Heterosexual transmission of HBV in Caucasians attending a Genitourinary medicine clinic

It was with interest that we read the letter by Daniels et al., concerning the heterosexual transmission of hepatitis B virus (HBV) and its acquisition abroad. It is clear that homosexual and bisexual men attending genitourinary medicine clinics may have a high prevalence of serological markers though the difficulty in screening and immunising this risk group was shown by an interesting study. However, their vaccination of these risk groups in areas of low endemicity has been found to be ineffective in reducing the overall rates of infection. As highlighted in the letter, there is a need for a heightened awareness of the testing of our clinics of heterosexual people who may not necessarily be perceived as being at risk from hepatitis B infection. This is demonstrated by the three family groups who were seen recently in our Liverpool clinic. It is our policy to offer serological testing for syphilis, human immunodeficiency virus and hepatitis B to all our new clinic attenders.

A 34 year old Caucasian female, married for 15 years, with no history of injecting drug use or sexual partners, was seen with a history of vaginal discharge. Routine screening showed positive hepatitis B surface antigen (HBSAg) and positive hepatitis B core antibody. Her 34 year old husband had serology consistent with past hepatitis B. A detailed history failed to reveal any other risk factors. Two of their children had serological findings similar to their father’s whilst a third child was non-immune (who since then has been immunised to prevent accidental horizontal transmission). A fourth child, a 14 year old female, was positive for HBSAg and IgG antibody (IgG). She showed elevated transaminases and liver biopsy confirmed chronic active hepatitis. She failed to respond to treatment with interferon alpha. Testing his wife revealed a past hepatitis B infection but markers were absent in their four children who have been immunised subsequently.

Family C derives from a country with a high endemicity for HBV. Recognition of a highly infectious sexually active adult allowed for proper counselling to prevent transmission. Again, a community based approach acting through the family at the primary health care level is required to combat the infection among this population.

Clearly there is a need for careful monitoring of heterosexual transmission at present. The question at present is whether a subgroup of heterosexual clinic attenders would benefit from hepatitis B immunisation or whether it should be offered to all genitourinary medicine clinic attenders.

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Oral sex and recurrent vaginal candidiasis

Markos et al. suggest that orogenital sex may be an important factor in recurrence of vulvovaginal candidiasis. Their study showed that orogenital sex was more commonly practiced by couples, where the woman was afflicted by recurrent vaginal candidiasis, in comparison with a control group from their genitourinary clinic attenders. There are, however, other explanations for their findings.

Since superficial dyspareunia is a frequent problem in women with recurrent vaginal candidiasis it is probable that, in couples so afflicted, orogenital sex becomes an alternative to vaginal intercourse as a painless and effective method of sexual satisfaction. Their findings could be explained purely on this basis.

Furthermore their study did not control for socioeconomic status. A study of approximately 2,000 sexually active females in London has demonstrated a greater frequency of orogenital sex amongst Caucasian women and women of higher socioeconomic status (Radcliffe KW-unpublished data). Therefore any study such as this needs to be controlled for these variables.

For these reasons we do not believe that the authors’ findings necessarily support their conclusion that orogenital sex is a cause of recurrent vaginal candidiasis.

Whether “reinfection” with particular pathogenic strains of candida is part of the aetiology of recurrent vaginal candidiasis is unclear. Clarification of this will need careful prospective studies. Severe recurrent vaginal candidiasis can be a cause of much stress on relationships. Adding to this, blaming the male partner for “reinfection” and depriving a couple of what may be their main source of sexual expression, may cause more problems than it solves.