Ind J Dermatol Venereol Leprol 1994; 60 : 323-26

A TEN YEAR STUDY OF STD CASES IN AN URBAN CLINIC IN CALCUTTA

Sadhan Kumar Ghosh, Alok Kumar Roy

Total 16440 patients attended the STD clinic during the 10 years period of study from 1984 to 1993. From 1988 number of STD cases were gradually decreasing probably due to less promiscuity in fear of AIDS and different measures taken to prevent transmission of HIV infection. But it does not lessen the importance of STD control, because syphilis is still prevalent (8%) with congenital syphilis. Peak in the incidence of chancroid (15%) is alarming as this may lead to increased transmission of HIV infection in near future. Male unmarried constituted the bulk of STD sufferers (44%) and married males (34%), while female unmarried and married patients were 1% and 20% respectively. 5.7% of antenatal mothers were strongly seroreactive for syphilis. Therefore all antenatal mothers should be screened for STD and routine serological test for syphils should be done.

Key Words : Sexually transmitted diseases, Urban clinic

Introduction

Syphilis, gonorrhoea, chancroid, lymphogranuloma venereum and granuloma inguinale were considered the five venereal diseases. Though after the invent of modern antibiotics, the treatment of venereal diseases has been easy and satisfactory with less morbidity and social and congenital stigma, but that does not diminish their importance as infectious diseases of general concern, but it does point out that the spectrum of this type of communicable disorder is broad and the number of people affected by more common sexually transmitted disorders (STDs) is high.[1] After the advent of human immunodeficiency virus (HIV) and AIDS, the impact and importance of STDs have again come to the fore-front. Sexual transmission is one of the modes of transmission of HIV infection, Mucosal trauma as is more likely in anal intercourse and the presence of other anogenital infections, especially if eroded or ulcerated - typically herpes simples, syphilis or chancroid - facilitate viral transfer.[2]

From the Department of Dermatology & Venereology, R G Kar Medical College Hospital, 1, Belgachia Road, Calcutta - 700 004

Address corresspondence to : Dr Sadhan Kumar Ghosh

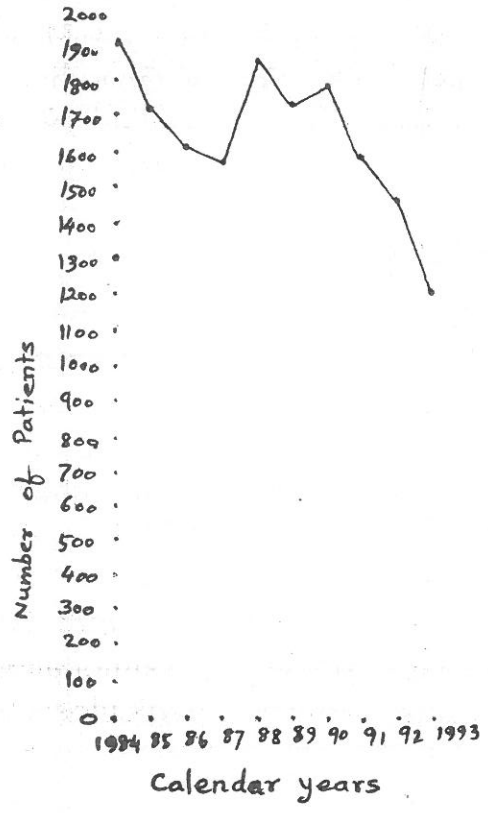
Therefore, control of STDs is a primary necessity for the prevention of HIV infection and development of AIDS. Though AIDS is not a major problem at the present moment in India in comparison to the Western and African countries, but it is the high time to take measures for control of HIV infection and STDs in our country. 221 AIDS cases including 14 foreigners and seropositivity rate per thousand 5.50 were reported by the National AIDS Control Organization, Ministry of Health and Family Welfare, Govt. of India during the period from 1st October, 1985 to 31st July 1992. More than 70% of these AIDS cases acquired the infection through hetero-sexual route.

