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Gastrointestinal obstruction associated with *Chlamydia trachomatis*

I read with great interest the recent report of Pegg and Owen regarding small bowel obstruction associated with *Chlamydia trachomatis*.¹ I would like to point out, however, that this phenomenon was first suggested in a similar case report in 1987,² and recently included in a review of abdominal pain syndromes caused by chlamydial infections.³

While both cases^{1,2} presented clinical, historical and serologic evidence of a chlamydial aetiology for the small bowel obstruction, the report of Pegg and Owen additionally demonstrated *C trachomatis* in the genital tract by ELISA testing.

The women in both reports had no genital tract complaints at the time of presentation, and their fallopian tubes appeared normal. Both of these cases strongly suggest that infection with *C trachomatis* may result in small bowel obstruction, and that pelvic symptoms may not be temporally associated with the abdominal disease.

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Value of performing biopsies in genitourinary clinics

We read with interest the recent letter in your journal concerning the value of

performing biopsies in genitourinary clinics.¹

Men with abnormalities of the skin of the penis frequently present to genitourinary physicians, who must therefore also be skilled in dermatology. This is particularly so in the light of the probable re-definition of our specialty as "dermato-venereology" in the unified post-1992 European Community.

In order to assess the specific dermatological problems encountered by a busy genitourinary medicine clinic, we set up an internal clinic for penile dermatoses. The criteria for referral were a penile dermatosis of uncertain diagnosis for which the clinician thought that a biopsy might prove helpful. The technique used was that of local anaesthesia followed by skin snip biopsy. All patients were thoroughly counselled before the procedure, which was generally regarded by the patient as not being as traumatic as initially envisaged.

Over a period of two months a total of 18 biopsies were performed with the following histopathological results: 5 nonspecific dermatitis, 3 viral warts, 3 lichen sclerosus et atrophicus, 2 lichen planus, 2 symptomatic subclinical papillomavirus infection, 1 granulomatous disease (currently undergoing investigation) and 1 trauma (probable dermatitis artefacta). Although only a small sample was taken, typically 0.5 mm in diameter, in only one case did the biopsy prove non-diagnostic.

It can be seen that in 11 out of 18 of cases, a specific diagnosis was able to be made for which a management plan could be devised. We would draw particular attention to the diagnoses of lichen sclerosus et atrophicus (LSA). Not only are there multiple names for the same histopathological condition (LSA, balanitis xerotica obliterans and kraurosis vulvae), but the malignant potential of this common² condition remains undefined and a standard text³ suggests six to twelve monthly follow-up for life.

Despite the longstanding combination of the specialties of dermatology and venereology on the continent, the literature on genital dermatology is scant. The three specialties of genitourinary medicine, dermatology and urology have overlapping interests in penile cutaneous disorders, but rarely have in-depth knowledge. Unlike the vulval cutaneous disorders,⁴ for exam-

ple, there is no standard textbook in the English language on penile dermatoses. Furthermore, confusions still exist over relatively common disorders, as described above. It is thus important to develop and improve lines of communication between genitourinary physicians, dermatologists and histopathologists at regular audit meetings.

We would therefore wholeheartedly agree with the conclusion of Drs Arumainayagam and Sumathipala that penile biopsy is a very useful diagnostic procedure in the setting of a genitourinary clinic. The more widespread use of this simple and minimally invasive procedure would allow us to gain greater insight into the ill-understood incidence and nature of genital dermatoses.

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Sexual assault of men: a series

The sexual assault of men has attracted little attention. The report of Hillman and colleagues describes five cases of male sexual assault from two large genitourinary medicine (GUM) departments during an unspecified time period.¹ We suspect their report is not representative of men attending GUM departments after sexual assault and write to report our experience.

