ABC of Sexually Transmitted Diseases

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PSYCHOSEXUAL PROBLEMS

Since the 1960s the increase in erotic entertainment has conveyed a clear message: the more sex the better. This has resulted in myths about sexual norms, which if believed may lead to behaviour resulting in the acquisition of sexually transmitted diseases or in sexual dysfunction, or both. The psychosexual problems seen in departments of genitourinary medicine are either secondary to sexually acquired infection or primarily psychological.

General reactions

When genital lesions are seen, felt, or suspected most patients lose interest in sexual intercourse, or at least restrain themselves for fear of infecting their partners. Those disinhibited by drugs or alcohol or of a psychopathic nature may, however, continue to have intercourse, and particular care must be taken to explain the dangers to others of such behaviour.

Marital discord—The innocently infected partner of a patient who has had intercourse outside a stable relationship may realise the implications of a sexually transmitted disease but may not want the diagnosis spelt out. The doctor therefore should not force the diagnosis on the patient but give him or her room to manoeuvre by saying, for instance, "Is there anything more you would like to know?". Often the answer is "No."

Anger, anxiety, guilt, and depression—Under the stress of having a sexually transmitted disease the extravert may become angry and the introvert anxious or depressed. Anger may be directed at the clinic staff as well as the person who transmitted the infection. Recognition of this anger may allow the doctor to intervene and discuss the facts and feelings surrounding a patient's illness. This may prevent later violence towards the patient's sexual partner. Unfortunately, in the case of the psychopath such intervention may not alter the patient's strong feelings or the outcome. The neurotic introvert is more likely to become anxious or depressed under stress, particularly when he or she has had intercourse outside a stable relationship. When severe these symptoms must be taken seriously. Clinical anxiety may be dealt with by letting the patient voice his feelings, and later by reassurance. In some patients the anxiety is so severe that a short course of benzodiazepines (such as diazepam 2 mg three times a day) may need to be given. Guilt and depression often go together, though most cases of depression seen in clinics are not severe; if necessary antidepressants such as mianserin 30-60 mg at night may be given; the dose should be built up slowly to prevent undue sleepiness in a working person. When the depression is deeper, psychiatric help should be enlisted, but the patient may refuse unless the psychiatrists are on the spot at the clinic. A clinically trivial condition such as recurring non-gonococcal urethritis, as well as the more serious problems of genital herpes, pelvic inflammatory disease, acute epididymitis, and hepatitis B, may all cause anger, anxiety, guilt, and depression. Allowing such patients to air their feelings is vital.

Secondary problems

Gonococcal and non-gonococcal urethritis are usually easily and rapidly treated, and early intercourse after tests of cure in an otherwise stable relationship may help to heal the psychological wound that one or both partners feel. Unfortunately non-gonococcal urethritis may be recurrent, and the man may be told not to resume intercourse until the inflammation clears. This may put an extra strain on the relationship, which can be exacerbated if the woman is asked to attend at each relapse. The physician may want to see such couples together, to gauge the effects of and necessity for sexual abstinence, to assess the relationship, and to help them discuss the urethritis and any underlying problems in the relationship.

Pelvic pain and its accompanying dyspareunia very quickly prevent satisfactory intercourse. Pelvic inflammatory disease also causes dyspareunia and many render the woman subfertile or infertile. As well as dealing with the woman's feelings of loss of health and fertility, the doctor may usefully see the couple together to pinpoint problems that have arisen out of one or both partners having had sex with others, and to discuss feelings of anger and resentment in the woman if it is the man who has had casual sex (this is often the case).

