Sexually transmitted infections in pregnant women and their partners: A clinicoepidemiological study at a tertiary care center, Mumbai, Maharashtra

Sir,

We read the article "Sexually transmitted infections (STIs) in pregnant women and their partners: A clinicoepidemiological study at a tertiary care center, Mumbai, Maharashtra" with great interest.[1] The authors have highlighted the importance of screening for STIs in pregnancy. While the article does rightly address the underwhelming and often ignored domain of sexual health in pregnancy, however, we have some observations which relate to the deficiencies and inconsistency in their observations.

1. The inclusion was based only on the symptomatology. For instance, vaginal discharge was not looked for unless it was reported to be symptomatic by the patient. As a routine per speculum examination was not performed, this could miss some cases of vaginitis or cervicitis due to STI-related pathogens. In a recent study from Southern India where all pregnant patients irrespective of their symptom status were screened by clinical and microbial testing at 8–24 weeks of gestation, 66.2% women were diagnosed with pathological vaginal discharge.[2] Furthermore, microbiological diagnosis of bacterial vaginosis and vaginitis was found to have a statistically significant association with preterm delivery, suggesting that microbiological examination of the vaginal smears can be a useful adjunct to the clinical examination to prevent potentially adverse outcomes
2. Secondly, if only symptomatic women were studied then we are left with only 3 women with anogenital warts-because the other infections, HIV, syphilis, Hepatitis B were detected by serology, as part of routine antenatal screening, and status of half of the HIV positives was already known. Scabies is not exactly an STI
3. Fourteen women were venereal disease research laboratory (VDRL) and treponema pallidum hemagglutination assay, positive in low titers and only 2 had high titer positivity for VDRL. All patients have been labeled as having latent syphilis without classifying them into early latent, late latent or syphilis of unknown duration. They have treated the patients with only one dose of benzathine penicillin 2.4MU. Patients with high VDRL titer should have been looked for active signs of primary or secondary stage. No follow-up on titers has been provided
4. It is mentioned that all patients were administered injection benzathine penicillin, 4 weeks before delivery. As the trimester and duration of pregnancy in which the patients were screened is not mentioned, should we presume that all patients with syphilis presented almost at the same time or the treatment was offered only 4 weeks before delivery by design
5. The authors observed that the prevalence of STI in their study cohort was 2.1%, which is lower than what is reported

in various studies. In a recent study from Northern India, the seroprevalence of STIs in pregnancy was as high as 22.5%.[3] In another 20-year cohort of STIs in pregnancy from Southern India, seroprevalence for STIs was 14.8%.[4] It is important to highlight the overall percentage of patients in whom STIs were incidentally detected only on screening, versus those who presented with them clinically. This would perhaps clarify the discrepant results and bring to light the need for better antenatal STI surveillance

6. It is mentioned in the discussion that none of their patients admitted homosexual orientation and none indulged in oral or anal sex. However, in the next line, 8.2% has been given for oral sex
7. The methodology for the identification of a pathogens, serology, or criteria for making the clinical diagnosis is not given.

The value of the information provided could have been enhanced with more careful presentation and interpretation of the results.

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Conflicts of interest
There are no conflicts of interest.

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