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Letter to the editor regarding “Laboratory detection of bacterial pathogens and clinical and laboratory response of syndromic management in patients with cervical discharge: A retrospective study”

Dear Editor,

We read the article “Laboratory detection of bacterial pathogens and clinical and laboratory response of syndromic management in patients with cervical discharge: A retrospective study” with great interest.¹ A relative lack of laboratory facilities for pathogen detection and other social and resource constraints often leaves sexually transmitted infections (STIs) to be managed on a syndromic and a rather empirical basis in India, as also highlighted by the authors. However, some nuances need to be addressed in this study. This retrospective study revealed “infectious” aetiology in only 30 (44.7%) patients. Though the non-infectious aetiology may not be of primary concern to the sexually transmitted disease (STD) specialist, the remaining half of these patients need some more academic attention. Surprisingly ureaplasma species was the commonly isolated organism on culture and polymerase chain reaction (PCR).

In Table 1 of the source publication,¹ the authors have provided a “demographic and clinical profile of cases and

controls” for a total of 70 patients. However, the significance and correlation of these items are not clearly defined in the methodology and the results. The analysis for bacterial isolates has been done on 67 pre-treated samples and 28 samples as post-treatment or test-of-cure. This incongruity of the denominator in the analysed data sets makes the “generalisation” of results and drawing inferences from it difficult. The clinical improvement has been graded from “complete” through ‘moderate’ to “minimal/none”, which again raises questions as to how this grading is practically employed for cervicitis by the patient or the examiner. An infection if eliminated is expected to control the discharge and symptoms completely in 4 weeks. Analysis of treatment response separately for patients with cervicitis and pelvic inflammatory disease (PID) for cases, where the aetiology was ureaplasma or mycoplasma species, would also be a better practical significance.

The essential result of this study implicates that ureaplasma is the culprit for most cases of infectious cervicitis, suggesting a “change in trend of cervicitis toward the non-gonococcal,

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non-chlamydia cause.” Our main concern here is the incrimination of ureaplasma as the “cause” of cervicitis based on “isolation” only. With molecular diagnostics such as PCR, there is enhanced sensitivity for the detection of bacterial flora, albeit with caution in its interpretation. Genital mucosa is a habitat for a plethora of microbes, both commensal and pathogenic. It has been seen that ureaplasma inhabits the female genital tract in asymptomatic, sexually active women with almost the same frequency as those with an STI.²⁻⁴ Isolation of ureaplasma species (by PCR) in a greater number of treated patients (29.3% vs 38.4%) is also a pointer towards this being a commensal. Recent European guidelines do not suggest routine screening or testing for ureaplasma or mycoplasma species since the majority of men and women infected or colonised with *U. urealyticum* do not develop the disease.⁴ Even under isolation, eradication of these organisms is unrealistic and promotes unnecessary antimicrobial resistance. The outcome of ureaplasma in the female genitourinary tract depends on the quantitative load as well as host immune responses.⁵ Hence, a quantitative PCR may help in these treatment decisions with the clinician’s discretion to treat these organisms in refractory cases. The difference between colonisation and actual causation is hence debatable.

As already highlighted by the authors themselves, the lack of a control group makes the interpretation difficult. The “minimal improvement” in about half of the patients in the study led to the conclusion that syndromic management is far from perfect for cervicitis. However, there are multiple factors for the same, and the detection of non-gonococcal flora might just be a bystander. It seems that the authors themselves are not very sure of the role of ureaplasma species, because in their 10-year (2010–2019) study they have focused only on the presence of *Chlamydia trachomatis* and the selected patients from 2016 to 2017, from a part of the larger study comprising 1671 females.⁶ For what specific emphasis is only 70 of the patients were recruited from all the female patients seen during that period, with isolation of ureaplasma species, which is more of a commensal organism, were selected is not clear.

The claim by the authors in the conclusion of response in half to 2/3 of the patients is not borne out by the point of cure test results given in Table 3³ (infectious aetiology 36.5% vs 38.4%). A larger study with a control group with regular monitoring of treatment response would perhaps be of more utility for clinical translation.

Declaration of patient consent

Patient’s consent not required as there are no patients in this study.

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Conflicts of interest

There are no conflicts of interest.

Use of artificial intelligence (AI)–assisted technology for manuscript preparation

The authors confirm that there was no use of artificial intelligence (AI)–assisted technology for assistance in the writing or editing of the manuscript, and no images were manipulated using AI.

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