Genital herpes may occur in one member of a partnership when the other has never knowingly had the infection. Both may be confused about where the infection has come from and may be angry, accusatory, or resentful of the other partner. Discussion enables the facts to be presented to the couple together (each may have read a different account of the subject in the popular press). It also provides an opportunity to discuss whether herpes, once healed, needs to disturb future sexual relationships (by and large it need not). Women and homosexual men who have had anorectal herpes may develop maladaptive behaviour after the primary attack. Vaginismus and anospasm may thus continue long after the ulcers have healed. Discussion between the doctor and the couple together with systematic desensitisation—for example, using the patient's or partner's finger as a dilator—usually succeeds in overcoming this problem in a few sessions.

Genital candidosis—Frequent recurrences of this condition may leave both partners confused, frustrated, and angry about the supposed source of the problem. A steady, stable relationship should be able to withstand this problem with the minimum of counselling to the woman. If the relationship is unstable, however, symptoms may assume dimensions out of all proportion to the signs. Furthermore, the finding of *Candida albicans* in genital secretions may tempt the physician to make an organic diagnosis, whereas the real problem may be vaginismus with the incidental discovery of *Candida albicans*.

Trichomonas vaginalis and *Gardnerella vaginalis* often cause offensive vaginal discharges, which the man may find offputting. After treatment the smell may disappear, but the woman may have lost confidence in herself, and the man may mistake the normal musty vaginal odour for the previous abnormal smell. The couple may need to be seen together to hear the physician assure them of the normality of the discharge. Again, marital disharmony may propagate such problems, and early discussion can often help to resolve them.

Syphilis is a special case, whether congenital or acquired. Many older patients still think of syphilis as "worse than cancer," and a few may have a catastrophic psychological response when they find out what their illness is. Congenital syphilis presenting in later life may devastate the patient when he realises the implication of his disease in respect of his parents.

Psychosomatic symptoms—Patients may complain of the symptoms of a sexually transmitted disease yet have no such illness. Others

initially have an infection, but the symptoms remain after the infection has cleared. Penile and urethral itching, penile and perineal pain, testicular pain, and pelvic pain may either be primary psychosomatic pains or represent symptoms of active sexually transmitted diseases. Reassurance and explanation of the symptoms are usually all that is required in urethral symptoms, whereas prostatic pain (prostadynia) may be very difficult to manage. Phenoxybenzamine 4 mg twice a day and amitriptyline 50-100 mg at night may help patients with prostadynia.

Loss of libido, secondary impotence—The patient may react to having a sexually transmitted disease or to a partner's infidelity by losing interest in intercourse, particularly with the partner concerned. If the couple stay together sexual problems may develop. Before discharge from care the patient's attitude towards starting intercourse should be ascertained. Loss of libido may be due to anxiety, depression, or just loss of interest in the partner. Secondary impotence may respond to counselling with short term psychotherapy to bring about a return to normal function.

Hypomania in the partner—Hypomaniac patients may have intercourse with a large number of partners and thus acquire a sexually transmitted disease and pass it on to innocent regular consorts. These patients need formal psychiatric help and their partners a sympathetic hearing when they come to the clinic for treatment. Hypomaniac patients usually refuse tests or treatment for the condition, so their "innocent" partners must be told not to have intercourse with them until they have been treated.

Organically based sexual problems can occur in the rare cases of late syphilis that are seen: tabes dorsalis (erectile failure), general paresis (sexual disinhibition), and angina with cardiovascular syphilis (restriction of sexual activity). These patients obviously need special counselling.

The problems of homosexual men are related to personality. The obsessional patient who is worried that he might be incubating the acquired immune deficiency syndrome (AIDS) finds it hard to cope with the fact that there are no screening tests to detect those incubating the disease. His ruminations that he has the disease can and often do lead to anxiety and a depressive illness. Such patients have responded well to a combination of clomipramine, building up to 50-60 mg at night, and supportive psychotherapy which takes the emphasis away from reassurance, which is only short lived in these patients. Treatment should go on for some time after the patient is able to accept the doubt of the situation.

