

Correspondence

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TO THE EDITOR, *Genitourinary Medicine*

Genital warts and the need for screening

Sir,

It is believed among genitourinary physicians that the presence of genital warts in women warrants screening for other sexually transmitted diseases (STDs). This view was supported by a study by Kinghorn,¹ in which he concluded that there was a relatively high incidence of other genital infections in women suffering from genital warts. At the time of this study routine tests for *chlamydia* were not available. The changing patterns of STD incidence over recent years might be expected to alter the risk of associated infections.

We recently reviewed 100 consecutive women attending our department with genital warts, all of whom were screened for other STDs. All were screened using standard methods for *Neisseria gonorrhoea*, *Candida albicans*, *Trichomonas vaginalis* and syphilis. Cervical swabs were tested for identification of *Chlamydia trachomatis* by micro-immunofluorescence. "Bacterial vaginosis" was diagnosed in women with a symptomatic malodorous vaginal discharge, and in whom microscopy of vaginal samples revealed "clue cells" or abnormal flora.

No women had positive syphilis serology or culture for gonorrhoea. The numbers (percentages) of women with positive diagnoses is shown in the table.

We found a lower than expected incidence of associated STDs in women with genital warts. Although a number of authors have concluded that there is an increased incidence of other genital tract infections in

women presenting with genital warts, they have largely failed to show a high incidence of STDs.

Kinghorn¹ highlighted in his study the significant proportion of women who had other genital infections. However the main infective agent discovered in his study was *Candida albicans*; there were in fact only 12.3% of women with gonorrhoea and 0.9% with "non-specific genital infection". Statistics from returns to the DHSS show that the incidence of gonorrhoea has fallen significantly since a peak in 1973.² It may well be that the apparent absence of an association between the presence of genital warts and this infection is a reflection of the decreased incidence in the general population. In our study only a single case of *trichomonas* vaginitis was found.

Longhurst and colleagues³ studied a group of women in a north-London general practice finding a 10.7% rate of *chlamydia* infection, by micro-immunofluorescence. Turner *et al*⁴ reporting on STD screening in a group of women attending for colposcopy after an abnormal smear showed 9% to have infection with *chlamydia*, 2% had *trichomonas* and 3% had positive syphilis serology.

It appears that the incidence of other STDs is no higher in an unselected group of women with genital warts than it would be among young sexually active women in general. A blanket policy of screening all women with genital warts for other sexually transmitted diseases, whilst ignoring a similar risk in women without warts may seem inappropriate. Further research might seek to establish particular high risk groups for selective screening.

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And on behalf of Lynn J Overington
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References

- 1 Kinghorn GR. "Genital warts: incidence of associated genital infections." *Br J Dermatol* 1978;99:405-9.

- 2 Communicable Disease Surveillance Centre. "Sexually transmitted disease surveillance in Britain-1984." *Br Med J* 1986;293:942-3.
- 3 Longhurst LJ, Flower N, Thomas BJ *et al*. A simple method for detection of *Chlamydia trachomatis* infection in general practice. *J R Coll Gen Pract* 1987;37:1255-6.
- 4 Turner MJ, White JO, Soutter WP. "The male factor in cervical neoplasia." *Contemp Rev Obstet Gynaecol* 1988;1:36-42.

TO THE EDITOR, *Genitourinary Medicine*

Trichomonas vaginalis infection in a lesbian

Sir,

We report a case of *Trichomonas vaginalis* infection in a lesbian. The 25 year old single Caucasian female was referred to our department with a 4 month history of offensive vaginal discharge and pruritus vulvae. She developed these symptoms after having sexual relationship with a casual bisexual girlfriend in London in December 1988. She denied sharing vibrators or sex toys, but admitted using her fingers for masturbating her partner and herself. She had gonorrhoea following heterosexual intercourse in September 1982 which helped her to change to homosexual practice, rather than initiate it. She had no STDs other than her gonorrhoea infection which responded successfully to treatment. The patient's sailor consort at that time, was treated too. She vehemently denied further heterosexual intercourse or contact since 1982.

On examination she had moderate erythema of the vulva with yellowish green frothy vaginal discharge suggestive of *Trichomonas* infection. Immediate wet drop examination of the discharge collected from the posterior fornix of her vagina confirmed numerous *Trichomonas vaginalis* protozoan (TV) and the clinical/microscopic diagnosis was confirmed by culture using oxid trichomonas media. Smears and cultures for candida, gonorrhoea, *Chlamydia trachomatis* and the serological tests for syphilis were negative. The patient was treated with a single 2.0 g oral dose of metronidazole following which she had an excellent response and had two

Table Incidence of associated lower genital tract infection in women presenting with genital warts (n = 100)

<i>Chlamydia trachomatis</i>	9%
Symptomatic candida	7%
Bacterial vaginosis	7%
<i>Trichomonas</i> *	1%
Any of the above	22%
Asymptomatic candida only	18%
No associated infection found	60%

*The single woman with *trichomonas* was also positive for *chlamydia*.