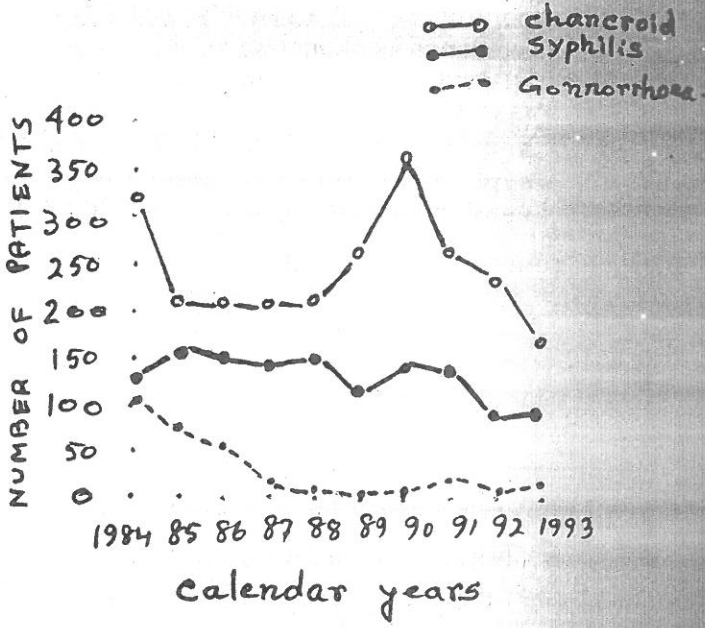
Besides the above diseases, there are numerous disorders that can be transmitted through sexual contact, namely, genital herpes, genital warts, molluscum contagiosum, hepatitis virus, chlamydia infections and non-gonococcal urethritis (NGU), genital candidiasis, trichomoniasis, amoebiasis, giardiasis, cryptosporidiosis, enterobiasis, strongyloidiasis, shigellosis, salmonallosis, campylobacter enteritis, pediculosis and scabies.[3]

Prostitution is very important in developing countries, where the large majority of STD episodes are contracted through them. In some urban and tropical areas, over half of the prostitutes were found to be infected with gonorrhoea, syphilis or HIV infection.[4,5] Prostitutes and promiscuous individuals especially form a reservoir. Homo-sexuals because of multiplicity of partners and less recognition of the pattern of oral and ano-rectal diseases are an increasing reservoir. High prevalence of STD, as a result of changing socio-economic factors has been reported from the rapidly developing oil rich middle-eastern countries.[6] The present study has been undertaken to have a view of the trend of STDs in a cosmopolitan city like Calcutta.

Meterials and Methods

Data were collected from the out-patient attendence register of STD clinic from the year 1984 to 1993. Demographic figures, clinical diagnosis and blood VDRL test of STD patients and antenatal mothers were studied. Clinical diagnosis was confirmed by gram staining of smears of urethral and vaginal discharges and routine examination of blood for serological test of syphilis.





Comments

From the year 1988 the number of STD cases were gradually decreasing with slight increase in 1990 may be due to less promiscuity in fear of AIDS and different measures taken to prevent transmission of HIV infection. In this study the greatest number of cases occurred in the age group 15-35 years. Male patients were found to be nearly four times of female patients. This could be explained because of demographic factors such as more young male being in urban centres and resorting to small pool of prostitutes. Secondly, men recognize the lesions more easily and present early for treatment. Moreover some societies do not facilitate women coming to a clinic for genital complaints, perhaps to be examined by a man. Male married patients were 34% and

Table I. Table showing male and female patients with their marital status.

Year	Males		Female		Child		Total
	Married	Un-married	Married	Un-married	Male	Female	Patients
1984	644	747	441	48	15	9	1904
1985	574	723	384	30	9	5	1725
1986	563	716	298	20	3	10	1610
1987	565	667	309	12	10	7	1570
1988	663	820	355	6	7	8	1859
1989	631	749	330	15	6	2	1733
1990	630	788	344	22	6	6	1796
1991	521	693	353	9	3	3	1582
1992	402	733	295	10	7	12	1459
1993	322	615	252	12	0	1	1202
Total with %	5515	7251	3361	184	66	63	16440
	34%	44%	20%	1%	0.4%	0.38%	100%

Table II. Table showing number of different STD patients attending the Clinic.