During 1989, 10 male patients attended this department reporting penetrative sexual assault by men. They presented four days to one year after the assault and patient details are

listed in the table. In contrast to the report of Hillman, the sexual orientation of only one patient was homosexual; seven were heterosexual and for two patients it was their first sexual experience. Only one patient knew his assailant prior to the assault and two patients experienced repeated assaults by previously unknown assailants over a period of months. Forced anoreceptive intercourse occurred in all cases, ororeceptive intercourse in two cases and active anal intercourse was demanded of one patient. Four patients had reported their assault to the police. The sexual orientation of only one assailant was known.

No patient had evidence of anal trauma or proctitis and investigations for syphilis, infection with *Neisseria gonorrhoeae*, *Chlamydia trachomatis* and non-gonococcal urethritis proved negative in the nine patients who were tested. Anti-HIV antibody was negative three months after the assault in all five patients who requested testing. In 1989, 36 women attended this department following rape: of these women, 11 (30%) were found to have an attributable sexually transmitted infection.

The prevalence of sexual assault of men is unknown, but the experience of "Survivors", an organisation providing care for male victims of sexual assault, confirms that this form of assault is not exceptional and usually goes unreported.² GUM departments can expect involvement in the management of men who have been sexually assaulted and our experience shows a spectrum of cases very different from those reported by Hillman *et al.*¹ Heterosexual "victims" comprised the major proportion of cases seen in this department but homosexual men may be more reluctant to disclose sexual assault. We found no evidence of sexually acquired infection in our patients and they were greatly relieved that their assault was not compounded by infection.

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Table Characteristics of male patients attending after sexual assault

Age (yr)	Sexual orientation	Number of assailants	Comments on assault
13	Heterosexual	2	Repeated attacks by previously convicted paedophiles
14	Heterosexual	2	Campsite in UK
17	Heterosexual	1	
19	Homosexual	1	Known homosexual assailant
19	No previous sexual experience	1	Repeated attacks by previously unknown assailant
21	Heterosexual	3	Prison in UK
23	No previous sexual experience	2	Mentally handicapped, strayed from hospital
25	Heterosexual	1	Abroad, when drugged
31	Heterosexual	1	Public lavatory in UK
37	Heterosexual	1	

Hillman *et al* reply:

We were most interested to read of the experience from Nottingham. It is very difficult to decide whether a sample of such an under-reported event as sexual assault is representative or not, and we hope that this was made clear in our article. We merely sought to provide an illustration of the different sorts of presentations which occurred to our clinic over a one year period.

The sexual orientation of male victims of sexual assault is unknown. Various reports have found that between 28%¹ and 93%² of victims are heterosexual, suggesting that this may be more a reflection of sample bias than the actual characteristics of the condition. In a recent community-based study of 100 male victims of sexual assault in the United Kingdom,³ we found that 39% regarded themselves as heterosexual following in-depth supportive counselling. Reporting the assault to the police was a rare event, possibly because of fear of an unfavourable reception.⁴

The lack of evidence of anal trauma in any of the men who claimed forced receptive anal intercourse to the Nottingham clinic was surprising, as our larger survey,³ in common with others⁵ found a high incidence of genital and non-genital trauma in such victims. Likewise we found a very high incidence of sexually transmissible infections in victims, again at variance with the Nottingham experience. The exact incidence and nature of sexual assault of men is extremely difficult to ascertain, and we welcome any further information concerning this ill-understood and infrequently reported phenomenon.

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Choosing equipment for colposcopy in genitourinary medicine

I read Mr Hare's article on choosing equipment for colposcopy in *Genitourinary Medicine* with interest.¹ I wish to add two comments based on my personal experience of providing this service in a genito-urinary clinic for some years.

Video camera and television I believe have superseded the SLR/Polaroid camera attachment. Not only is it invaluable as a teaching and research tool but also in patient management. Visualisation of the abnormality or lack of it as well as subsequent diagnostic and treatment procedures where necessary, coupled with the attending doctor's or nurse's comments, enables the patient to understand the condition, thus dispelling many of the misconceptions women have of the disease and its treatment with great psychological advantage. This improves patient cooperation and compliance. While