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A case of neonatal conjunctivitis caused by chlamydia?

Sir,

A 23-year-old woman phoned the surgery one evening, commenting on a television programme about chlamydia that her friend had seen. She requested a test for chlamydia as her baby, now some 17 months old, had had conjunctivitis at the age of two weeks. To put her mind at rest I obtained the appropriate swab from the pathology laboratory and at a later date took a cervical swab. To our mutual surprise it was positive. Was the neonate's conjunctivitis chlamydial? Unfortunately, this question can never be answered satisfactorily as the child had been treated with chloramphenicol eye drops before cultures were taken.

The mother, a primigravida with no significant previous gynaecological history, was 21 years old and unmarried when her daughter was delivered normally, following an episiotomy, in hospital. At 32 weeks pregnant the mother had had a slight pinkish vaginal discharge for four days, with slight abdominal pain and at 38 weeks there had been a somewhat excessive vaginal discharge but a high vaginal swab taken at the time was negative though there was no specific test for chlamydia.

Five days after the birth both mother and baby seemed well and were allowed home, two days later the baby developed a sticky eye. This failed to clear within two days with saline bathing by which time there was a definite purulent conjunctivitis. Treatment with sulphacetamide sodium eye drops 10% was started, and again there was no good response over several days and treatment with chloramphenicol eye drops was started. Initially there seemed to be a good response but the condition apparently recurred despite continued treatment. The child was then seen at the local ophthalmology outpatient department. On examination it was found that the right eye was quiet but there was

oedema of the left lid and congestion of the conjunctiva and conjunctival discharge. The baby was admitted to the local eye hospital where swabs were taken for chlamydia and bacteria. *Staphylococcus albus* only was isolated. While awaiting the culture results the child was prescribed gentamicin eye drops and penicillin eye drops for both eyes, she made an uneventful recovery and was discharged after four days. A bacterial swab taken at the outpatient department five days later grew nothing.

The most frequent cause of neonatal conjunctivitis is chlamydia. Many such infants are seen after leaving hospital by a member of the primary health care team when the conjunctivitis first develops. As with all infections the appropriate swabs, in this case for chlamydia and bacteria, should be taken before treatment is started. There are now several sensitive tests for chlamydia which could be used routinely for all cases of neonatal conjunctivitis, though a more appropriate test would be a cervical swab from the mother when 36–37 weeks pregnant. If this proved positive, treatment with oral erythromycin prior to delivery would cure the mother's chlamydial infection, preventing any sequelae including conjunctivitis in the neonate. However, because of the resources required, screening all pregnant women may be impracticable but all pregnant women at high risk should be screened, for example unmarried women and those who have complained of a vaginal discharge, especially a bloodstained vaginal discharge before or during their pregnancy.

There are two main diagnostic methods currently used for the detection of chlamydia in clinical specimens. First, the isolation of the organism and visualization — the viable elementary body form of chlamydia present in clinical specimens infects tissue culture cells and the resultant inclusions are detected by staining techniques, for example, Giesma, iodine or immunofluorescence.¹ Secondly, direct demonstration of chlamydia in clinical specimens using a fluorescein labelled

monoclonal antibody, for example the Imagen chlamydia test (Ciba). The ELISA chlamydia test (Abbott) is an alternative diagnostic test for a genus specific chlamydia antigen and provides an enzyme amplification system to enhance the test signal. False positives occur using these immunological tests.

Chlamydia trachomatis has been recognized as a frequent cause of sexually transmitted urethritis^{1,2} and has been implicated in a variety of clinical conditions. It is now important for general practitioners to think of the possibility of chlamydial infections and to be aware of the diagnostic tests which are available.

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References

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Rubella vaccination — what happens in practice

Sir,

Rubella infection in the first trimester of pregnancy is still responsible for avoidable congenital abnormalities and terminations of pregnancy. The Department of Health and Social Security recommends that all girls aged 10–14 years and all seronegative women of reproductive age who are not pregnant should be offered vaccination and informed of their immune status.

The general practitioner's role in rubella vaccination is unclear. In order to determine the views of the general practitioners in the Brent and Harrow Family Practitioner Committee area, we circulated a questionnaire to them.

A response rate of 84% was obtained after three mailings. Of the respondents,