

genitourinary clinic consultant, he was allowed by the physician at the High Commission to go ahead with his proposed visit and eventual permanent settlement in the host country. This case re-emphasises the importance of undiagnosed syphilis in the elderly.<sup>12</sup>

However, sexual abuse of the elderly must be kept in mind in this context. A moving case of syphilis in a 68 year old lady after rape has been well documented.<sup>3</sup> So also has the diagnosis of syphilis been reported in two elderly female patients, one in coma, following possible sexual abuse, as serological tests performed six months previously on one, and three years earlier on the other were non-reactive.<sup>4</sup> Moreover, screening tests for dementia in a home for the elderly revealed three cases of neurosyphilis with positive serology.<sup>2</sup> Perhaps this is a solemn reminder of how little is known of this problem in the elderly.

B CHATTOPADHYAY  
Public Health Laboratory and  
Department of Microbiology,  
Whipps Cross Hospital,  
London E11 1NR,  
UK

- 1 Woolley PD, Anderson AJ. Prevalence of Undiagnosed Syphilis in the Elderly. *Lancet* 1986;ii:1034.
- 2 Gaman WN. Screening test for dementia in personal care home. *Can Med Assoc J* 1984;130:106.
- 3 Bierman SM. A piece of my mind: the 'terrible' question. *JAMA* 1985;253:No 5, 641.
- 4 Luke EA Jr. Syphilis in the elderly. *JAMA* 1985;254:No 13, 1722-3.

## MATTERS ARISING

### Sexually transmitted diseases in rape victims

We read the report of Estreich *et al*<sup>1</sup> on victims of sexual assault with interest and can confirm findings of similar rates of STD in such victims referred by a police surgeon in Leeds.

In a 24 month period after July 1988 52 female victims of sexual assault (mean age 19.5 yr, range 13 to 48) were referred by a local police surgeon and attended the Department of Genito-

urinary Medicine, Leeds between 3 days and 4 weeks after the incident.

Fourteen women (28%) had a sexually transmitted disease (seven *Chlamydia trachomatis*, two *Neisseria gonorrhoeae*, five *Trichomonas vaginalis*). A further six women had non specific cervicitis and four had abnormal cervical cytology (two had CIN, the other two defaulted from follow up). Interestingly four of eleven women who were examined within 96 hours of assault had an STD indicating that such women may be at risk from pre-existing STD.<sup>2</sup> There were no cases of genital warts, herpes simplex or syphilis. All women were counselled for HIV and 11 specifically asked to be serotested mainly because of fear of acquisition of infection. None had any defined high risk factors but in only two cases were the assailants recognised. All serological tests for HIV were negative.

Prior to 1988 very few cases were referred from the local police surgeons. Since then we have developed excellent links with one who examines the majority of assault victims and these now constitute an important source of referral of such women to the department. Local women police constables have taken a supportive role and often accompany victims to the department if requested. A review of all rape cases a few months ago indicated infrequent referrals by voluntary organisations (such as Rape Crisis) and we have now instigated closer links with these groups with a consequential increase in numbers seen. These organisations regularly change personnel and it is therefore important to audit cases of sexual assault that are referred on an ongoing basis, and to maintain a dialogue, so that such women, who have high rates of genital infections, continue to be offered the essential screening services provided by genitourinary medicine departments.

S P R JEBAKUMAR  
PA DE SILVA  
E F MONTEIRO  
Department of Genitourinary Medicine,  
The General Infirmary at Leeds,  
Great George Street,  
Leeds LS1 3EX, UK

- 1 Eistreich S, Forster GE, Robinson A. Sexually transmitted disease in rape victims. *Genitourin Med* 1990;66: 433-8.
- 2 Jenny C, Hooton T, Bowers A, *et al*. Sexually transmitted diseases in victims of rape. *N Engl J Med* 1990;322: 713-6.

### A rapid stain for the diagnosis of granuloma inguinale

The paper entitled *A rapid stain for the diagnosis of granuloma inguinale*<sup>1</sup> is a welcome addition to the existing procedures. It is, therefore, worthwhile to utilise it for rapid diagnosis of the disease. However, this has its limitations for in only 38% of donovanosis is it positive. In 62% it is not of help. Consequently it has major limitations as a diagnostic tool. It is, therefore, imperative to "suspect" the diagnosis of donovanosis on the basis of morphological characteristics of the ulcer.<sup>2,3</sup> Despite the clinical features being cardinal, the condition may have to be differentiated from chancroid/chancroidal ulcer,<sup>4</sup> primary chancre, herpes progenitalis, and squamous cell carcinoma. In fact, at this centre it is customary to make the diagnosis by undertaking a battery of tests to exclude aforementioned genital ulceration. These tests include: dark-ground microscopy for *Treponema pallidum*, gram-stained surface smear for *Haemophilus ducreyi*, Giemsa-stained surface smear for giant cells/balloon cells for herpes progenitalis, Giemsa-stained tissue smear for demonstration of intra-mononuclear Donovan bodies, haematoxylin-eosin stained tissue sections to establish the histological features of donovanosis<sup>5</sup> and to exclude squamous cell carcinoma, and demonstration of Donovan bodies in tissue section using slow Giemsa (overnight) technique,<sup>6</sup> serological diagnosis of syphilis, attempt to recover *Haemophilus ducreyi* on culture.

The clinical diagnosis, supplemented by these procedures improve the diagnostic success to almost 100%.

It is worthwhile to highlight the slow-Giemsa (overnight) technique,<sup>6</sup> in which the tissue sections are placed in a 10% Giemsa-stain for 17 hours. It was possible to demonstrate Donovan bodies in 95% of the cases. The Donovan bodies were found distinctly and in large numbers in the mononuclear cells (intra-cellular). Furthermore, it was easy to demonstrate multicystic cells containing Donovan bodies, well recognised as cells of Greenblatt.

