Book review

PRIMARY CLINICAL CARE
Book 6
Sexually Transmitted Diseases

Despite being numbered six, this is the first of a series of 15 manuals on *Primary Clinical Care* to be produced by the Health Services Development Unit of the Department of Community Health of the University of the Witwatersrand.

These manuals aim to present core medical and clinical knowledge which will enable primary health care workers to provide safe and adequate primary clinical care.

The general lay-out is easy to follow and attractive to read. Each chapter begins with a list of contents and usually ends with a summary and a series of self-evaluation exercises. There is a considerable amount of repetition but since the material is repeated in different forms this improves rather than detracts from the manual.

There are a large number of well-executed line drawings, most of which make an important contribution to an understanding of the text. There is an appropriate emphasis on social factors which contributetothe spread of sexually transmitted diseases. However there is very little on prevention, including on the use of condoms.

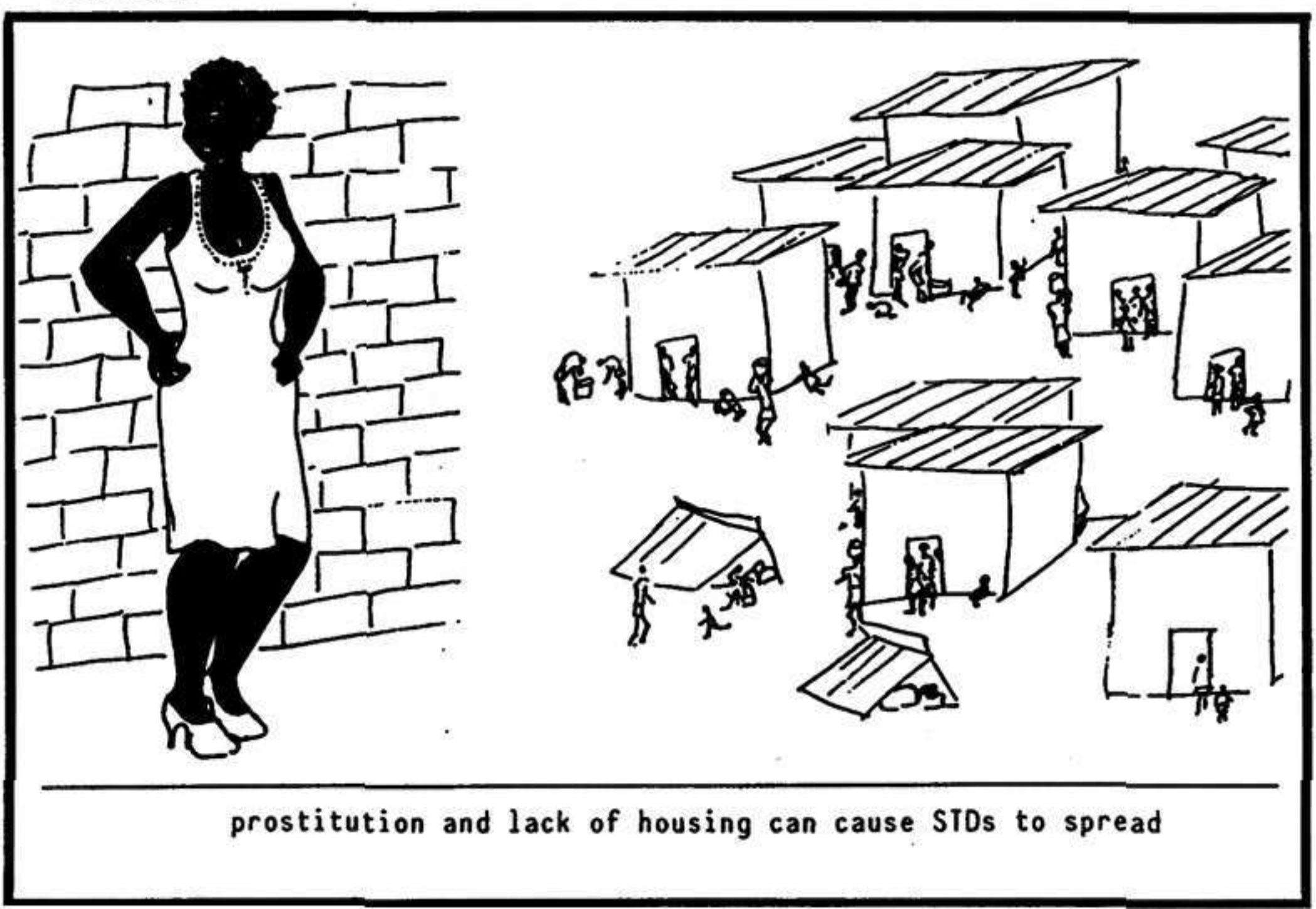
In general the content of the volume is felt to be appropriate for primary health care workers although theuse of language varies somewhat inconsistently from the unsophisticated 'sore' to words such as epididymo-orchitis. The diseases selected are well-chosen although a good case could be made out for the inclusion of a section on A.I.D.S. and Hepatitis B. It would also have been appropriate if a greater effort had been made to indicate prevalence rates so that health workers would be aware of the most likely cause of symptoms in situations where several organisms cause similar clinical features.

