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TO THE EDITOR, *Genitourinary Medicine*

Labial adhesions after genital herpes infection

Sir,
It was interesting to note from the case reported by Walzman and Wade¹ that this was thought to be a rare complication. In our experience, severe primary attacks of herpes in the young can very easily lead to labial

adhesions, especially under the clitoral hood, and often along the labia minora and labia majora. If left untreated, this same process during healing could lead to fusion across the midline. On most occasions, this is avoidable by early diagnosis, treatment with acyclovir and frequent follow up.

To illustrate this point, we have seen two females aged 19 and 21 years in the past 18 months with florid primary herpes. Since they both followed similar courses, only one will be detailed.

The initial attack involved both labia, introitus, perineum and mons pubis, with bilateral tender inguinal lymphadenopathy. On their first visit, HSV cultures were obtained from the lesions, further examination proving to be too painful. Treatment was started with oral acyclovir 200 mg five times daily for 5 days, and cotrimoxazole 960 mg twice daily for 5 days. The patient was advised to have frequent saline washes.

When reviewed 5 days later, most symptoms had abated, but she still complained of dysuria. On examination, the ulcers were clean, but had a serous exudate, which was already causing some adhesions under the clitoral hood and between the labia. These adhesions were gently separated, and the patient advised to separate the labia when in the bath. Further STD screening was still not possible. During her third visit an STD

screen including cervical smear was done: all were negative. However, now the upper one-third of the labia minora and majora had fused. This adhesion was gently separated and vaseline gauze was applied. She was given vaseline gauze to take home and told to change the gauze between the labia at frequent intervals to prevent further adhesions. On this treatment the area healed well and there were no further problems with adhesions. Since then, both patients have attended the clinic with recurrences of herpes infection, which were not severe.

These cases illustrate that labial adhesions can occur very easily in florid primary herpes, and are most common at the healing stage, probably due to the formation of a fibrinous exudate. Early diagnosis, close vigilance and good counselling help prevent permanent damage.

Yours faithfully,
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Matters arising

Trichomonal vaginitis refractory to conventional treatment

Dr Seligman states in his letter to *Genitourinary Medicine*¹ that vaccination has proved useful in the prophylaxis of recurrent trichomoniasis, although not for the treatment of resistant organisms. We have recently reported the case histories of two patients² who failed to respond to oral metronidazole (400 mg twice daily for 7 days) and oral nimorazole (one gram 12 hourly for 3 days). The minimum inhibitory concentration of metronidazole for these organisms under aerobic conditions was 125 mg/l and 32 mg/l (control strain 1 mg/l). Following failure to respond to conventional treatments, both patients received vaccination with Gynatren, a lyophilisate of inactivated selected strains of *Lactobacillus acidophilus*, as a course of three intramuscular injections of 0.5 ml at two weekly

intervals. Within one month of the final injection both patients became free of their symptoms of an altered vaginal discharge with vulval discomfort for the first time for six months and four years respectively. Unfortunately, only one woman was able to attend for tests of cure which confirmed that her infection had been eradicated.

This response is in accordance with other reports demonstrating a cure rate of 84%-100% following the third injection.^{3,4} Although unable to explain its mechanism our experience leads us to believe that Gynatren has a role in the treatment of trichomoniasis caused by resistant organisms and not solely as a prophylactic measure.

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