

harbour asymptomatic genital tuberculosis, a thorough clinical examination can be helpful in the presence of cranial lesions with a wide differential diagnosis.

Contributors

RB, SP, PS, DS, SG were following this patient clinically; RS provided the pathology details and the image; the manuscript was written by RB and read, edited, and finalised by all authors.

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Seroprevalence of reproductive tract infections in women in northern India—a relatively low prevalence area

Recent years have witnessed a growing concern about the reproductive tract infections (RTI), especially those that are sexually transmitted. The serious threat of AIDS has further drawn attention to the importance of RTI/sexually transmitted diseases (STD),¹ especially in developing countries like India where RTI diagnosis and treatment facilities are extremely limited. Women with RTI are asymptomatic, which if undetected or untreated can lead to complications in the index woman. It is, therefore, worthwhile screening of all women of reproductive age for various RTI so that appropriate interventions can be planned and initiated.

We analysed a total of 2526 women attending the antenatal outpatient department of obstetrics and gynaecology of Nehru Hospital attached to Post Graduate Institute of Medical Education and Research, Chandigarh, for screening of RTI during a 3 year period. This project was approved by the institute's ethics committee. The women were divided into six groups based on clinical histories and various signs and symptoms: group I, pregnant women (n = 600); group II, contraceptive advice seekers (n = 378); group III, contraceptive users (n = 525); group IV, women with infertility (n = 464); group V, women with leucorrhoea (n = 288); group VI, women with a diagnosis of pelvic inflammatory disease (n = 271). Endocervical swabs were collected from all patients and were sent to the microbiology laboratory for Gram stain and culture of *Neisseria gonorrhoeae* (New York city medium). ELISA was also carried out for antigen detection of *N gonorrhoeae* (Abbott laboratories) and *Chlamydia trachomatis* (Chlamydia CELISA, Cellabs Pvt, Ltd, Brookvale, Australia). Venous blood was collected from all women, sera were separated and stored at –20°C till further use. Sera were subjected to the standard Venereal Disease Research Laboratory (VDRL) test and Treponema pallidum haemagglutination (TPHA) test (Serodia-TPHA, Fujirebio Inc, Tokyo, Japan) for syphilis, enzyme linked immunosorbent assay (ELISA) for HbsAg (Auszyme Monoclonal, Abbott Laboratories, USA), and HIV (HIV-1/HIV-2 third generation plus EIA, Abbott Laboratories, USA). Western blot was done if ELISA for HIV was positive.

The mean age of the women in the study group was 30.6 years and the parity ranged from 1 to 6. Overall, seroprevalence of RTI in various groups was 1.82% (n = 46/2526).

Each of syphilis and hepatitis B infection were found in 17 women (0.67%), followed by *C trachomatis* in 11 (0.43%) and HIV seropositivity in one (0.02%) (table 1). Though figures of RTI were quite low, all the infections were more common in the pregnant group compared to the other groups. However, surprisingly, *N gonorrhoeae* was not found in any of the women.

Our study reveals that the prevalence of RTI, especially those that are sexually transmitted, is low. Similarly low prevalence of RTI has been reported from Thailand² and Bangladesh.³ Moreover, a very low prevalence of HIV has earlier been reported from Chandigarh.⁴ This is in contrast with studies from the developing world, where prevalence rates ranging from 30–40% have been reported.^{5–7} Even the low risk populations have a prevalence ranging between 15–20%.⁸ The low prevalence in this region is attributed to the better personal hygiene, environmental conditions, healthy sexual behaviour and good socioeconomic status of the patients residing in this area. However, ours is a tertiary care centre and most cases had been treated before they were referred to this hospital. However, even at such a low prevalence, there are still likely to be cost effective interventions for RTI prevention and care—for example, screening of pregnant women for syphilis may be cost effective when prevalence is 1% in this population.

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Table 1 Seroprevalence of RTI in the various groups of women

| Tests positive | Group I (n = 600) | Group II (n = 378) | Group III (n = 525) | Group IV (n = 464) | Group V (n = 288) | Group VI (n = 271) | Total (n = 2526) |
|--------------------------------|-------------------|--------------------|---------------------|--------------------|-------------------|--------------------|------------------|
| Syphilis | 6 | 3 | 0 | 4 | 1 | 3 | 17 (0.67%) |
| Gonorrhoea | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| <i>C trachomatis</i> infection | 6 | 1 | 1 | 3 | 0 | 0 | 11 (0.43%) |
| Hepatitis B | 9 | 0 | 4 | 4 | 0 | 0 | 17 (0.67%) |
| HIV | 0 | 0 | 0 | 0 | 0 | 1 | 1 (0.02%) |
| Total | 21 | 4 | 5 | 11 | 1 | 4 | 46 (1.82%) |

Group I, pregnant women; group II, contraceptive advice seekers; group III, contraceptive users; group IV, women with infertility; group V, women with leucorrhoea; group VI, women with diagnosis of pelvic inflammatory disease.

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Chaperoning in genitourinary medicine: supporting patients and protecting doctors

I read with interest the result of the postal survey regarding chaperoning in genitourinary medicine (GUM) clinics.¹ The notable observation is that female patients were offered a chaperone far more often than males (on all occasions when the examiner was a male (32/32) and frequently when the examiner was a female (13/40)). Chaperoning was offered less frequently when the patient was a male with a female examiner (7/37) and infrequently with a male examiner (3/39).