Other homosexual men, in spite of being well informed of the risks of developing hepatitis and AIDS, continue to have passive intercourse with large numbers of sexual partners. The doctor should nevertheless press home gently but firmly that this lifestyle may be harmful. In some sections of the gay community intercourse with multiple partners is of paramount importance to the individual, and a change of lifestyle may be seen as a severe loss. The result may be a depressive illness.

The under aged and rape victims—Under age girls and rape victims are not uncommonly seen to have screening tests for sexually transmitted disease. They usually need careful, thorough, and sympathetic examination, explanation, and counselling.

Primary psychosexual problems

Patients presenting to departments of genitourinary medicine with primary psychosexual problems can be classified into those with psychological reactions to a supposed sexually acquired condition and those with psychosexual conditions—for example erectile failure, premature ejaculation—that are unrelated to sexually transmitted disease.

Psychological reactions

Many patients attend clinics for a check up because of fear of having acquired a sexually transmitted disease. Most are easily and permanently reassured after investigation. Some, however, continue to believe or fear that they have contracted an infection in spite of extensive and frequent reassurance. It is important to differentiate between delusions of venereal disease, which are fixed ideas that the patient cannot be talked out of (found in schizophreniform illnesses, psychotic depression, and monosymptomatic delusions) and phobias or obsessional fears, which the physician can talk the patient out of as being illogical, although the fear may return fairly quickly. Patients with the fixed belief of venereal disease should be referred to a psychiatrist. Patients with monosymptomatic delusions which are well encapsulated with good preservation of personality are, however, usually unwilling to see a psychiatrist as they think they have venereal disease and cannot see that the problem is psychological. This means that the genitourinary physician or general practitioner may have to manage the patient.

Pimozide, a phenothiazine-like agent, 4-10 mg at night often greatly reduces or abolishes the patient's symptoms, which return when medication is stopped. Antiparkinsonian drugs such as orphenadrine may need to be given. These patients should not be given antibiotics since this invariably confirms their worst fears. Obsessional patients will sometimes refuse psychiatric help, in which case clomipramine 10-80 mg at night, building up slowly, should be given and the aid of a psychologist enlisted to treat the ruminations definitively.

Primary conditions

Patients with decreased libido, erectile dysfunction, premature ejaculation, frigidity, impotence, and vaginismus may all present to a department of genitourinary medicine. These patients do not believe or fear that they have a transmitted disease, but many patients and their general practitioners think that a department of genitourinary medicine, perhaps because of the acceptance of confidentiality by the staff, is an ideal place for the assessment and possible treatment of these problems. Treatment may be possible within the clinic or by referral to psychiatrists or psychologists with a particular interest in such problems.

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Clinical curio: pink disease is not dead

Mothers commonly use a variety of creams, some of them bought across the counter, to treat nappy rash. Not all such preparations are safe. We describe an infant who developed pink disease associated with use of a mercurial ointment.

A baby boy, a second twin born at 35 weeks' gestation weighing 2150 g, developed a nappy rash at two weeks of age. The rash was unresponsive to a cream prescribed by the family doctor, and so the mother began applying Conotrane, a cream containing hydrargaphen 0·05% and dimethicone '350' 20%, bought from a chemist. The infant became fretful and refused feeds. He began to vomit and the stools were watery. There was considerable erythema of the whole body with irritability, photophobia, and watering of the eyes. When we discovered that a cream containing a mercurial had been used it became apparent that the infant was suffering from pink disease, confirmed by a raised urinary mercury concentration of 120 μg/ml.

The manufacturers of Conotrane (W B Pharmaceuticals) know of only one other case of pink disease that may have been related to use of the cream. Only 10 reports of adverse reactions have been recorded by the DHSS over 18 years, and none of these were related to mercury intoxication. Pink disease was commonly recognised when mercurial teething powders were in use. Ingestion of mercury contained in house paint and wallpaper and contact with agents used in rinsing nappies can also cause pink disease. Generalised rash, irritability, photophobia, and pink discolouration are seen early in the illness followed by desquamation of palms and soles and hypotonia.

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