genitourinary clinic consultant, he was allowed by the physician at the High Commission to go ahead with his proposed visit and eventual permanent settlement in the host country. This case re-emphasises the importance of undiagnosed syphilis in the elderly.¹²

However, sexual abuse of the elderly must be kept in mind in this context. A moving case of syphilis in a 68 year old lady after rape has been well documented.³ So also has the diagnosis of syphilis been reported in two elderly female patients, one in coma, following possible sexual abuse, as serological tests performed six months previously on one, and three years earlier on the other were non-reactive.⁴ Moreover, screening tests for dementia in a home for the elderly revealed three cases of neurosyphilis with positive serology.² Perhaps this is a solemn reminder of how little is known of this problem in the elderly.

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- 1 Woolley PD, Anderson AJ. Prevalence of Undiagnosed Syphilis in the Elderly. *Lancet* 1986;ii:1034.
- 2 Gaman WN. Screening test for dementia in personal care home. *Can Med Assoc J* 1984;130:106.
- 3 Bierman SM. A piece of my mind: the 'terrible' question. *JAMA* 1985;253:No 5, 641.
- 4 Luke EA Jr. Syphilis in the elderly. *JAMA* 1985;254:No 13, 1722-3.

MATTERS ARISING

Sexually transmitted diseases in rape victims

We read the report of Estreich *et al*¹ on victims of sexual assault with interest and can confirm findings of similar rates of STD in such victims referred by a police surgeon in Leeds.

In a 24 month period after July 1988 52 female victims of sexual assault (mean age 19.5 yr, range 13 to 48) were referred by a local police surgeon and attended the Department of Genito-

urinary Medicine, Leeds between 3 days and 4 weeks after the incident.

Fourteen women (28%) had a sexually transmitted disease (seven *Chlamydia trachomatis*, two *Neisseria gonorrhoeae*, five *Trichomonas vaginalis*). A further six women had non specific cervicitis and four had abnormal cervical cytology (two had CIN, the other two defaulted from follow up). Interestingly four of eleven women who were examined within 96 hours of assault had an STD indicating that such women may be at risk from pre-existing STD.² There were no cases of genital warts, herpes simplex or syphilis. All women were counselled for HIV and 11 specifically asked to be serotested mainly because of fear of acquisition of infection. None had any defined high risk factors but in only two cases were the assailants recognised. All serological tests for HIV were negative.

Prior to 1988 very few cases were referred from the local police surgeons. Since then we have developed excellent links with one who examines the majority of assault victims and these now constitute an important source of referral of such women to the department. Local women police constables have taken a supportive role and often accompany victims to the department if requested. A review of all rape cases a few months ago indicated infrequent referrals by voluntary organisations (such as Rape Crisis) and we have now instigated closer links with these groups with a consequential increase in numbers seen. These organisations regularly change personnel and it is therefore important to audit cases of sexual assault that are referred on an ongoing basis, and to maintain a dialogue, so that such women, who have high rates of genital infections, continue to be offered the essential screening services provided by genitourinary medicine departments.

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- 1 Estreich S, Forster GE, Robinson A. Sexually transmitted disease in rape victims. *Genitourin Med* 1990;66: 433-8.
- 2 Jenny C, Hooton T, Bowers A, *et al*. Sexually transmitted diseases in victims of rape. *N Engl J Med* 1990;322: 713-6.

A rapid stain for the diagnosis of granuloma inguinale

The paper entitled *A rapid stain for the diagnosis of granuloma inguinale*¹ is a welcome addition to the existing procedures. It is, therefore, worthwhile to utilise it for rapid diagnosis of the disease. However, this has its limitations for in only 38% of donovanosis is it positive. In 62% it is not of help. Consequently it has major limitations as a diagnostic tool. It is, therefore, imperative to "suspect" the diagnosis of donovanosis on the basis of morphological characteristics of the ulcer.²³ Despite the clinical features being cardinal, the condition may have to be differentiated from chancroid/ chancroidal ulcer,⁴ primary chancre, herpes progenitalis, and squamous cell carcinoma. In fact, at this centre it is customary to make the diagnosis by undertaking a battery of tests to exclude aforementioned genital ulceration. These tests include: dark-ground microscopy for *Treponema pallidum*, gram-stained surface smear for *Haemophilus ducreyi*, Giemsa-stained surface smear for giant cells/ balloon cells for herpes progenitalis, Giemsa-stained tissue smear for demonstration of intra-mono-nuclear Donovan bodies, haematoxylin-eosin stained tissue sections to establish the histological features of donovanosis⁵ and to exclude squamous cell carcinoma, and demonstration of Donovan bodies in tissue section using slow Giemsa (overnight) technique,⁶ serological diagnosis of syphilis, attempt to recover *Haemophilus ducreyi* on culture.

The clinical diagnosis, supplemented by these procedures improve the diagnostic success to almost 100%.

It is worthwhile to highlight the slow-Giemsa (overnight) technique,⁶ in which the tissue sections are placed in a 10% Giemsa-stain for 17 hours. It was possible to demonstrate Donovan bodies in 95% of the cases. The Donovan bodies were found distinctly and in large numbers in the mononuclear cells (intra-cellular). Furthermore, it was easy to demonstrate multicystic cells containing Donovan bodies, well recognised as cells of Greenblatt.

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