Correspondence

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TO THE EDITOR, *Genitourinary Medicine*

Changes in incidence of STD among heterosexual patients: fear of AIDS?

Sir,
The health problem of the acquired immunodeficiency syndrome (AIDS) seems to affect the overall number of patients attending sexually transmitted diseases (STD) clinics^{1,2} and it is expected it will modify sexual practices among high risk individuals in order to reduce incidence of this disturbing disease.³

In an attempt to contribute to the knowledge of the effect of AIDS information on a sexually active population with known risk factors, all clinical records belonging to patients who attended from January 1986 till June 1987 at the one public STD clinic of Madrid working free of charge, under anonymous conditions, were reviewed. Cases diagnosed as urethritis and/or cervicitis were selected (table).

In this retrospective study an increasing trend in the number of patients coming for STD diagnosis (HIV infection included) was observed during this period. However, the incidence of urethritis and cervicitis decreased at the same time. Most of the patients were identified as heterosexuals and the incidence of urethritis/cervicitis decreased in particular among them, specially from September 1986 (fig).

These findings may reflect the awareness of sexually active people of the risk of HIV infection, and be a hopeful sign of a behaviour change towards a safer lifestyle. Moreover, our results are similar to those obtained from the official epidemiological surveillance system of communicable diseases in Spain, which indicates a declining

Fig Comparative data of patients attending for STD, and incidence of urethritis and cervicitis.

incidence of gonorrhoea and syphilis in the past three years.^{4,6}

Nevertheless unlike other findings published before,^{7,8} heterosexual patients were apparently changing their sexual attitudes more quickly than homosexual men. STD reduction is only an indirect marker of the positive impact of AIDS education campaigns and it does not necessarily mean that people at higher risk for AIDS are following the main preventive measure against HIV transmission during sexual intercourse (the systematical use of condoms). The adult population (including the heterosexual group) is, however, certainly making an encouraging effort to

control the AIDS epidemic, even in geographic areas where non blood heterosexual transmission of HIV is still low.

MD Moya*

A de la Loma†

F Menéndez*

B Menéndez*

JM Hernanz*

CS Sandoval,* Madrid; Centro Nacional de Microbiología, Virología e Inmunología Sanitarias, Majadahonda,† Madrid, Spain.

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- 3 Anon. World population and HIV. *Public Health*, 1987;101:397-8.
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Table Incidence of urethritis and cervicitis diagnoses between January 86 and June 87

Patients	No	Urethritis and Cervicitis (%)	
		Gonorrhoea	Non-specific
Heterosexual men	774	46 (5.9)	69 (8.9)
Homosexual/bisexual men	1154	129 (11.2)	208 (18)
Women*	1183	43 (3.6)	299 (25.3)
Total	3711	218 (7.0)	576 (18.5)

*All were identified as heterosexuals

- 5 CDC. Progress toward achieving the national 1990 objectives for sexually transmitted diseases. *MMWR* 1987;36:173-6.
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TO THE EDITOR, *Genitourinary Medicine*

Treating chancroid: summary of studies in South Africa

Sir,

We were interested to read the article by Ballard *et al*¹ which summarised the effective treatments for chancroid with particular reference to single dose therapies. Guidelines on the general management of genital ulcer disease in Southern Africa were also given. However, patients who are HIV Ab positive and this article failed to consider the effects of concomitant HIV infection on both natural history and treatment efficacy.

Cameron *et al*² concluded that treatment failure in chancroid using single doses of trimethoprim-sulphonamide or a quinolone was significantly associated with HIV Ab positivity. Treatment failure appeared to be a good clinical indicator of such positivity. Furthermore, the article suggested the use of benzathine penicillin together with single dose anti-chancroid therapy in genital ulcer disease where diagnostic facilities are limited.

It has been shown that benzathine penicillin fails to reach treponemacidal levels in CSF.³ Reports on the development of neurosyphilis after treatment with benzathine penicillin⁴ strongly suggest it is not optimal therapy even in the immunocompetent. Neurological relapse after treatment of early syphilis with benzathine penicillin in HIV Ab + patients has now been reported.^{5,6} Moreover, the natural history of syphilis in HIV infection is not yet fully understood but reports suggest that there may be an accelerated progression of late complications in such patients who receive treatment.⁶

Thus, the management of genital ulcer disease along the lines suggested without taking into account HIV status would appear to leave a susceptible population open to the possibility of ineffective chancroid treatment and the late complications of syphilis.

Yours faithfully,
G W Middleton
G E Forster

Whitechapel Clinic,
The London Hospital (Whitechapel),
London E1 1BB, UK

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TO THE EDITOR, *Genitourinary Medicine*

Evaluation of abnormal cervical cytology results in a genitourinary clinic

Sir,

Drs Coker *et al* in their letter to this journal¹ expose the tendency for female genitourinary patients to possess abnormal cytology necessitating colposcopy. In our colposcopy clinic we have attempted to answer the corollary: do colposcopy patients have STDs we are failing to diagnose?

Modern theory holds that CIN is a sexually transmissible disease.² Long established thought in genitourinary medicine makes it necessary, in the presence of an STD, to search for others. It may be expected therefore that STD will be found in colposcopy clinic patients.

The cost effectiveness of identifying and treating all such STDs at one consultation appears attractive. In the Jessop Hospital, the facilities are ideal to perform this function since the clinic is co-managed by two consultants; one gynaecologist (VAB) and one genitourinary physician (DAH). Genitourinary patients with abnormal

Table Positive findings in 75 consecutive colposcopy patients

<i>Chlamydia trachomatis</i>	1
<i>Ureaplasma urealyticum</i>	2
<i>Candida albicans</i>	7
<i>Gardenerella vaginalis</i>	6
Ureaplasma + Gardenerella	2
Ureaplasma + Candida	5
Anaerobes + Gardenerella	1
Mycoplasma, Gardenerella + Candida	1
Mycoplasma, Gardenerella + Ureaplasma	1
Group B Streps. + Candida	1
Total	27

cytology are managed "in-house" and if necessary are then referred for appropriate treatment to Jessop Hospital.

Seventy five consecutive patients referred directly to the Jessop Hospital for colposcopy were screened. These were females with abnormal cytology from sources other than genitourinary medicine.

A sexual and medical history noting age, marital status, age at first intercourse and number of sexual partners was solicited. Patients with a recent (one month) history of antibiotic ingestion were excluded.

Tests comprised urethral swab for Gram staining and culture, high vaginal specimens for dark ground illumination, Gram staining and culture, and cervical samples for Gram staining and viral culture. Endo-cervical testing for *Chlamydia trachomatis* was performed with a monoclonal antibody labelled with fluorescein (Microtrak, Syva). Samples were obtained after cytology had been performed, but before formal colposcopic procedures.

Positive findings are shown in the table. If organisms of low potential risk or commensal status are excluded, then carriage of pathogens in this group of patients is seen to be low. Only one patient had *C trachomatis* with 11 other patients having ureaplasma and/or mycoplasma. Eleven patients had mixed infections, and 13 others were only candida (7) or gardenerella (6).

Review of sexual, contraceptive, smoking and obstetric history failed to reveal any useful risk factors. These findings would appear to agree with other similar studies³ and it may be concluded that microbiological screening of all new colposcopy patients is not effective or economic.

However, our colposcopy clinic may not be representative in that patients found to have abnormal smear tests in genitourinary medicine clinics have already been screened prior to attendance for treatment at this hospital. Where this system does not operate the risk of STD may be consequently higher.