Donovanosis in developed countries: Neglected or misdiagnosed disease?

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Table 1. Logistic regression analysis of variables predicting genitourinary clinic attendance

<table>
<thead>
<tr>
<th>Variable</th>
<th>Regression coefficients</th>
<th>Standard error</th>
<th>Wald statistics</th>
<th>P value</th>
<th>Odds ratio</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-0.014</td>
<td>0.039</td>
<td>0.135</td>
<td>0.714</td>
<td>0.986</td>
<td>0.914</td>
<td>1.064</td>
</tr>
<tr>
<td>Marital status*</td>
<td>1.451</td>
<td>0.684</td>
<td>4.495</td>
<td>0.034</td>
<td>4.268</td>
<td>1.116</td>
<td>16.321</td>
</tr>
<tr>
<td>Ethnic group†</td>
<td>0.316</td>
<td>1.160</td>
<td>0.074</td>
<td>0.785</td>
<td>1.372</td>
<td>0.141</td>
<td>13.336</td>
</tr>
<tr>
<td>White</td>
<td>0.182</td>
<td>1.563</td>
<td>0.866</td>
<td>0.352</td>
<td>2.951</td>
<td>0.302</td>
<td>28.826</td>
</tr>
<tr>
<td>Asian</td>
<td>2.667</td>
<td>1.611</td>
<td>2.738</td>
<td>0.098</td>
<td>14.391</td>
<td>0.611</td>
<td>338.672</td>
</tr>
</tbody>
</table>

* Coded as ‘with someone’ (married or cohabiting) or ‘alone’ (single, separated, divorced and other); reference category = ‘alone’
† Reference category = other groups

It’s possible that patients feel protected through having received antibiotics at the time of TOP. However, the Sheffield cohort of TOP patients following screen and treat policy achieved 71.4% attendance rate at the GU clinic, and we cannot fully explain the difference. One possibility may be the wider geographical spread of our patients. In our cohort, those who lived closer to a GU clinic were more likely to attend, and this has implications for GU services delivery in Birmingham, where outreach models may be more appropriate.

The success of contact tracing in these women was also lower than for gynaecology referrals (21.3% vs 42%), and was much lower than the success rate of 52.1% amongst TOP cases in Iceland and 69% in Sheffield. It was not possible to ascertain whether the patients had attended elsewhere for treatment. Of those who attended GU clinics, 47.5% of women required re-treatment (mostly due to re-exposure). Of the participants who attended, 46.2% were chlamydia-positive, which demonstrates the benefits of chlamydia screening, in addition to universal antibiotic prophylaxis, for women undergoing TOP and their partners.

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References


Donovanosis in developed countries: neglected or misdiagnosed disease?

Sir: In the review article on Donovanosis and in the relevant comment of Dr Gupta the authors presented data about the prevalence of granuloma inguinale (GI) in different regions of India. In the developed countries the cases of GI are extremely rare but may be underestimated.

In this time of rapid communications and transport the number of human mobile population (HMP) is increasing every year and the United Nations Population Division has estimated that the number of HMP in the world will rise to one billion people in 2001. There is a possibility that in the developed world some cases of GI in HMP are not identified by clinicians inexperienced in tropical diseases, or that they are treated — and accidentally cured — through aspecific use of antibiotics, which are more and more often self-administered. As a matter of fact the Calymmatobacterium granulomatis is responsive to a number of commonly used antibiotics.

In order to evaluate the prevalence of GI in our hospital we conducted a retrospective analysis of clinical records of patients attending the Depart-
ment of Preventive Medicine for Migrations, Tourism and Tropical Dermatology, which offers treatment and assistance to an underprivileged population in Rome (Italy).

The clinical records of all patients with a definite diagnosis of GI, over a 108-month period (January 1993–December 2001), were reviewed. Records were identified by a computer-assisted search of the anatomic pathology and medical microbiology laboratory records. Of the 13 records identified 10 were males, and six of the 13 cases (46.1%), an unusually high percentage, were observed in the years 2000 and 2001. In all patients the clinical presentation was genital ulceration in ano-genital area (penis, gland, anal canal, vulva) and tests for treponemmas, Chlamydia trachomatis, Haemophilus ducreyi, Koch bacillus, herpes simplex virus type 1 and herpes simplex virus type 2 were negative. HIV-1 antibodies were detected in three men and none in the women. The following information was extracted from the records: age, parity, marital status, residence, nationality, date of the last trip in endemic zone for GI, site of lesions, clinical presentation, duration of complaints, investigations, treatment and follow-up. A definite diagnosis of GI was made both by obtaining tissue smears and staining through a Rapi-Diff Giemsa test and/or by obtaining biopsy specimens that were fixed in formalin and sections stained with Giemsa and Warthin-Starry silver stains to detect characteristic Donovan bodies9,10. The majority, 10 (77%) were in the age range 18–38. An estimation of the incubation period was not possible because many patients denied recent sexual intercourse or had long-standing ulceration. Nine (69.2%) patients were from rural areas and in the majority of cases, 11 patients (84.6%), the ulcers had appeared after a trip in the origin countries. Hyper trophy ulcers were much less common than the ulcers-granulomatous variety that represents the majority of ulcers diagnosed, 18 (85.7%) and all the ulcers were only in the genital area. In conclusion, this study confirms our clinical impression of the increasing prevalence of GI and probably of other tropical diseases in the developed countries, especially among migrant and poor people living in big Western metropolis. Future public health policies all over the world will need to take into careful consideration the changed perspectives of the incidence and prevalence of some tropical diseases in the developed countries. Moreover, particular attention should be given to improve access to sexually transmitted disease services providing treatment and counselling for migrant people, especially if illegal.

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Inflammatory markers in the vagina in early pregnancy

Sir: Bacterial vaginosis is associated with late miscarriage and preterm birth1,2, but as stated by Wiggins and colleagues3, the mechanism behind the association is unclear. In a sample of 92 women < 14 weeks pregnant they found no difference in vaginal mucinase activity in women with or without bacterial vaginosis.

We conducted a pilot study in 39 women to see if the maternal inflammatory response in very early pregnancy could be assessed by measurement of vaginal cytokines and related inflammatory markers. Previous studies have found raised levels of cervico-vaginal interleukin 1β (IL-1β) and interleukin 8 (IL-8) in women with preterm labour4, and of IL-1β in pregnant women with bacterial vaginosis5. However, there have been no studies of vaginal cytokines in very early pregnancy. We wanted to examine vaginal cytokine profiles in newly pregnant normal women and in those with miscarriage, preterm birth or bacterial vaginosis. In order to recruit women in very early pregnancy (mean gestation seven weeks) the study was based in two general practices.

Consecutive women presenting at < 10 weeks’ gestation who gave informed consent were asked to provide a self-administered vaginal swab, vaginal smear and first pass urine at the surgery,