GUM nurses and doctors are particularly vulnerable because the open access of the services exposes them to situations where they have no prior knowledge of the patient's background, social, behavioural, psychological, or mental state. The vulnerability is accentuated by the fact that sexual history and intimate examination are part of the routine clinical assessment in most of the situations. This vulnerability was called into a course of action in our clinic in 1996 when a senior male clinical assistant was a recipient of allegations (from a male patient in his 50s). The clinical assistant was nearing retirement, after an unblemished long service in general practice, with over 20 years' experience as an assistant in GUM. The patient expressed extremes of behaviour, grandiose imagination, and swings of mood, which became a reason for clinical concern. The concerns were raised with the patient's general practitioner (GP) who advised that the patient suffered problems with alcoholism and was undergoing mental rehabilitation, and that he would attend the patient's condition urgently at home. The GP telephoned the clinic later to indicate that the patient had recovered from his episode and he would like to speak with the consultant GU physician. The patient offered a clear and strong apology regarding what he described as "inappropriate course of behaviour and action" and reiterated that his initial allegations against the senior clinical assistant were, in all, unsafe and untrue.

The incident of false allegations has proved the particular vulnerability of doctors and nurses in the GUM clinic setting. A review of the procedures of chaperoning in the GUM clinic was conducted. The clinic then introduced a system of guidelines whereby all clinical examinations and tests are done in the presence of a chaperone (irrespective of the sex of the patient or the examiner). The nursing staff have realised and appreciated the benefits of attendance to support the

patients and to assist the doctors (during the clinical examination and tests). The time spent in the clinical room proved useful in the preparation and labelling of samples. Gaining knowledge about the clinical assessment of clients proved to be valuable to nurses during health advising. The application of the named nurse procedures has meant that the attending nurse would follow the patient all through the clinical assessment, microscopic tests, the introduction of treatment/therapy, and health advising thereafter. This continuity of care is more acceptable to the patient and more satisfactory to the nursing staff.

The issue of funding for chaperoning could be argued under the remit of professional safety. Professionals in other services take stringent methods to protect themselves from what could be less dangerous and damaging situations to their professional careers. Therefore, chaperoning in GUM must be viewed in the light of providing support to patients and protection to staff.

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STI case management at a South African teaching hospital

In South Africa, KwaZulu-Natal (KZN) is at the centre of the HIV epidemic and sexually transmitted infections (STIs) are endemic in this province.¹ Improving the quality of STI health care causes a cost effective reduction in HIV prevalence and STI incidence.² Despite the introduction of national standard treatment guidelines (STGs), based on the syndromic management approach (where antibiotics are prescribed according to algorithms and non-medicinal aspects of care are emphasised), poor case management has been found in rural KZN clinics.³ This study determined the quality of care received by STI patients at King Edward VIII Hospital (KEH), Durban. As the province's main academic hospital, KEH has represented the best level of health care for the average citizen of KZN since 1936. Patients with STI are managed syndromically.

The drug treatment of 97 black African outpatients with STI (73% female, average age 29 years) was compared with STGs. Patients also completed a questionnaire assessing non-drug management. Drug treatment complied with STGs in 79% of patients. When assessment included non-drug measures (partner notification cards, condoms, and correct drugs) it fell to 24% compared to 9% found among nurses, with simulated patients in rural KZN clinics.³ Although overall care appears better in the urban setting, the real difference is at the level of drug treatment (where 79% v 41% received recommended drugs), as in both cases only about a quarter of the patients who had correct drug treatment also received appropriate non-drug care. Patients had appropriate counselling in 56% of cases. This was measured in terms of receiving at least one message in each of the five categories shown in table 1. Despite 72% of patients being encouraged to use condoms, 52 patients were not shown how to do this. Of these, only 31 knew how to use them.

Care givers were interviewed and vignettes were used to compare ideal and actual practice. Barriers to patient care and possible solutions were canvassed. All care givers gave appropriate answers for the ideal management of their fictitious case, but reported a difference between ideal management and actual practice in terms of non-drug aspects of management. All care givers failed to give drug information and to promote health seeking behaviour. Barriers to patient care were lack of time, staffing shortages, and motivation. There was a perception that non-drug management was not the responsibility of the tertiary care giver.

Care givers favoured the option of introducing a packet containing information, condoms, and a referral card, which could be issued with medication. In rural KZN a similar intervention resulted in improved case management in 83% of cases compared with a control group of 12% ($p < 0.005$).⁴ Such packets could help improve STI management in this tertiary setting, which has no dedicated STI clinic.

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Table 1 Categories of patient counselling showing one important example in each category

| Counselling category | Example | "Yes" response (%) | 95% CI |
|--------------------------|---------------------------------|--------------------|----------|
| Drug information | Told to take medicine | 65 | 55 to 74 |
| Partner referral | Told partner must be treated | 56 | 45 to 66 |
| Health seeking behaviour | Told about the signs of STI | 50 | 39 to 60 |
| Risk reduction | Told that STI enhances HIV risk | 57 | 46 to 67 |
| Condom promotion | Encouraged to use condoms | 72 | 62 to 81 |