

Correspondence

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TO THE EDITOR, *Genitourinary Medicine*

Symptomless gonorrhoea in women in Maiduguri (north eastern Nigeria)

Sir,

One of the important reasons for the continued rising incidence of gonorrhoea is the difficulty of identifying and treating women with the disease who are symptomless. As a result of that, the infected women, particularly those in the developing world, fail to seek medical attention and continue to serve as a reservoir of gonococcal infection for others, and themselves are at risk for complications of the disease. Review of relevant published reports clearly suggests a high incidence of symptomless gonorrhoea in African women. Hopcroft *et al* found 18% of 200 women attending a family planning clinic in Kenya had gonorrhoea,¹ and Nasah *et al* in Cameroun (west Africa) found that 15% of 1326 women attending maternity or child health centres had gonorrhoea.² In a study carried out at Ibadan (western Nigeria), Onifade and Osoba reported gonorrhoea in 2.05% of patients attending gynaecological clinics and in 5.2% of those attending antenatal clinics. The present study was undertaken to assess the prevalence of symptomless gonorrhoea in Maiduguri, capital of Borno State (north eastern Nigeria), where no such data are available, and polygamy is much more common than in Ibadan.

A total of 120 women attending the gynaecology clinic at the General Hospital, Maiduguri were examined for gonorrhoea by smears and cultures of material from the urethra and endocervix. The smears were stained by Gram's method for intracellular Gram negative diplococci, and the primary cultures were made on Thayer-Martin agar in a candle jar at 37°C. *Neisseria gonorrhoeae* isolates were identified by their characteristic morphology, oxidase activity, and carbohydrate fermentation reactions. Of the 120 women examined, 18 (15%) were infected with *N gonorrhoeae*. Although these findings are comparable with those reported by Hopcroft *et al* from Kenya¹ and Nasah *et al* from Cameroun,² they are substantially higher than those of Onifade and Osoba from western Nigeria.³

This higher incidence of symptomless gonorrhoea in a cross section of the population under study may reflect an upward surge in the prevalence of gonorrhoea in Nigeria during the past five years (1982-7). Furthermore, it clearly suggests that there is a considerable reservoir of gonococci in the female population in Maiduguri, north eastern Nigeria. The incidence reported may possibly be related to an increase in promiscuity in general or to the socially accepted practice of polygamy, which might promote the spread of gonococcal infection. In conclusion, the lack of awareness of the presence of gonococcal infection in women contributes to the perpetuation and spread of the disease, and failure to seek treatment at an early stage leads to serious consequences later. In view of the above observations, routine testing for gonococcal infection should be considered an essential part of prenatal care.

Yours faithfully,
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References

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- 2 Nasah BT, Ngumatcha R, Eyong M, Godwin S. Gonorrhoea, Trichomonas and Candida among gravid and non-gravid women in Cameroun. *Int J Gynaecol Obstet* 1980; 18:48-52.
- 3 Onifade A, Osoba AO. Screening for sexually transmitted diseases in gynaecological and prenatal clinic in Ibadan, Nigeria. *Nigerian Quarterly Journal of Hospital Medicine* 1982; 1:15-20.

TO THE EDITOR, *Genitourinary Medicine*

Chlamydiae infect the placenta less often than gonococci

Sir,

Several years ago we reported common prepartal infection of the placenta by *Neis-*

seria gonorrhoeae in Gabonese women.¹ It could be a source of infection in ophthalmia neonatorum caused by *N gonorrhoeae* after caesarian section or *N gonorrhoeae* amnionitis, although ascending infection after prolonged rupture of membranes was usually cited as the probable mechanism.^{1,2} Similarly, *Chlamydia trachomatis* may be isolated from babies with ophthalmia neonatorum after caesarian section.³⁻⁷ Chlamydial antigens were detected in three placentas by immunofluorescence using polyclonal sera, but not by culture in one study of 24 placentas,⁸ or in another of 68 placentas.⁹ One case of intrauterine infection with *C trachomatis* has been reported.¹⁰ The usual incubation period for chlamydial ophthalmia neonatorum is at least three to five days. Earlier infections, at birth or starting on days 1 to 3, have been ascribed to prolonged rupture of membranes, higher infecting doses, or prepartal infections.¹¹⁻¹³

We have examined 63 placentas by culture and immunofluorescent staining for *C trachomatis*, and failed to find evidence of chlamydial infection. Culture and immunofluorescence (Micro Trak, Syva Biomerieux, France) for *C trachomatis* and culture for *N gonorrhoeae* were performed on cervical samples taken two or three days after delivery and placental scrapings taken less than an hour after delivery at Franceville Provincial Hospital.^{11,14} Histopathological sections of placental tissue and membranes were stained with monoclonal antibodies to *C trachomatis* and stained with immunoperoxidase (Cultureset, Ortho Diagnostics).

C trachomatis could be detected in cervical samples from six of the women and *N gonorrhoeae* in three. From the placentas, neither culture, nor immunofluorescence, nor histopathological sections stained by immunoperoxidase were positive for *C trachomatis*. *N gonorrhoeae* was cultured from the placenta of one woman. In our previous study we reported culture of *N gonorrhoeae* from three placentas of five infected women in a cohort of 192.¹ Thus, we found *N gonorrhoeae* in the placentas of four of eight infected women, but *C trachomatis* could not be identified in the placenta of any of six women infected with *C trachomatis* or in any of the other 57 women.

Babies with ophthalmia neonatorum after