There are certain aspects of the content that could be misleading in the opinion of this reviewer. These include:

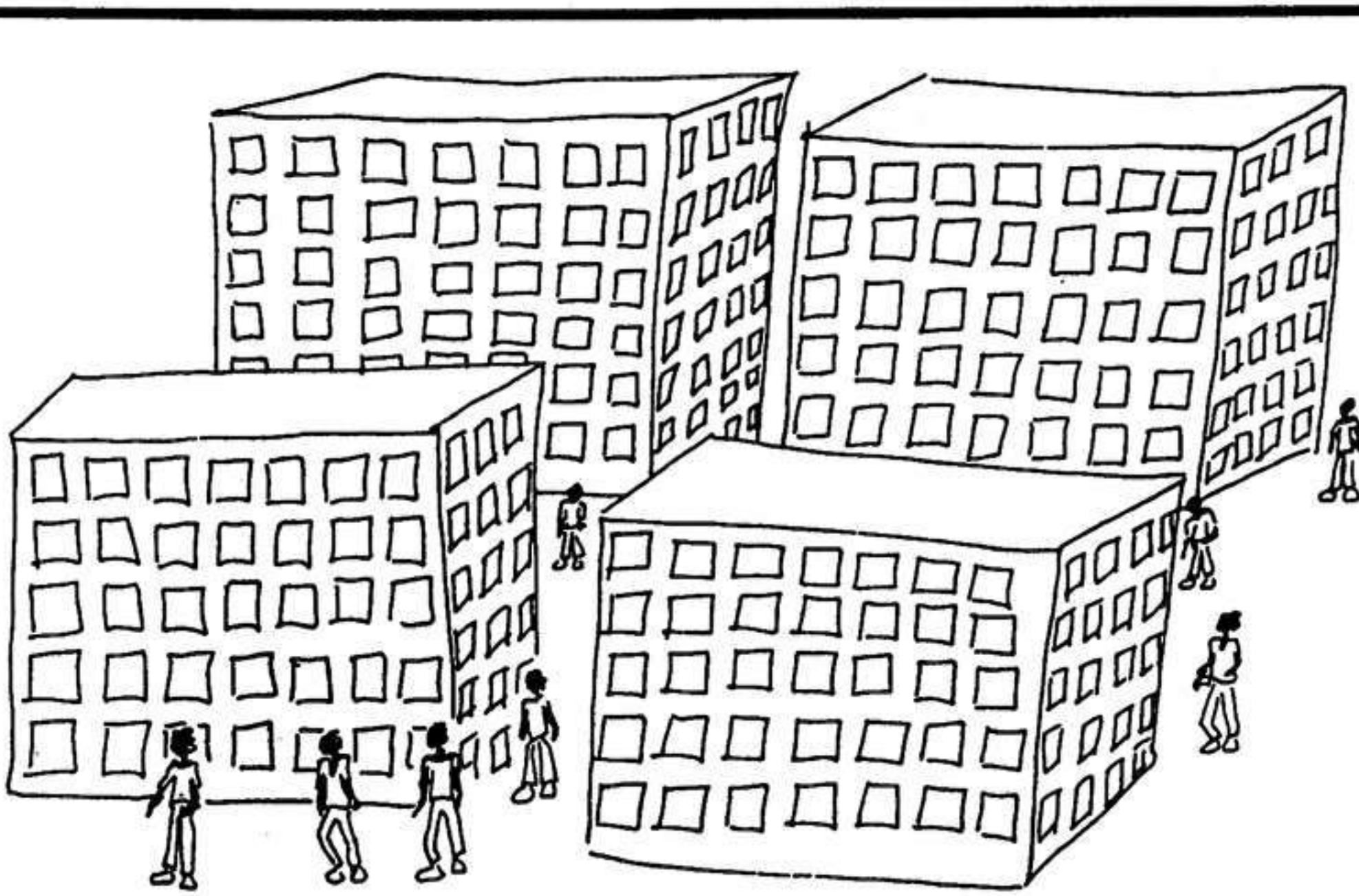
* Syphilis, chancroid, genital herpes and lymphogranuloma venereum are all

