
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. 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 are not immune to genital ulcer disease and this article failed to consider the effects of concomitant HIV infection on both natural history and treatment efficacy.

Cameron et al 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 treponemalidal levels in CSF. Reports on the development of neurosyphilis after treatment with benzathine penicillin 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.

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.

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,
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References

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 journal 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. 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 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 specimen 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 casual status are excluded, then carriage or pathogens in this group of patients is seen to be low. Only one patient had C trachomatis with 11 other patients having ureaplasmal and/or mycoplasma. Eleven patients had mixed infections, and 13 others were only positive for candida (7) or gardenerella (6).

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Review of sexual, contraceptive, smoking and obstetric history failed to reveal any useful risk factors. These findings would appear to agree with other similar studies 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.

Table Positive findings in 75 consecutive colposcopy patients

<table>
<thead>
<tr>
<th>Organism</th>
<th>Positive</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia trachomatis</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Ureaplasmal urealyticum</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>Candida albicans</td>
<td>7</td>
<td>9.3</td>
</tr>
<tr>
<td>Gardenerella vaginalis</td>
<td>6</td>
<td>8.0</td>
</tr>
<tr>
<td>Ureaplasmal + Gardenerella</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>Ureaplasmal + Candida</td>
<td>5</td>
<td>6.7</td>
</tr>
<tr>
<td>Anaerobes + Gardnerella</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Mycoplasma, Gardnerella + Candida</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Mycoplasma, Gardnerella + Ureaplasmal</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Group B Streps. + Candida</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Total 27
Correspondence

David Hicks* 
Valerie Brown,† 
Robert C Spencer*

Royal Hallamshire Hospital,* 
Jessop Hospital for Women,† Sheffield.

References
1 Coker DM, Ahmed-Jusuif I, O'Mahoney C, 
Alewatagama AB. Evaluation of abnormal 
cervical cytology results in a genitourinary 
clinic. Genitourinary Medicine 1988;64: 
281–2.
2 Kitchener HC. Does HPV cause cancer? Br J 
3 Toon PG, Arraud JR, Wilson LP, Sharp DS. 
Human papillomavirus infection of the 
uterine cervix of women without cytological 
signs of neoplasia. Br Med J 1986;293: 
1261–4.
4 Walkinshaw SA, Roberts ADG, Cordiner JW. 

TO THE EDITOR, Genitourinary Medicine

Labial adhesions after genital herpes infection

Sir,

It was interesting to note from the case 
reported by Walzman and Wade† 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 
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 examina-
tion 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 symp-
toms had abated, but she still complained 
of dysuria. On examination, the ulcers were 
clean, but had a serous exudate, which was 
probably 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 
not 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 her-
pes, 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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Reference
1 Walzman M, Wade AAH. Labial adhesions 
after genital herpes infection. Genitourin Med 

Matters arising

Trichomonal vaginitis refractory to conven-
tional treatment

Dr Seligman states in his letter to Genito-
urinary Medicine that vaccination has 
proved useful in the prophylaxis of recurrent 
trichomoniases, although not for the 
treatment of resistant organisms. We have 
recently reported the case histories of two 
patients who failed to respond to oral 
metronidazole (400 mg twice daily for 7 
days) and oral nimosazole (one gram 12 
hourly for 3 days). The minimum inhibitory 
concentration of metronidazole for these 
organisms under anaerobic conditions was 
125 mg/l and 32 mg/l (control strain 1 mg/l). 
Following failure to respond to conventional 
treatments, both patients received vaccina-
tion with Gynatren, a lyophilisate of inactivated selected strains of Lactobacillus 
acidophilus, as a course of three intra-
muscular 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.4 Although 
unable to explain its mechanism our 
experience leads us to believe that 
Gynatren has a role in the treatment of 
trichomoniases caused by resistant 
organisms and not solely as a prophylactic 
measure.

References
1 Seligman SA. Trichomonal vaginitis refractory 
to conventional treatment. Genitourin Med 
2 Pattman RS, Sprott MS, Kearns AM, 
Earnshaw M. Failure of mebendazole to cure 
metronidazole-resistant trichomonal vagini-
tis. Genitourin Med. (In press.)
3 Milovanovic R, Grici R, Stojkovici L. Changes 
in the vaginal flora of trichomoniases patients 
after vaccination with Solco-Trichovac. In: 
Rütgers H, ed. Gynäkologische Rundschau. 
4 Lorenz U, Rütgers H. Clinical experience using 
Solco-Trichovac in the treatment of 
trichomonas infections in women. In: 
Rütgers H, ed. Gynäkologische Rundschau. 