traditional belief not an insignificant number of elderly people are engaged in sexual activity as has been described recently.[3-5]
(2) What are the long term sequelae of carriage of chlamydia without treatment.
(3) What is frequency of false positive ELISA tests amongst low risk patients as in this study in the absence of facilities for simultaneous culture for chlamydia.

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Annular lesions in congenital syphilis

The incidence of congenital syphilis has markedly decreased over the years. However, in underdeveloped societies where proper antenatal care clinics are still not established, sporadic cases of congenital syphilis are seen. Recently we have seen a case of congenital syphilis which presented with well defined annular lesions mimicking tenia infection.

A one year old female child, born after 8 months of gestation, presented with a progeric look and multiple wide spread, asymptomatic skin lesions. The lesions were more or less symmetrical, well defined, hyperpigmented, scaly and annular with central clearing. Patches over the wrists showed successive rings mimicking ternia imbricata (figs 1 & 2). The child also had recurrent serosanguinous discharge from the nose, frequent episodes of upper respiratory tract infection and diarrhoea.

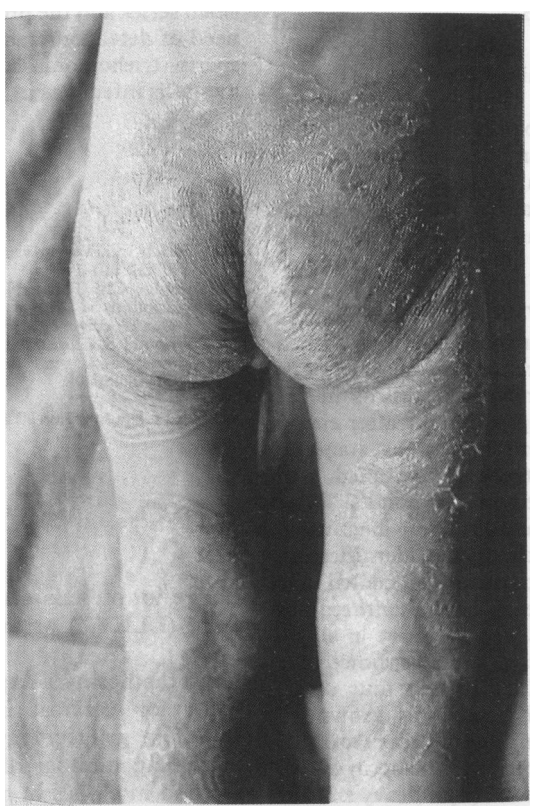

Figure 1 Well defined scaly lesions with raised borders over buttocks and popliteal fossa.

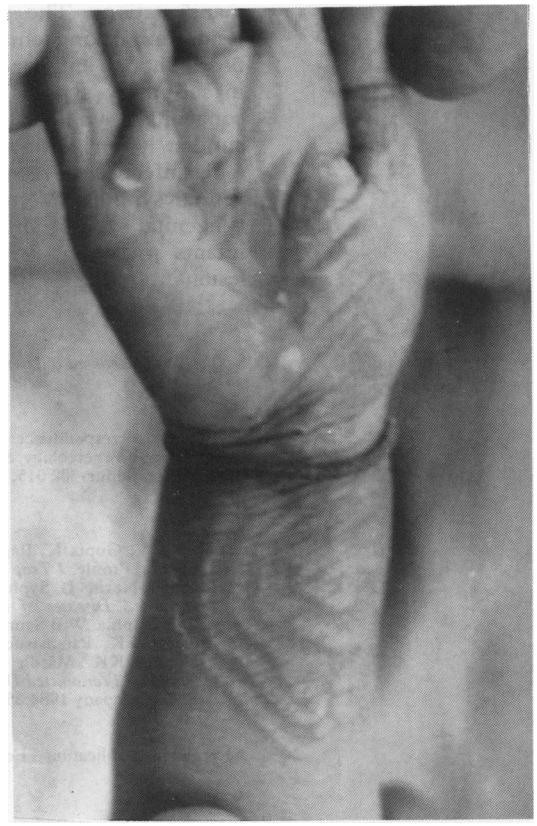

Figure 2 Successive rings over wrist with scaling of palm.

Examination of the child revealed delayed milestones, unclosed anterior fontanalle, sparse and lustreless hair, depressed nose, absence of nasal septum, stenosed nasal cavity and generalised lymphadenopathy. The skin of the palms and soles had only fine scaling. Mucous membranes, eyes, liver and spleen were normal. Serum VDRL was positive in both mother (1:32) and child (1:1024) while negative in the father. Similarly FTA-abs test was positive in the mother and child and negative in father. The parents as well as child were negative for HIV antibodies. Skeleton radiographs showed periosteal reaction in the upper end of the tibiae with deposition of new bone under the periostium, ostiochondritic changes in the upper end of tibiae, fibulae and lower end of the femurs. Potassium hydroxide mount and culture for fungus were negative. Her skin lesions cleared soon after penicillin therapy which further confirmed that the annular skin lesions were manifestion of syphilis.