stated to be common causes of genital sores. Lymphogranuloma venereum and syphilis are a very uncommon cause of genital sores in women whereas chancroid probably occurs more frequently than all the others added together.

* Blood transfusion is listed as a cause of syphilis but this must be exceedingly rare. The possibility of the transmission of trichomonas vaginalis and gonorrhoea through the use of shared towels in the impoverished conditions in *which many women live is not mentioned.*
* Gonorrhoea, non gonoccal urethritis, trichomonas vaginalis and candidiasis are all stated to be common causes of discharge. from the vagina or penis but the latter two rarely, if ever, lead to penile discharge. Symptomatic vaginal discharge due to trichomonal infection is so much commoner than the others as to demand special mention lest the readers assume all these are of equal prevalence.
* The nature of the ulcer in primary syphilis is described in classical terms (single, painless) whereas it is just as likely to be multiple as it is to be single, and just as likely to be painful as it is to be painless. The most useful diagnostic feature for a chancre is the presence of associated inguinal lymph nodes which are firm, discrete and enlarged. This is not the lymphadenopathy illustrated in the text.
* Condylomata lata associated with secondary syphilis are described in the illustrations as common in axillary and inguinal sites but are very rare except in the perineal region.
* The rash in secondary syphilis is described as non-itching whereas in fact it may itch. The very useful diagnostic feature of a rash affecting palms and soles is omitted.



