Syndromic management of genital ulcer disease—a critical appraisal

Control of sexually transmitted diseases (STDs) is of paramount importance in the present era keeping in mind the risk of HIV transmission.

WHO recommends use of simple algorithms for syndromic management which are based on a constellation of signs and symptoms produced by different (or a majority) of the organisms causing each of these syndromes (WHO Technical Report Series, 810, Geneva, 1991). Need for syndromic management was felt because clinical diagnosis of STDs is not always correct and time taken by laboratory tests might delay the treatment, thus prolonging the period of infectivity.

We find one of the flow charts related to genital ulcer disease (GUD) quite impractical for the following reasons:

(1) Signs and symptoms may not be consistent or specific for diseases like transient chancroid, herpetic chancroid, chancroidal ulcers. Ulcers of lymphogranuloma venereum and herpes genitalis might be impossible to differentiate even by the most experienced specialists. Presence of HIV could alter the typical morphology of all GUDs.

(2) Genital ulcers due to mixed infections might create a diagnostic and therapeutic dilemma.

(3) In developing countries GUD related lymphadenopathy is difficult to differentiate from lymphadenopathy following tuberculosis, leprosy and infected lesions over lower limbs in people who walk bare feet especially when the genital ulcer has healed.

(4) The flow chart does not address the problems of GUD in women, such as hidradenitis presenting as vaginal discharge, nor does it include treatment for sexual partners.

(5) Chemical ulcers following cleansing of the genital area with antisepsics like chlorhexidine as a part of prophylactic behaviour may mimic GUD/balanoposthitis of bacterial or candidal aetiology. Treatment for presumed infective aetiologies (non-diseases) would be a huge waste of precious drugs in developing countries, morals and ethics apart. With even a faint possibility of drug resistance, the consequences could be serious. Similarly treatment for traumatic ulcers, fixed drug eruption, Behcet’s disease and aphthosis etc, as for GUD such as syphilis or chancroid is uncalled for.

(6) The psychological trauma incurred by misdiagnosis of non-STDs as STDs might well cause serious disharmony in the conjugal life of patients.

(7) False labelling of disease would generate wrong epidemiological data. This would greatly hamper formulation of pragmatic STD control programmes for the future.

Hence we believe that the stress should be on: (1) Individual assessment of cases, (2) Proper clinical supervision and guidance of junior clinicians and paramedical staff, (3) Appropriate referral whenever required.

We would welcome views and suggestions of other physicians from developing countries.

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Factors affecting reattendance rates at genitourinary medicine clinics

Anecdotal evidence suggests that many patients who attend departments of genitourinary medicine subsequently reattend. The factors which determine whether a patient returns with a new diagnosis are less clear. As the workload of genitourinary clinics increases it may become increasingly important to identify those at risk of subsequent infections so that they may be targeted for active health promotion, although it is unclear how successful this is. In an attempt to analyse these factors we looked at all patients who attended between January and December 1987 and subsequently reattended over a five year period between January 1989 and December 1993. Patients with HIV infection were excluded from the analysis.

Of the 5824 patients who attended the Department of Genitourinary Medicine at Edinburgh Royal Infirmary with a new diagnosis in 1987, 1107 (19%) reattended on at least one occasion between 1989 and 1993. A multivariate analysis using logistic regression analysis was performed to assess which factors were significant in patients who reattended with a diagnosis of gonorrhoea or chlamydia or non-specific urethritis (NSU). Gonorrhoea was diagnosed as has been described previously and a diagnosis of chlamydia/NSU was made on the basis of positive cell culture from endocervical swabs in women and from the detection of greater than 10 pus cells per high power field on a Gram stained urethral smear in men, where gonorrhoea had been excluded by culture.

The results of the analysis are shown in the table. Of the 15 patients who reattended with a diagnosis of gonorrhoea following a negative HIV test in 1987 five (33%) had rectal infection, compared with two (9%) out of 29 patients with gonorrhoea who had not been HIV tested when seen in 1987.

Reattendance with gonorrhoea was associated with social class and sexual orientation of the patient with an increased rate of infection in social classes 4 and 5, and in homosexual patients. Chlamydial infection or NSU were...