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The Indian Journal of Dermatology, Venereology and Leprology is a bimonthly publication of the Indian Association of Dermatologists, Venereologists and Leprologists and published by Medknow Publications.

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Melasma was found in only 4 (3.15%) cases during pregnancy and in one with history suggestive of antepartum PID.

This study highlights that melasma in women is possibly due to photosensitivity in patients with chronic PID in a majority of cases. The association of melasma with pregnancy and oral contraceptives reported earlier was possibly due to increase proliferation of chlamydia during pregnancy due to lowered body immunity and milder nature of PID in those on oral contraceptives,[7] respectively.

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Comments on "Serological study for sexually transmitted diseases in patients attending STD clinics in Calcutta"

Sir,

It was interesting reading "Serological study for sexually transmitted diseases in patients attending STD clinics in Calcutta" published in Indian J Dermatol Venereol Leprol 2002; 68 275-278. We have some queries: comments for the authors to address.

What was the purpose of doing a qualitative VDRL test (which is more relevant in field conditions) in such a reputed institute of serology? A test with undiluted serum can result in false negativity because of the prozone phenomenon. Any titre cannot be considered significant (reactive). The VDRL test always has a standard cut off value for the uniform interpretation of results. However, the authors have not mentioned any such value in their article. In a developing country like India, various chronic infections can result in a false positive VDRL test in 1-3% of the patients. Further, a 'reactive' non-treponemal test indicates a present infection or a recently treated or untreated infection.[1] The result needs to be correlated with the medical history, examination and even with specific treponemal tests.

TPHA is a quantitative test reported in titre and so agglutination at a particular titre is more meaningful than mere agglutination. It is well known that a low degree of TPHA positivity will remain for years even in cases who have been adequately treated.[2] VDRL and TPHA tests indicate the same disease and adding them up falsely increases the total number of positive tests without any logical basis.

Serologic assays may be useful in detecting the prevalence of *Chlamydia trachomatis* infections of the genital tract in the community. Since 45-65% of patients may have IgG antibodies resulting from past infection, only a certain level of titre or demonstration of a four-fold rise in titre in a repeat sample is meaningful. Detection of IgM antibodies is more helpful in establishing acute chlamydia infections of the genital tract.[3] The present test report does not make us any wiser.

The results section is confusing; tabulating one or more serological tests in various combinations does not give any meaningful information. The article does not give us any idea about what the authors want to convey - single sample seropositivity without any cut off value?

It is commendable that the authors have tried to study the serum sample of such a large number of STD clinic attendees. However, a better-designed and interpreted study would have resulted in more useful information especially coming from such a leading centre. We hope our comments will be taken in the spirit they are meant to be.

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Response by the author

Sir,

With reference to the queries of Dr. Dogra and Dr. Kumar on our article "Serological study for sexually transmitted diseases in patients attending STD clinics in Calcutta", our comments on the various points raised by them are as follows:

1. As had been clearly mentioned in the Introduction, one of the main objectives of the study was "to ascertain the prevalence of syphilis, hepatitis B, chlamydia and HIV infection among patients attending different STD clinics in Calcutta".

2. Since the VDRL test is a low cost, rapid and a good screening test, all the samples were first subjected to qualitative tests and samples showing reactivity were then further subjected to a quantitative test. In fact, it has been clearly mentioned in the article, under Materials and Methods that "Quantitative test was performed on all reactive sera including those showing weak or rough reaction". Moreover, all the VDRL reactive sera, including all biological false positive sera were subjected to the TPHA test, which is a very specific test.

3. As mentioned under Materials and Methods, the TPHA test was performed using TPHA 200 kits, manufactured by Newmarket Laboratories Ltd., UK, strictly as per the manufacturer's instructions. If one goes through the literature of the kit in detail, it will be observed that the final dilution of the sample is 1:80. Hence this is again a quantitative test and not qualitative. This is the standard method for the TPHA test.

4. About the comment that adding up VDRL and TPHA tests "falsely increases total number of positive tests without any logical basis", it appears that the data has been misinterpreted. It must be clarified that Table V showing two tests positive, i.e. VDRL+TPHA, indicates that the same sample was positive for both VDRL as well as TPHA. So there is no question of increasing the total number.

5. Yes, we agree that IgM antibodies are more helpful in establishing acute chlamydia infections of the genital tract, but the present study was undertaken more from the epidemiological point of view. The values obtained from this assay are intended to be an aid for diagnosis only.

6. Table II clearly shows positivity for different serological tests among different age groups, infection being most commonly observed in the 15-30 years age group (20.13%), followed by the 30-45 years age group (12.69%) and the > 45 years age group (4.38%). It thus shows that the 15-30 years age group is the most vulnerable, and because of their risky behavior, this age group is susceptible to multiple infections.

7. Single sample positivity proves that only one infection was positive. All the serological tests, viz. HBsAg, TPHA, chlamydia-IgG, were done by kits, as per the manufacturers' instructions and guidelines. The HIV test was done at the School of Tropical Medicine, which is a NACO centre for HIV detection. All the sera were tested by the ELISA method, using kits from INNOTEST HIV-1/HIV-2 Sp. Innogentics N.V., Belgium. ELISA reactives sera were confirmed