>
</tr>
<tr>
<td>6</td>
<td>75</td>
<td>85</td>
<td>10</td>
<td>glans</td>
<td>exophytic verrucous whitish nodule sharply circumscribed, erythematous, and ulcerated plaque</td>
<td>SCC</td>
<td>well differentiated</td>
</tr>
<tr>
<td>7</td>
<td>66</td>
<td>70</td>
<td>15</td>
<td>glans</td>
<td>sharply circumscribed, erythematous, eroded, crusted, and indurated plaque</td>
<td>SCC</td>
<td>undifferentiated</td>
</tr>
<tr>
<td>8</td>
<td>33</td>
<td>67</td>
<td>34</td>
<td>glans</td>
<td>sharply circumscribed, erythematous, eroded, crusted, and indurated plaque</td>
<td>SCC</td>
<td>undifferentiated</td>
</tr>
</tbody>
</table>

*Previously reported cases.1

PLS = penile lichen sclerosus; Ca = carcinoma; PCR = polymerase chain reaction; HPV = human papillomavirus; SCC = squamous cell carcinoma; VC = verrucous carcinoma.


Letters, Notices

Second Department of Health guidelines have recommended that HIV screening be offered to all pregnant women in high seroprevalence areas.3–5 In 1999 the Department of Health extended these recommendations to all regions aiming to reduce neonatal HIV infection by 80% by 2002.6 We present the case of an infant with symptomatic HIV infection, whose mother’s antenatal HIV test was negative and discuss the implications.

A 3 month old female, born at term by spontaneous vaginal delivery and breastfed, presented with a 1 week history of increasing respiratory difficulty. Following further deterioration, she was transferred to St Mary’s Hospital and ventilated. Pneumocystis carinii pneumonia (PCP) was diagnosed on bronchoalveolar lavage. Anti-HIV antibodies were present in serum and HIV infection was confirmed by the detection of HIV-DNA in peripheral blood mononuclear cells (PBMC) by PCR amplification. HIV-1 infection was confirmed in both parents. Her asymptomatic mother had received antenatal care from the 12th week of gestation and was HIV seronegative at 29 weeks. To investigate a...
The HIV antibody test is usually performed at the booking visit with other routine antenatal screens. This allows the parents time to adjust to the diagnosis before delivery, to consider family planning issues and interventions to minimise the risk of mother to child transmission. In addition, mothers with advanced immunosuppression benefit from antiretroviral therapy.

Although rarely reported, an HIV seronegative mother whose partner has undiagnosed HIV infection is at continued risk of infection. This may become more common in the United Kingdom as heterosexual intercourse is now the most common risk for HIV infection in newly diagnosed patients. Primary HIV infection during gestation or lactation is associated with an increased risk of mother to child transmission.

Repeat antenatal screening late in pregnancy, as is recommended for syphilis in the United States, would identify some primary HIV infections during gestation. However, if maternal infection is not prevented transmission during lactation would remain a risk and there would be significant logistic and cost implications. The extension of testing for HIV (and other infections) to the partners of pregnant women is appealing as both maternal and infant infections could be prevented (and the infected male may benefit from antiretroviral therapy).

Table 1. Peripartum HIV test results

<table>
<thead>
<tr>
<th>Time (in weeks of gestation)</th>
<th>Hospital where blood taken</th>
<th>HIV antibody screening tests</th>
<th>HIV specific antibody tests (CPhL in-house ELAs)</th>
<th>HIV western blot</th>
<th>HIV RNA (copies/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 T = 12 weeks (“Booking blood”)</td>
<td>X Blood was stored and retrospectively tested</td>
<td>i Clear negative Detect-HIV6</td>
<td>Clear negatives, (OD/CO) HIV IgG=0.49, IgM=0.36, IgA=0.44</td>
<td>—</td>
<td>Not detected (&lt; Limit of detection) Cobas Amplicor HIV-1 Monitor v1.56</td>
</tr>
<tr>
<td>2 T = 29 weeks</td>
<td>Y Index antenatal test (serum not available for repeat retrospective testing)</td>
<td>i Weak positive</td>
<td>Clear negatives</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>3 T = 13 weeks (“Booking blood”)</td>
<td>Y Blood was stored and retrospectively tested</td>
<td>i Abbot Assay HIV 1/2 (CO=0.42)</td>
<td>OD=0.030, CO=0.144</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>4 T = 13 weeks post partum (child presents)</td>
<td>St Mary’s</td>
<td>i Weak positive</td>
<td>OD=9.01, CO=0.252</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Possible false negative result, other sera stored at various times were retrieved and tested. The results, which show seroconversion late in pregnancy, are summarised in table 1.