Years	Syphilis	Gonorrhoea	Chancroid	N.G.U.	L.G.V.	G.I.	Others
1984	127	107	321	67	32	0	1250
1985	155	76	207	56	33	0	1198
1986	152	53	208	81	28	0	1088
1987	145	14	208	78	32	0	1093
1988	155	6	214	77	43	0	1364
1989	117	4	268	106	13	0	1225
1990	140	4	362	114	12	0	1164
1991	140	20	262	90	9	0	1061
1992	83	5	232	88	7	1	1043
1993	93	16	172	44	4	0	873
Total with %	1307	305	2454	801	213	1	11359
	(8%)	(2%)	(15%)	(5%)	(1%)	1	(69%)

Table III. Table showing Serological positivity in STD clinic attendents and Antenatal cases.

Years	Total VDRL tests done	Reactive	Non-reactive	ANC Reactive	ANC Non-reactive
1984	1369	98	1217	5	52
1985	1312	146	1166	8	79
1986	1209	152	1057	6	48
1987	1219	138	1081	3	55
1988	1353	137	1216	0	49
1989	1224	142	1082	3	53
1990	1143	104	1039	6	98
1991	1083	129	954	4	67
1992	942	74	868	2	70
1993	918	18	900	1	58
	11772	1138	10634	38	629
		(9.7%)	(90.3%)	(5.7%)	(94.3%)

male unmarried 44% whereas female married 20% and female unmarried only 1%. The increased number of unmarried male patient is probably because a stable marriage with both partners living together protects the couple from STD. Female married patients were 20

imes more than the unmarried, probably due o social stigma of attending STD clinic, but married females usually attend the clinic with their diseased husband. Less than 1% of total patients was child, because child sexual abuse is much less in our country than in western countries because of stable family.[7]

In this study the commonest STD was found to be chancroid (15%) and in 1990 peak incidence occurred (31%). In industrialized western countries, chancroid is the cause of 1-2% of cases of genital ulceration. These observations are similar to previous reports.[7-9] Syphilis was found in 8% of patients and it was fairly steady during the study period and 6 cases of congenital syphilis were detected.

In our country, pregnant mothers do not always attend the antenatal clinics and take adequate treatment. Further resort to traditional remedies or purchased antibotics can lead to increased opportunity of transmission and delay in cure.

Gonorrhoea was found in 2% and NGU in 5% of total patients. A steady decline in the incidence of gonorrhoea is likely to be due to advent of quinolone derivatives and early self-medication. L.G.V. was detected in 1% of total STD clinic attendents and only 1 case of granuloma inguinale was found during the last 10 years. It is similar to the previous observation.[9] In the present study 5.7% of antenatal mothers were VDRL test strongly reactive, which is a significant finding and indicates the need of regular check-up for syphilis and also other STDs.[10]

References

1. Kenneth A Arndt. Manual of Dermatologic therapeutic, 4th Edn. Boston : Little, Brown & Co., 1989; 135-46.
2. Piot P, Laga M. Genital ulcers, other sexually transmitted diseases and the sexual transmission of HIV. Br Med J 1989, 298 : 623-4.
3. Arya O P, Osoba AO and Bennett. Tropical Venereology, 2nd Edn ISE. Edinburgh : Churchill Livingstone, 1984; 4.
4. Khoo R, Sng EH, Goh AJ. Incidence of sexually transmitted diseases in prostitutes in Singapore. Asian J Infectious disease 1977; 1: 77-9.
5. Lahiri VL, Jain NK, Elhence BR, Dhir GG, Lahiri B. Study of sexually transmitted diseases in 50 prostitutes of Agra (India). Asian J Infectious diseases 1978; 2 : 221-2.
6. Farid M, Sallam, TH, El Shiemy S. Sexually transmitted diseases in Abu Dhabi : Epidemiological features of a consecutive series of 1780 cases. Emirates Medical Journal 1981; 2 : 84-6.
7. Csonka GW, Dates JK. Sexually transmitted diseases. A text book of genito-urinary medicine, 1st edn. Bailliere Tindall 1990; 352-89.
8. King A, Nicol C, Rodin P. Venereal Diseases, 4th edn. ELBS 1980; 251.
9. Kapur TR. Pattern of Sexually transmitted diseases in India. Ind J Dermatol Venereol 1982; 48 : 23-4.
10. Mabey DCW, Lioyd-Evans NE, Conteh S, Forsey T. Sexually transmitted diseases among randomly selected attenders at an antenatal chlinic in the Jambia. Br J Ven Dis 1984; 60 : 331-6.