Letters in Response to Previously Published Articles

Clinical and epidemiological profile of sexually transmitted infections in a tertiary care centre in Kerala: A 1-year observational study

Sir,

I read with great interest the article by Jayasree *et al*.[1] The article would have been more informative if the authors had clarified certain issues for the benefit of the readers. This indeed may be due to the limited space available to the authors to put in all facts but still some issues do need attention. There are many parameters which have been recorded but not analyzed related to their effect on the incidence of sexually transmitted infections in the study population, namely economic status, educational status, age at coital debut, condom usage, rate of circumcision, relevance of casual contact and contact with a commercial sex worker in relation to the occurrence of sexually transmitted infections.

Specifically:

- "A statistically significant association was found between sexual abuse in childhood and smoking ($P = 0.004$), alcohol and injectable drug use ($P < 0.001$) in adulthood. What is the relevance to the present study and how much statistical significance can be attached to these five women and nine men with history of child abuse (with increased history of smoking, alcohol use (quantity, frequency not defined) and homosexual activity). Is child abuse the cause for homosexual activity? No definition is given to say what constituted "homosexuality" in the sense that it becomes a risk factor for acquiring sexually transmitted infections.
- We expect that symptomatic patients will report to the clinic. Hence, how did these nine patients with syphilis of unknown duration present or were they detected as part of the workup of a patient? How were the human immunodeficiency virus (HIV)-positive patients diagnosed to have syphilis? What were the cut-off dilutions in HIV-seronegative and HIV-seropositive patients?
- What were the diagnostic/laboratory methods used to reach a diagnosis in all these patients?
- The number of contacts (97%) reporting to the clinic (including contacts of unmarried women) is really appreciable. Most of the male partners (89.5%) including some of the married men revealed a history of extramarital contact, casual or with a commercial sex worker. Is it the effect of good counseling or sympathetic history taking or both?
- What were the sexually transmitted infections detected in these male contacts and what was their incidence?
- What about female contacts of the men who attended the sexually transmitted infection clinic? Was contact tracing and diagnosis undertaken?
- Contact tracing was possible in only 50%, partner referral brought in 97% of the contacts. Hence, was contact tracing concentrated on only 3% of these remaining contacts?
- Do we consider vulvovaginal candidiasis as a true sexually transmitted infection requiring tracing and examination of the contact?
- What was the marital status of these "polygamous" men and women? Sexual behavior cannot be equated with marital status.
- In one paragraph, it is mentioned that 7% men were living separately. In another paragraph, it states that men migrants who were away from their spouses formed 39% of the population, whereas Table 1 shows only four men were living separately.
- What is the inference of "significant difference" between marital status of men and women?

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Conflicts of interest

There are no conflicts of interest.

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1. Jayasree P, Binitha MP, Najeeba R, Biju G. Clinical and epidemiological profile of sexually transmitted infections in a tertiary care centre in Kerala: A 1-year observational study. Indian J Dermatol Venereol Leprol. 2015; 81:500-503.

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