VIRENDRA N SEHGAL  
Department of Dermatology  
and Venereology,  
Lady Hardinge Medical College,  
New Delhi 110001  
India

- 1 O'Farrell N, Hoosen AA, Coetzee K, van den Ende J. A rapid stain for the diagnosis of granuloma inguinale. *Genitourin Med* 1990;66:200-1.
- 2 Sehgal VN, Shyam Prasad AL. Donovanosis: current concepts. *Int J Dermatol* 1986;25:8-16.
- 3 Sehgal VN, Shyam Prasad AL. A clinical profile of donovanosis in a non-endemic area. *Dermatologica* 1984;168:273-8.
- 4 Sehgal VN, Shyam Prasad AL. Chancroid or chancroidal ulcers. *Dermatologica* 1985;170:136-41.
- 5 Sehgal VN, Shyam Prasad AL, Beohar PC. The histopathological diagnosis of donovanosis. *Br J Venereal Dis* 1984;60:45-47.
- 6 Sehgal VN, Jain MK. Tissue section Donovan bodies—identification through slow Giemsa (overnight) technique. *Dermatologica* 1987;174:228-31.

### Is a test of cure necessary following treatment for cervical infection with *Chlamydia trachomatis*?

We read with great interest, the recent article by Radcliffe *et al.*<sup>1</sup> We have undertaken a retrospective study of chlamydial infection in female patients.

Our policy has been to screen for *Chlamydia trachomatis* by testing on two occasions at an interval of one week and to confirm cure after treatment by a similar routine of two tests undertaken within 7 and 14 days of completion of treatment. Our findings support the conclusion that tests of cure may not be necessary.

During the 11 months from January 1990 to November 1990, 151 female patients were diagnosed as *Chlamydia trachomatis* positive by tissue culture on irradiated McCoy cells of combined genital samples from the urethra and cervix. Following diagnosis, 150 patients were treated, one having defaulted. The standard regimen was doxycycline 100 mg bd for 10 days with erythromycin stearate 500 mg bd

or qds for 10 days in the pregnant or those who could not tolerate doxycycline. Epidemiological treatment of male partners was undertaken.

Twelve patients (8%) had repeat positive chlamydia cultures during the study period. Of these, five reattended after two negative tests of cure and another four, while not completing two tests of cure, reattended at least three weeks after treatment suggesting reinfection rather than relapse. Only three were found positive at a routine test of cure (table).

We agree with Radcliffe *et al* that the need for chlamydia testing twice after treatment may not be necessary. However, our study has indicated that more than one screening sample is necessary to diagnose initially chlamydial infection. Only 131 patients (87%) were positive on first testing with the remaining 19 (13%) being diagnosed on the second screening test one week later.

The reasons for so many failed diagnoses on the first visit may be due to a number of contributory factors such as scanty material, poor sampling or delay in inoculating the culture media.<sup>2</sup> Hence we suggest that the time and money saved in not performing two routine tests of cure may be utilised more profitably for initial diagnosis, by undertaking two screening tests on separate occasions. Nevertheless patients still need review to undertake contact tracing, assess treatment compliance and assess the likelihood of reinfection.

CS WIJESURENDRA  
C WHITE  
RA SPARKS  
ARG MANUEL  
Department of  
Genitourinary Medicine,  
Newport Road,  
Cardiff CF2 1SZ, UK

- 1 Radcliffe KW, Rowen D, Mercey DE, *et al.* Is a test of cure necessary following treatment for cervical infection with *Chlamydia trachomatis*? *Genitourin Med* 1990;66:444-6.

- 2 Kallings I, Mardh PA. Sampling and specimen handling in the diagnosis of genital *Chlamydia trachomatis* infection. *Scand J Infect D (Suppl)* 1982;32:21-4.

### Guidance for the planning and design of genitourinary medicine clinics

We read with keen interest the paper of Thin and Lamb concerning the planning and design of genitourinary medicine (GUM) clinics<sup>1</sup>; its guidelines will be very useful for providing GUM and STD (Sexually Transmitted Diseases) clinics with a proper setting and a functional work organisation. Yet, we feel that the importance of adequate computerisation should be more stressed.

The STD Centre of Galliera Hospital<sup>2</sup> is equipped with a network of Personal Computers (PS2 50 IBM) connected by a Token Ring to another Personal Computer (PS2 80 IBM) which is the "server unit". This hardware configuration allows one to get information from the server unit in real time. The software package for the management of medical records which we ourselves have adapted to our needs offers several advantages in comparison with normal filing,<sup>3</sup> that is:

- the confidential nature of data,<sup>4</sup> thanks to entry passwords;
- automatic graphic visualisation of the most important laboratory examinations; this is very useful, above all for those therapies which require frequent monitoring (for instance AZT in HIV-positive patients);
- quick review of clinical and laboratory data;
- collecting of data on sexual and contraceptive practices and drug abuse, which allows statistic processing referred to STD;
- immediate reading of data from any work station and by any authorised physician or nurse;
- quick filing of medical written reports.

We feel that a computer system like this could be very helpful in the management of GUM and STD clinics and that the planning and design of these centres should consider this need.

LUIGI MASSONE  
GIUSEPPE SOLARI

Table Results of tests of cure

	Number of patients	Number positive for chlamydia (% in parentheses)
Patients treated	150	150 (100)
First TOC	120	2 (1.6)
Second TOC	111	1 (0.9)
No TOC	22	Not known

TOC = Chlamydia test of cure.