Polyoidal and giant molluscum contagiosum

The letter by Kumar and Dawn1 on a case of solitary, giant penile molluscum contagiosum (MCV) merits further comment and clarification. We have observed a cardiac transplant recipient who was therapeutically immunosuppressed, with recalcitrant facial MCV, some of which are "giant MCV". This clinical entity does exist in non-HIV patients contrary to Kumar and Dawn's statement. We have just completed a clinical survey that showed a positive correlation between CDC categories B and C HIV disease and facial MCV, compared with genital lesions in stage CDC A and non-HIV clinic attenders (p < 0.001 Fisher's exact test) (table). The clinical and molecular study by Thompson et al2 also demonstrates the facial predilection of MCV in advanced HIV disease, but not to the exclusion of genital lesions as in Petersen's study.3 This suggests that genital MCV occurs in HIV infected patients, as a sexually acquired infection early and once established may present in an opportunistic form; however, the clinical site marking is determined by the degree of immunosuppression.

A J RBA
B T GOH
Department of Genitourinary Medicine,
Ambrose King Centre,
Royal London Hospital,
London E1 1BB, UK


Anatomical sites of MCV infection in patients at HIV and GUM clinics

<table>
<thead>
<tr>
<th>HIV status</th>
<th>Total no. patients with MCV</th>
<th>Face</th>
<th>Genital/trunk/limb</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV CDC C</td>
<td>12</td>
<td>12 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>HIV CDC B</td>
<td>4</td>
<td>3 (75%)</td>
<td>1 (25%)</td>
</tr>
<tr>
<td>HIV CDC A</td>
<td>3</td>
<td>0 (0%)</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Presumptive HIV neg</td>
<td>70</td>
<td>(1.43%)*</td>
<td>69 (98.57%)</td>
</tr>
<tr>
<td>GUM patients</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Cardiac transplant recipient.

Ignored trichomonal infestation diagnosed by Papanicolaou smear

The retrospective study of Petersen et al4 on ignored trichomonal infestation diagnosed by Papanicolaou smear reiterates the value of clinical judgment and phase contrast microscopy as part of the diagnostic screening in the evaluation of women (and men with urethral discharge) who attend an STD clinic.5

A recent audit in our unit evaluating the efficacy of saline wet-mount phase contrast microscopy in the diagnosis of trichomonalis in the period 1992-1994 confirms its continued usefulness as part of the diagnostic armamentarium in screening attenders at a general medicine (GUM) clinic. Our unit in the north east England region serves a catchment population of about 320,000 residing in the coastal city of Sunderland and its suburbs. As a routine, after obtaining relevant medical, sexual, contraceptive histories and a genital examination, a saline wet-mount smear from the posterior vaginal fornix in women and a urethral scrape from men with urethral discharge were examined by phase contrast microscopy. They were initially scanned at ×100 looking for motile trichomonads and then at ×400 to confirm motility and morphology of trichomonads. Samples from the posterior vaginal fornix and urethral discharge were inoculated into commercially available Oxoid Trichomonas Medium (Basingstoke, UK Ltd.), incubated at 37°C and examined after two days and seven days for motile trichomonads. Gram-stained smears were done on vaginal, urethral and cervical sites including cultures for Neisseria gonorrhoea, Gardnerella vaginalis, Candida albicans and Chlamydia trachomatis (ELISA). Serological tests were done for syphilis and hepatitis B surface antigen routinely and for HIV (I and II) antibodies in cases of known risk factors.

Cervical cytology was not performed as a routine, after obtaining requesting only testing for HIV antibodies but agreed to infective screening after counselloing. The rest attended for a check-up. Other STDs identified in the women (spondyloepiphyseal dysplasia, Nectiera gonorrhoea in 4.6% (2), Chlamydia trachomatis 18.6% (8), Candida albicans 18.6% (8), genital warts 16.2% (7), Gardnerella vaginalis 6-9% (3), Herpes simplex Type 1 in 2-3% (1)). An incidental finding of septrate vagina was noted in a 15 year old seen because of genital warts.

In this study, saline wet-mount phase contrast microscopy identified 88.3% (38) of the women and 50% (1) of the men in the first attendance, allowing prompt treatment. Subsequent culture identified 95.3% (41) of the women and 50% (1) of the men. Opportunistic cervical cytology was done in 14 of the women and trichomonalis was identified only in 75-3% (11) confirmed by culture.

Various hypotheses for the decline in incidence of trichomonalis had been made,6 but we believe that routine phase contrast microscopic examination of saline wet-mount vaginal material from the posterior fornix and urethral discharge should remain as an essential screening measure for trichomonalis in STD clinics, recognising the failure rate of various culture medium.4 However, direct immunofluorescence with monoclonal antibodies holds promise as a sensitive and specific alternative to the culture media for the rapid detection of Trichomonas vaginalis in clinical specimens.7

T C HARRISON
K M SARAVANAMUTTU
Department of Genito-Urinary Medicine,
London Medical School,
The Royal Free Hospital,
London NW3 2QG, UK

Address correspondence to: Dr Tuboony C Harry.


The value of colposcopy in genitourinary medicine

In view of Griffiths' further comments on colposcopy in genitourinary medicine,1 it seems that a brief final observation may be justified.

The original paper2 was a retrospective report which looked back to 1973. The paper clearly identified that the colposcopy approach that was being explored was exactly that of the very wide use of the colposcope as practised throughout Germany, Spain, Italy and much of France and South America. Simply magnification of the cervix is considered to be a better way to detect a range of cervical diseases. This includes infections and inflammatory conditions. Clearly this broad approach can...