Family Practice Forum

Sexually Transmitted Diseases in Women: An Agenda for Action

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Sexually transmitted diseases are a major health care problem affecting women today. Pelvic inflammatory disease causes untold misery to its victims and is responsible for over $500 million of health care expenditures and eight million visits to physicians in the United States annually.[1] Chronic pelvic pain, abscess, tubal and ectopic pregnancies, as well as sterility, are some of the complications caused by pelvic inflammatory disease.[2] Disseminated gonococcal infection, another major complication of gonorrhea, occurs primarily in women.[3] Chlamydial cervicitis, additionally, causes all the complications that have been traditionally associated with gonorrhea.[4,5] Genital herpes simplex is perhaps the most serious sexually transmitted disease in either sex, considering both the potentially catastrophic complications of the disease and that no effective treatment is available. Congenital syphilis is by no means a medical curiosity. There are more than 10 million new cases of various types of sexually transmitted diseases occurring yearly, and the bulk of these go unreported.[1]

One of the most difficult obstacles to surmount in the control of sexually transmitted diseases in the heterosexual population is that primary lesions of many of these diseases affect the female without her knowledge. The syphilitic chancre in the woman is often located on the cervix or inside the vagina, so that the patient could not know of its existence. This holds true in gonorrhea, nongonococcal urethritis, and genital herpes. All three of these diseases cause obvious symptoms in males but are often asymptomatic or only mildly symptomatic in females. When symptoms do occur, they do not clearly point to the correct diagnosis.

Sexually active women who are seen by most private physicians today are not screened for gonococcal infection, even when symptoms of vague lower abdominal pain and discharge suggest gonorrhea as a diagnostic possibility. Because of the stigma associated with venereal disease, the woman's physician may neglect to suggest that she be cultured for gonorrhea; if the patient is insulted, she may seek a new physician. On the other hand, if the physician does not suggest a gonorrhea culture, the patient may be embarrassed to ask for the test to be performed unless she is certain that her sex partner was infected with gonorrhea. The result of this mutual embarrassment is that neither patient nor physician suggests the test, and the patient remains uncultured and untreated.

Women who are symptomatic tend to self-refer to a gynecology clinic rather than a venereal disease clinic. Unfortunately, few gynecology clinics offer the comprehensive services offered by the municipal sexually transmitted disease clinics, particularly in the areas of education, counseling, contact tracing, and sophisticated laboratory backup. Most gynecology clinics are unprepared to culture for gonorrhea, perform a Tzanck smear for herpes simplex, or do the darkfield examina-

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tion for syphilis. It is indeed unfortunate that, because of the difficulty in documenting the existence of herpes and nongonococcal cervicitis in women, large-scale screening of chlamydial cervicitis or cervical herpes in asymptomatic patients is not thought to be cost effective.[6]

What should be done to combat sexually transmitted diseases in women? It is of primary importance that all obstetrics-gynecology clinic and outpatient facilities, including the emergency room of every acute care hospital, be properly equipped for the diagnosis and treatment of sexually transmitted diseases. Mandatory follow-up recultures should be performed to confirm the efficacy of treatment.

Physicians must be made aware of the importance of contact tracing.[7] Treating only the female patient is not sufficient. Unless male sex partners are rendered free of disease, the patient and additional women will be reinfected by the same infected male.[8] Contact tracing is of particular importance to the pelvic inflammatory disease patient, whose contact is often a male with asymptomatic urethral gonorrhea.

Continuing medical education seminars concerning sexually transmitted diseases and their complications should be available to health professionals. Sexually active women should also be educated about sexually transmitted diseases and have themselves screened periodically for them.

The women's movement has taken the lead in advocating the use of condoms and diaphragms for contraception. Barrier method contraceptives have the additional benefit of being of prophylactic value against sexually transmitted diseases. Several spermicidal jellies that are ordinarily used with the diaphragm have been shown to be effective in preventing the transmission of gonorrhea.[9] It is regrettable that research is not being directed toward improving the dual-purpose barrier methods of contraception.

Research, design, and production of a reliable and inexpensive gonococcal, chlamydial, and herpes simplex serological test must be effected. A convenient method for the culture of chlamydia and herpes during pelvic examination would be an invaluable aid in the diagnosis of these diseases and would probably hasten the development of vaccines against them.

In 1972, Congress allocated funds to the United States Public Health Service to initiate a gonorrhea screening program. The program is directed primarily toward high risk asymptomatic females attending facilities providing screening services, such as public hospitals, outpatient gynecology departments, prisons, and venereal disease clinics. The nationwide gonorrhea screening program has been responsible for the detection of millions of asymptomatic women, preventing them from developing pelvic inflammatory disease and other complications of gonococcal infection.[10] The very success of the program demonstrates that much more can be done to control sexually transmitted diseases in women. The federal government has kept venereal disease appropriations at the 20 to $30 million annual level. A minimum appropriation of $100 million yearly is required for an adequate disease control program. It should not be forgotten that this would have a great impact on eliminating the massive expenditure devoted to the treatment of gonococcal pelvic inflammatory disease.

Success in sexually transmitted disease control can only be achieved by combining the efforts of the medical profession and the women's movement. Family physicians, gynecologists, nurse practitioners, physicians' assistants, public health officials, venereologists, and women's groups must work cooperatively to attack the roots of the problem.

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