prostitution and lack of housing can cause STDs to spread



STDs can spread easily in migrant worker hostels and jails

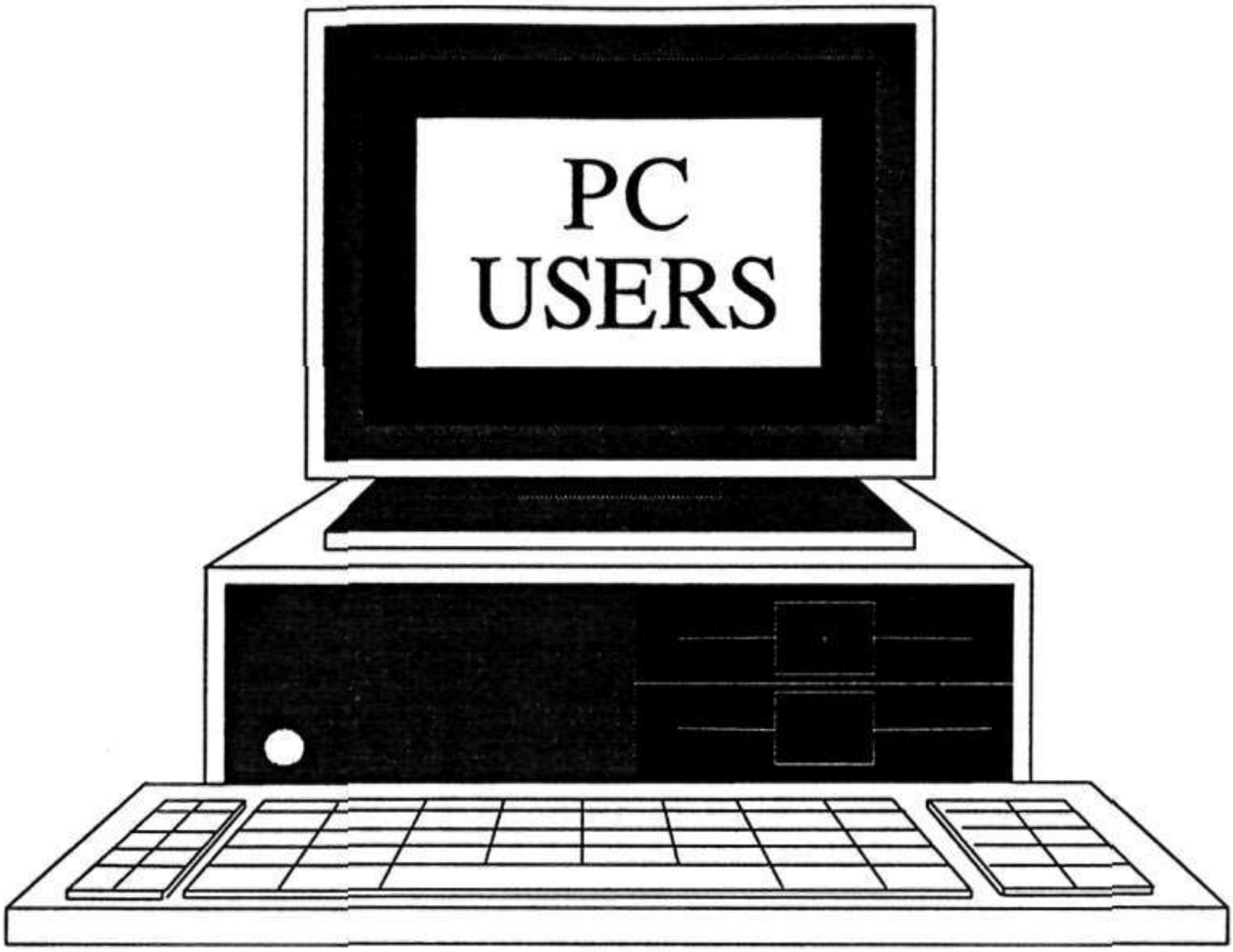
* The value of a repeat test for syphilis in late pregnancy is omitted. It is important to stress that congenital syphilis is a preventable disease.
* The regime prescribed for the treatment of syphilis is benzathine penicillin 2.4 megal units or tetracycline. This is satisfactory for those who have had the disease for less than one year and who are not pregnant. However the majority of pregnant women with syphilis are diagnosed because of positive serology and there is no indication as to how long the disease has been present. In this case it is essential to treat the patient for at least three weeks. Tetracycline should not be used.
* The illustrations of chancroid and syphilis ulcers are virtually identical. Inguinal lymphadenopathy rarely occurs with chancroid in women.
* The diagram illustrating herpes is misleading in that the lesions often do not occur in clusters.
* Evidence for the value of Acyclovir ointment in the treatment of genital herpes is tenuous. Therapy more appropriate for the primary care situation is probably local antisepsis to reduce the risk of secondary infection.
* Cold sores are not usually considered amongst sexually transmitted diseases and would be better omitted.
* A regime of treatment lasting from 14-21 days is advised for lymphogranuloma venereum. In a text of this nature it would be better to be dogmatic about the exact length of time the treatment is to be given.
* The fact that more than half of the women with gonorrhoea are symptomless

should be stressed; and that men can also have the disease and be free of symptoms.

