

LETTER

Management of vaginal discharge

To the Editor: In the February 2004 issue of *CME*, Professor Anwar Hoosen¹ discusses the management of vaginal discharge. Although the description of the symptomatology of vaginal discharge in sexually active women, typical for particular causative organisms, is correct, he fails to stress that this is not specific enough to be used as a lead to an aetiological diagnosis. It is generally accepted that on inspection of the genitalia one can at most diagnose the presence of a discharge, and even that is not simple since the differences between 'normal' and 'abnormal' are far from evident. In addition, the two-swab test to differentiate between discharge from vaginal and endocervical origin is a very crude test and lacks sensitivity.

He also describes bedside tests (better referred to as point-of-care tests) for the diagnosis of bacterial vaginosis and trichomoniasis. Although positive tests in the hands of well-trained clinicians are specific, these tests lack sensitivity. Also, a positive test does not exclude mixed infection with another pathogen. Mixed infections are seen used because they obscure the diagnosis. This inability to arrive at a reasonably reliable diagnosis during a consultation is one of two main reasons for the syndromic approach to management of female discharge and other STD syndromes.

Laboratory tests for the aetiological diagnosis of female discharge that are sensitive and specific enough to arrive at a reliable diagnosis, are currently all based on nucleic acid amplification technology. A full set of such tests is available in South Africa only in a few specialised laboratories. Private laboratories offer the commercially available tests for cervical pathogens (*Neisseria gonorrhoeae* and *Chlamydia trachomatis*) only. Other tests, like culture and microscopy, are too insensitive to allow for a reliable laboratory diagnosis. This is compounded by the fact that test results will at best be available 2 days after receipt of the specimen in the laboratory. The delay in initiation of treatment if based on laboratory results is unacceptable from a patient management as well as from an epidemiological perspective. This is the second major reason behind the syndromic management approach. Laboratory tests in private practice as well as in the public sector should only be done in patients who fail syndromic management. If such tests are performed, they should include the full spectrum of possible pathogens and not only tests that are commercially available. Such tests should be performed and interpreted in specialised centres as indicated in the referral guidelines that are currently being revised at national level.

In summary, there is no place for a symptom-based diagnosis of the cause of vaginal discharge. This holds true for all health care workers: nurses, general practitioners and O&G specialists alike. Point-of-care tests should currently not be used. Laboratory tests should be restricted to cases in which syndromic management

fails and should be performed in laboratories that have a full set of the most sensitive tests available.

Eva Marumo

Deputy Director
STI/HIV & AIDS Prevention Unit
National Department of Health

1. Hoosen AA. Management of vaginal discharge. *CME* 2004; **22**: 72-78.

Professor Hoosen responds: The response to my article on management of vaginal discharge seems to mix up a few issues. The lack of correlation between clinical and laboratory diagnosis of vaginal discharge in populations with a high prevalence of infections is well established and supported by numerous publications. The value of the two-swab test for diagnosis of sexually transmitted cervical infections is limited and was shown to have a sensitivity of 75% and a specificity of 21% in our local study.¹ The value of syndromic management for women presenting with vaginal discharge at the point of first contact, be it to primary health centres or private doctors, is well established for populations such as which have a high prevalence of mixed cervico-vaginal infections. This is mentioned in my article and supported by the National Department of Health's STI programme.

To state that point of care tests should not be used shows a lack of understanding for the use of the microscope at the patient bedside. The recommendations of Amsel R *et al.*² for diagnosis of bacterial vaginosis are still valid today and microscopy is extremely useful for diagnosing yeast and trichomonal infection. Our study on vaginal infections in diabetic women shows the value of using point of care tests in a population of diabetic women in which cervical infection was virtually non-existent.³ Point of care tests are extremely useful for diagnosing vaginal causes of vaginal discharge due mainly to bacterial vaginosis, candidiasis and trichomoniasis. Stating that point of care tests should not be used at all is tantamount to 'throwing out the baby with the bath water.'

A A Hoosen

Department of Microbiological Pathology
MEDUNSA

1. Moopanar D, Hoosen AA, Moodley J, *et al.* *South African Journal of Epidemiology and Infection* 1993; **8**: 74-76.
2. Amsel R, Totten PA, Spiegel CA, *et al.* *American Journal of Medicine* 1983; **74**: 14-22.
3. Hoosen AA, Peer AK, Seedat M. *Sexually Transmitted Diseases* 1993; **20**: 265-268.