TRICHOMONAS VAGINALIS

Sir,

We read with great interest the article, "Trichomonas vaginalis - an indicator for other sexually transmitted infecting agents" by Agrawal et al published in the Indian J. Dermatology Venereology and Leprology. Vol 66: No. 6: 241-44. We would like to offer some comments over this study. Firstly, the word "Excessive vaginal discharge" has not been clearly defined as this is to be classified as physiological or pathological leucorrhoea. There is no mention regarding the nature of the discharge and no attempt has been made to correlate the clinicomicrobiological profile of the patients. Also it has not been commented whether on speculum examination the discharge was emanating from vagina or cervix. The symptomatology of these females in relation to itching, soreness, relation of discharge to menstruation, abdominal pain and others are surprisingly omitted. How many of 350 females were pregnant or if not, what type of contraception were they using, is also not included in the study. Pregnancy alters the biochemical as well as hormonal environment of vagina and that along with congestion has a definite bearing on the amount of discharge that is produced. Non barrier methods make environment for candidiasis and Chlamydia trachomatis[1] to flourish more. Method of contraception used has been completely ignored. Socioeconomic status of the female that has been shown to have an inverse relation with trichomoniasis, (lower the status, higher the prevalence) has also not been looked into.[2,4]

No point is made regarding the methods used (wet mount microscopy. Giemsa staining, inpouch TV test or culture) that detected Trichomonas vaginalis in 61.7% of women in the age group of 20-30 years. In sexually active age group, the finding of Trichomonas vaginalis in 61.7% of females as compared to 8.7% C. trachomatis and 23% N. gonorrhoea contradicts the earlier age stratified epidemiological picture of these infections provided in previous studies which demonstrate that prevalence of Trichomonas vaginalis is much less than C. trachomatis and N. gonorrhoea in sexually active age group.[2,3] With increasing age the prevalence of C trachomatus, C triachomatis and N.gonorrhoea decreases, thereby proving that Trichomonas vaginalis has a different dynamics of infection as compared to other two pathogens. It was surprising to note that in all 350 females the etiological agent was found and none had the diagnosis of idiopathic vaginal discharge. In the sexually active age group, bacterial vaginosis is the most prevalent cause of vaginal discharge.[4] In a recently published study from Delhi by Vishwanath et al[4] in 478 females of poor socioeconomic status, no cause could be elicited in 40% and bacterial vaginosis was the most frequent but proved diagnosis in 26% whereas Trichomonas vaginalis ranked a poor fifth with an incidence of 10%. In the present study bacterial vaginosis is completely missing from the aetiological list which is very hard to accept.

In this study no reference has been made to the symptomatology of males (burning micturition, urethral discharge, testicular pain and scrotal tenderness). So presumably most were asymptomatic. The finding of Trichomonas vaginalis in 82.3% male counterparts crosses many times more the figures that has been reported. Lanceley and Mcentergart[5] quote a study by Karnarky in which 25.3% of husbands of women with Trichomonas vaginalis were infected.[5] Further studies have isolated Trichomonas vaginalis in 41.9% (Burch) and 60% (Drummond) from urethra of males that were symptomatic. Further, some specific risk factors that predispose a male towards trichomoniasis have not been referred to, especially factors like males indulging in polygamous relationship and their circumcision status because polygamy enhances the chances of trichomoniasis and uncircumcised males are more predisposed to this infection.[6] Also it is not stated from where and with which method T.

vaginalsis was isolated from males.

Serology of C. trachomatis can be positive even in normal individuals and can certainly act as confounding factor while estimating its prevalence. Also the details of serology done for syphilis are missing from the data provided. Neither the number of VDRL positives nor the dilutions are mentioned. This is important because every VDRL positive case cannot be labelled as a case of syphilis till the time paired samples are taken and a cut off limit of these dilutions are drawn. Otherwise this will lead to very erroneous conclusions. VDRL positivity cannot be taken as active T. pallidum infection. Nothing has been said regarding the type of lesions or the stage of syphilis from where T. pallidum was isolated. Similarly, methodology of isolation of H.ducreyi is not mentioned - (sampling method and media used for isolation). We are well aware of the great difficulties in the isolation of H. ducreyi from the vaginal secretions. We would definitely like to know the achievement of the authors on this aspect. It is certainly very difficult to believe the statement of authors that in females suffering from candidiasis, trichomoniasis gets promoted. This is a serious compromise with the altered biochemical profile that the two agents require to be pathogenic. Candidiasis requires an acidic pH in vagina i.e. strictly opposite to the alkaline pH under which T. vaginalis flourishes.[7] We would like to know how can two agents with opposite biochemical requirement compliment each other. We are of the firm opinion that the information provided in the study is very little to challenge the earlier very elegantly designed and painstaking studies giving us epidemiological, clinical and investigative findings in women with vaginal discharge. Coexistence of so many sexually transmitted pathogen (if actually present for which there is no reliable evidence) is merely due to faulty conclusions drawn by authors and this study does not draw any worthwhile conclusions.

Bhushan Kumar
Rajesh Jain
Department of Dermatology, Venereology and Leprology. PGIMER, Chandigarh.

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SILDENAFIL NITRATE : ITS PRESCRIPTION

To the Editor

Union Ministry of Health has given a circular that sildenafil nitrate (SN) should be prescribed by psychiatrist, urosurgeons and endocrinologists, not by Dermatologists (Dermatovenereologists). But according to teaching curriculum of Medical council of India, Dermatovenereologists are entitled to treat venereal diseases including erectile dysfunction which has been included in the textbook of sexually transmitted diseases as a separate chapter. Most of the patients of ED attends the clinics of Dermatologists but they seem to have no right to treat the patient. Local chemist's association has been instructed by proper authority not to serve the prescription other than these specified three groups.

I want to know whether any possibility of legal liability arises by treating ED by the physicians other than these specified three groups.

Kalyan Chakraborty
Skin Clinic, 883, Jessore Road, Kolkata - 700 055.