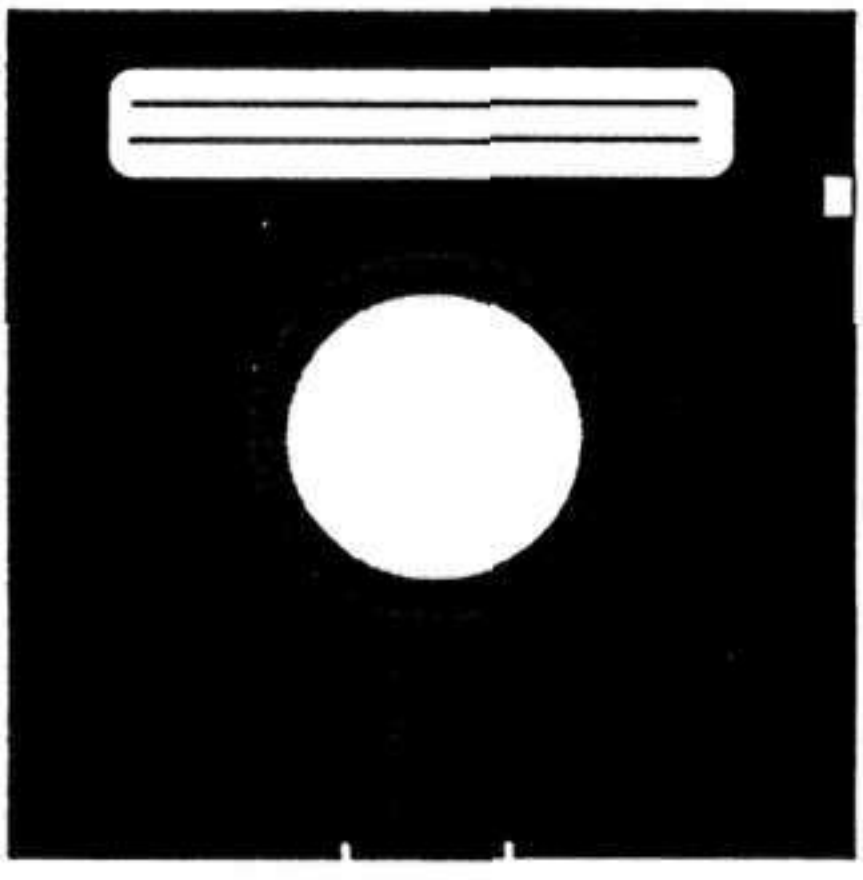
* Urethral strictures are listed as complications of gonorrhoea but it is not stated that these are excessively rare in women and can be completely prevented in men with early treatment.
* The diagnosis of trichomonas infection by microscopy is not usually based on the appearance of its structure as is suggested by the illustration, but by its characteristic movements. These are not mentioned.
* Oral contraceptives are not now thought to be aetiological factors in the causation of vaginal moniliasis.
* Painting the vagina is an effective therapy for vaginal candiasis but the importance of using adequate amounts of the dye should be stressed.
* The discharge associated with Gardnerella rarely produces a recognisable fishy odour unless 10% KOH is added to it on a slide or swab.
* Podophyllin is not contra-indicated in pregnancy as the drug acts locally. It would however be inadvisable to use it following cautery as then there is the risk of absorption.
* The treatment of mild PID is not clearly specified. It would appear that a regimen of 4 or 5 different drugs is advised.
* Inflammation of the vulva, perineum and inner thighs are not characteristic of trichomonas infections. This will occur with any excess vaginal discharge if the women does not have the facilities to keep herself clean.
* In most situations in which primary health care nurses are working, trichomonas infections are probably much commoner than gonorrhoea. Thus it is appropriate to use trichomonacides before using drugs active against the gonococcus in cases where therapy is commenced on the basis of clinical features alone.
* The management of urethral discharge in males provided in the summary is confusing. Is both penicillin AND tetracycline/erythromycin advocated in all cases?
* Metronidazole is not contra-indicated in pregnancy although it is best to avoid its use in the first 90 days.
* While it is traditional to pay lip service to treating both partners in the management of trichomonas infection, I have yet to see any evidence proving that this is of value as a routine measure. It is better to reserve treatment of the male for situations where infection is recurrent. The male should then be treated at the clinic.
* Co-trimoxazole (Bactrim/Septrin) is now packaged in two strengths, hence dosage needs to be specified.
* The advice to check for freedom from active herpes before advocating vaginal delivery is appropriate, but the means whereby a primary health care nurse can do this is not specified. Ideally vaginal cultures should be taken. This is obviously impracticable hence some rule of thumb must be suggested. Viral shedding can continue after the herpetic lesions have apparently healed.
* There are a few spelling errors or misprints: co-trimoxazole, vulva, podophyllin, gonnococcal, orally, group.

The reviewer appreciates that some of these comments may be the result of personal idiosyncracies. Few, if any, are of great significance and do not indicate problems which detract seriously from the usefulness of this manual. It can be warmly recommended for the use of the medical workers for whom it was designed.

S.M. ROSS
Professor of Community Obstetrics, Department of Obstetrics and Gynaecology, University of Natal Medical School, P.O. Box 17039, Congella, 4013



Give us your Wordstar, Multimate, Word Perfect, MS Word, Xywrite and Ventura Publisher disks and we will give you professionally typeset full page make up. Or send downline to us via modem.



Call Steve
or Godfrey
at 23-3816 / 4204

MediaLink

TheDTPbureau