The common clinical presentation of congenital syphilis include skin lesions, osseous changes, hepatosplenomegaly and anaemia.[1] The incidence of mucocutaneous lesions in congenital syphilis varies from 15–60%[2]. Vesiculobullous eruptions, papular or papulosquamous lesions, wrinkling of skin, moist lesions like condyloma lata and desquamation of skin are the usual cutaneous

manifestations. The present case had annular lesions mimicking tenia infection and a depressed nose. Though annular lesions are frequently seen in secondary syphilis, they are rarely seen in congenital syphilis.[3] However, well defined annular lesions with a raised border mimicking tenia infection have not been reported in congenital syphilis. We suggest that possibility of congenital syphilis should also be considered in infants presenting with asymptomatic annular lesions.

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Antitrichomonal (cross) immunity as an important factor in vulvar vestibulitis syndrome pathogenesis

Vulvar vestibulitis syndrome (VVS), characterised by tenderness and erythema of the vaginal introitus,[1] has not been aetiologically connected with an infective agent.[2] According to personal clinical observations, it seems that in this syndrome genital trichomoniasis is more rare than in the usual population of sexually active women. The aim of this letter is to point out the possibility that extragenital trichomonas infections, with consecutive sensitisation, including crossed circulating immunity, may also cause the manifestations of vulvar over-sensitisation and erythema in cases of trichomonas infection of the sexual partner's sperm.

In six women with VVS, which lasted more than 6 months, trichomonads (Ts) were searched for in cervicovaginal secretions, urine sediments, morning expectorated mucus as well as in the partner's fresh sperm (up to 1 hour after ejaculation). Wet smears were stained by standard methods and immediately microscopied. All materials were inoculated in Diamond's TYM medium[3] enriched with 10% heat-inactivated horse serum and rice starch. Species identification was determined by microscopy of cooled wet preparations, wet smears and cultures of cervicovaginal secretions were negative in all six women. Smears of respiratory mucus showed the presence of aflagellary T forms in four cases, while in the cultures *T tenax* was grown. *T vaginalis* was grown in cultures of urine sediment of the remaining two women and in sperm of five partners. Peroral or perrectal (by a heavy smoker with gastric ulcers) metronidazole, with instructions regarding respiratory mucus expectoration (especially postural and postprandial), resulted in significant regression of vulvar symptoms in all women. In three cases with respiratory trichomoniasis, in both urine-positive women and in all five sperm positive partners, metronidazole removed the parasites. In the last woman (a heavy smoker) with respiratory trichomoniasis, metronidazole significantly reduced respiratory mucorrhea but smears remained positive. As all women used coitus interruptus as the main contraceptive method a condom was recommended after therapy.

In the voluminous literature about trichonomiasis, the association of chronic trichomonas infection and epithelial dysplasia is well known. Such an association has its parallel in the histopathological findings of the vulva affected by VVS.[2] Trichomonas more frequently colonise Caucasians and women aged between 20 and 30 years, which corresponds to the incidence of VVS. Monogamous sexual relations associated with monostrain trichomonas infection (constant family isolate with stable antigenic battery and accommodated woman's immune apparatus) erode to a lesser extent the host-immunity, so enabling competent interspecific antitrichomonal cross-immunity. Aggressive vulvar hygiene with consecutive skin erosions, facilitates contact between host immune forces and trichomonas antigens (released intracellular proteases).

The very close relation of VVS with extragenital trichomoniasis in my patients is probably the consequence of host-parasite interaction on the basis of antitrichomonal immunity, which fails to clear up focal infection but which often successfully disables colonisation of trichomonas on distant mucous surfaces. Interspecies immunity may explain the absence of those parasites in the genitals of women affected by VVS although clinical symptoms and the pathological picture suggest their involvement. The results of this small series and the proposed concept suggest the need of detection/eradication of sexual partner's sperm trichomoniasis and extragenital trichomoniasis infections in VVS patients.

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Large loop excision of the transformation zone (LLETZ) or loop diathermy

Loop diathermy is a popular method of treatment for cervical intra-epithelial neoplasia (CIN) in gynaecology. There are a small but increasing munber of operators who use this method in clinics of genitourinary medicine.

I write to report some of the findings on the past 100 patients, who have completed at least