

LETTERS TO THE EDITOR

Value of performing biopsies in genitourinary clinics

Genitourinary physicians come across patients who present with conditions other than sexually transmitted diseases. Ability to recognise these conditions and the performance of confirmatory biopsies whenever necessary enables us to institute appropriate therapy without delay. We reviewed incisional biopsies of the penis we had carried out in 45 patients at the Department of Genitourinary Medicine, Birmingham, during the period between January and December 1989.

Fourteen (32%) patients had balanitis xerotica obliterans (BXO). Although the diagnosis of BXO can be made clinically, biopsy is necessary to distinguish this condition from balanitis chronica circumscripta and non-specific inflammation.¹ Four patients required circumcision for phimosis. Symptoms have been controlled with topical steroids in 10 patients whilst the remainder were lost for follow-up. Two patients with clinical evidence of plasma cell balanitis had their diagnosis confirmed on histology and both responded to topical steroids. Biopsy is always indicated to differentiate this condition from the premalignant erythroplasia of Queyrat.²

Psoriasis was diagnosed in six patients who had lesions confined only to the penis, and they were referred to a dermatologist for further management. Lichen planus was reported in six patients of whom only two had lesions elsewhere (oral cavity). All six patients responded to topical steroid therapy.

Squamous cell carcinoma was diagnosed in a 71 year old man with a meatal ulcer, who was then referred to the urologist. Herpes simplex virus was also isolated from the ulcer, in this patient.

Bowenoid papulosis was reported in two patients who were successfully treated with cryotherapy. Bowenoid papulosis has been reported to be a reservoir for human papilloma virus type 16 and is thought to be a high risk lesion in the aetiology of cervical can-

cer.³ Two patients had squamous cell papillomata of viral aetiology and a further three had histological evidence of viral warts, all of whom were treated with cryotherapy.

Chronic dermatitis was diagnosed in five patients all of whom responded to topical steroid therapy. Biopsies from two patients were reported as non-specific dermatitis. Angiokeratoma was diagnosed in one patient. In one patient the biopsy was inconclusive.

In this review, penile biopsy was useful either to establish or confirm the clinical diagnosis in 44 patients, which enabled us to commence appropriate treatment without resorting to empirical methods. Patients can also be referred to other specialties if necessary, preventing further delay in commencing treatment. We conclude that biopsies are easy to perform and have a major role in the management of a proportion of patients attending genitourinary clinics.

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Detection of *Chlamydia trachomatis* in semen samples

It is not uncommon to come across during microscopy semen samples which contain moderate numbers of pus cells. Routine culture for bacteria, however, is usually unhelpful as most of them grow skin commensals only. We decided to apply in addition to bacterial culture the amplified ELISA technique ("IDEIA", Boots Celltech) to detect *Chlamydia trachomatis* in semen samples with pus cells.

The laboratory normally receives fresh semen samples from the out-patient clinics or general practitioners investigating patients suffering from infertility under their care. Forty seven semen samples with pus cells ranging between 25-100 or more per high power field were examined by the amplified ELISA technique ("IDEIA", Boots Celltech). Two specimens (4.2%) were positive by this method. Bacterial culture grew a mixture of non-pathogenic skin micro-organisms only.

A non-invasive sampling method for detecting *Chlamydia trachomatis* in urines of male patients has recently been described, where positive detection rates varied between 12.3% to 16.4%.^{1,2} These rates increased to 19% when sterile pyuria samples were processed for *C. trachomatis*. Demonstration of their presence in semen may have some implications as far as infertility is concerned. As asymptomatic carriage of chlamydia is well known not only in females but also in males, perhaps this study should be extended to cover all semen samples referred from infertility clinics irrespective of the presence of pus cells.

Ideally all positive results on semen should be confirmed by chlamydia culture as recommended for female patients³ to eliminate false positives from interfering substances. Otherwise the ELISA technique for chlamydia can be applied to a centrifuged urine deposit or an urethral swab to confirm positive semen results. Moreover localisation of chlamydia infection, as in urethra, epididymis or the prostate, may be important particularly from the point of view of management so far as the choice and duration of antibiotic therapy is concerned.

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