The HIV antibody test is usually performed at the booking visit with other routine antenatal screens. This allows the parents time to adjust to the diagnosis before delivery, to consider family planning issues and interventions to minimise the risk of mother to child transmission. In addition, mothers with advanced immunosuppression benefit from antiretroviral therapy.

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Contributors: PG obtained samples and results, monitored virology and immunology, wrote and amended paper; RP monitored virology and immunology, amendments to paper; HL was involved in clinical management of child, amendments to paper; JP monitored PHLS Colindale tests, amendments to paper; GT was involved in clinical management of mother, helped write and amend paper.

Economic advantages of ligase chain reaction for diagnosis of genital Chlamydia trachomatis infection in GUM clinic attenders

Editor.—Genital infection with Chlamydia trachomatis is highly prevalent and recognised as a major threat to public health. There is now a wealth of evidence to demonstrate the superiority of DNA amplification techniques over antigen detection and culture.1 Only one large study has directly compared ligase chain reaction (LCR) with enzyme immunoassay (EIA) on identical clinical material1 and no studies have analysed the health economic impact of LCR in a genitourinary medicine (GUM) clinic population.

We studied the diagnostic effectiveness and cost of LCR compared with EIA. All GUM attendees undergoing sexual health screening were offered the opportunity to participate. Men presenting with dysuria or urethral discharge were defined as symptomatic. Swabs were collected in a pre-randomised order from the cervix in female patients and 4–5 cm proximal to the urethral meatus in male patients. Urethral specimens in male patients were evaluated for evidence of urethritis (defined by ≥4 polymorphs per high powered field).

LCR was performed using a standard immunoassay technique (Organon Chlamydia-Tek),3 with confirmation of reactive tests by microdot DIF1 LCR (LCX system, Abbott Laboratories) was also performed on every specimen.4 Specimens
A total of 148 male and 153 female patients were tested; 23/148 (16%) swabs from male patients were positive for Chlamydia trachomatis by LCR (see fig 1).

The sensitivity, specificity, and positive predictive values, and cost/test of LCR and EIA, respectively, were 100%, 100%, 100%, 100%, £564 and 58%, 100%, 95%, 100%, £4.05.

Of 33 cases of chlamydial infection, 15 cases (12 (92.2%) in men and two (20.0%) in women) would have remained undetected if EIA had been used alone.

Although EIA tests cost less than LCR, the inferior detection rate for EIA (17 patients screened per case detected) compared with LCR (nine patients screened per case detected) was also included in analysis of the results. The cost per case of chlamydial infection detected using EIA in this population was £65, compared with £50 for LCR.

In a hypothetical cohort of 100 GUM attendees, with an 11% prevalence of chlamydial infection (as in the present study), testing with EIA would cost £805 and would detect 6.4 of the 11 cases. Testing with LCR would cost £564 and detect all 11 cases. The additional cost of LCR is thus £159. The additional benefit is 4.6 additional cases detected with EIA.

In summary, this study demonstrates that although EIA tests cost less than LCR, the increased case detection rate, the cost of LCR per additional case detected is equivalent to that of EIA, and EIA had been used alone.

The scientific programme will encompass the breadth of chlamydial research from clinical and epidemiological studies to molecular and cell biology of all species of Chlamydia. Further details: Professor A Demir Serter, Department of Clinical Microbiology and Infectious Diseases, Ege University, Faculty of Medicine, 35100 Bornova, Izmir, Turkey (Fax: 90 232 343 71 30; e-mail: ishicix@tasa.ucsf.edu).

The 41st St Andrew's Day Festival Symposium on Therapeutics The 41st St Andrew's Day Festival Symposium on Therapeutics will be held on 6–7 December 2001 at the Royal College of Physicians of Edinburgh. Further details: Ms Eileen Strawn, Symposium Co-ordinator (tel: 0131 225 7324; fax: 0131 220 4393; email: e.strawn@rcpe.ac.uk; website: www.rcpe.ac.uk).

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

Further details: Dr Fransc Figueras, Congress Promotion Secretary (fax: +34 93 451 74 38; www.perinatol2001.com).

The 10th International Symposium on HIV/AIDS 16–19 December 2001, Mumbai, India Further details: Dr Chander P Puri, President, Indian Society for Study of Reproduction and Fertility, Institute for Reserach in Reproduction, Jeeangir Merwanji Street, Parel, Mumbai 400012, India (Tel: 413770 (Direct) 4132111-2-4-7; fax: 091-022-4964853 or 091-022-4139412; e-mail: vichin@bom4.vsnl.net.in OR dirirr@vsnl.com).
A mobile phone text message and *Trichomonas vaginalis*

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