Vaginitis emphysematosa

Vaginitis emphysematosa is usually a self limited cystic disorder of the vagina. The paucity of reports on this rare entity and the fact that it can first present to the sexually transmitted diseases (STD) clinic where, for want of a better diagnosis, it may be passed off as condyloma acuminatum, prompted us to document the condition in a young woman.

Case report

A 29 year old gravida 8, para 8 woman presented with an asymptomatic growth in the vaginal introitus of 2 years' duration. It had started spontaneously and gradually attained the size of a small lemon, and had remained as such for months. On examination she was of average build and nutrition without any associated disorders like diabetes and hypertension. Local examination revealed a pedunculated mass measuring 2 cm in diameter protruding from the right side of the labia minora. There was no discharge and no other abnormality was visualised. The natural history of vaginitis emphysematosa has been observed that inflammation is generally mild and absent. This may also account for the lack of symptoms in most of these patients. The natural course for vaginitis emphysematosa is to resolve spontaneously and in most cases this has been an incidental finding. On those occasions when the mass makes the patients seek advice simple excision may be done as in the present case. Apart from solid tumours like condyloma acuminata, other benign cystic lesions of the vagina like inclusion cyst, Gartner duct cysts, and endometriosis should be considered in the differential diagnosis.

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References


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Management of screened chlamydia positive women

Evidence based and minimally harmful management of screened positive people is an essential component of any screening programme. In the pilot chlamydia programme the protocol for those who screened positive included testing for other genital infections, and partner notification. This policy is not evidence based and requires evaluation before roll out of the screening programme nationally.

During the 12 month period September 1999 to August 2000 in Wirral and Portsmouth women throughout the communities up to the age of 25 years were offered a urine LCR test, in general practices, family planning clinics, gynaecology, antenatal and termination of pregnancy services. Departments of genitourinary medicine (GUM) also offered the test though clearly these were usually for diagnosis rather than true screening.

Results were sent to everyone tested, as in other screening programmes, and an overall positivity of some 10% was found. Both pilot sites had a central office, which was the initial point of contact for all testing positive. This avoids disparities in treatment by different health professionals and services and had the added benefit of removing concerns raised about time required in each service for managing results, treating, counselling, and partner notification. As our previous experience showed that many people delayed or did not attend a department of GUM when referred, two experienced health advisers were appointed on Wirral and based in the pilot office. These community health advisers had overall responsibility for ensuring and documenting that correct management occurred. People testing positive and reporting symptoms or risk factors were strongly advised to attend the department of GUM and were given a referral letter. However, those who were asymptomatic and who indicated that they did not wish to go were treated according to patient group directions with doxycycline, azithromycin, or erythromycin as appropriate. In these cases the health advisers undertook partner notification and sometimes their treatment. The pilot coordinator (JJH) undertook overall clinical responsibility and saw patients as needed.

During the 12 months of the pilot programme 112 women tested chlamydia positive by the “screening” test in GUM and most returned there for management. Sexually
transmitted infections in these women comprised three cases of gonorrhoea, 30 of genital warts, and six of herpes simplex. There were also 11 cases of candida and 18 of bacterial vaginosis. These figures represent multiple infections for several women.

Four hundred and six women screened in other healthcare settings tested chlamydia positive. The community health advisers treated 321 of these and 85 agreed to attend GUM. Five of these women (5.8%) had another sexually transmitted infection comprising only one case of gonorrhoea, two cases of genital warts, and two cases of genital herpes. There were also nine cases of candida and 17 of bacterial vaginosis.

If efficient and effective treatment for chlamydia is to take place in the community then health advisers will be essential as in the Viral pilot scheme. They will need to establish in each case whether there are symptoms or special risk factors that transform the process from screening to one of diagnosis. Although diagnosis should involve testing for all relevant causes of the symptoms, we have found no evidence to support this as routine in a screening programme if it is known that the community prevalence of other significant infections is low. The invasive nature and possible stigmatisation by seeking for other infections together with the cost to individuals and the health service could be balanced against any personal or community benefits from the strategy.

The women who chose to be treated in the community were offered a test for gonorrhoea (by LCR) on the original urine sample which had been frozen in the Liverpool Public Health Laboratory. Two of 192 women accepting this were found to have a positive test and were then referred to GUM clinics. This appears to be an acceptable and efficient means of finding this infection in those who would not otherwise present for testing.

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References

NOTICES

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, regional office of the World Health Organization

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).

7th Congress of the European Society of Contraception, “Changing attitudes to contraception and reproductive health”

10–13 April 2002, Genoa, Italy

Further details: ESC Central Office, OrgaMed, Essenenstraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.uwem.be).

MSSVD course in STIs and HIV: Module 1, Epidemiology of STIs and Bacterial Infections


Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 3YP (tel: 01372 454210).

MSSVD course in STIs and HIV: Module 2, Sexual Health and Sexuality

26 April 2002, at the Institute for Materials, 1 Carlton House Terrace, London

Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 3YP (tel: 01372 454210).