LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Laboratory request forms

Sir,

Laboratories are accustomed, although hardly reconciled, to receiving request forms with inadequate clinical information, which may adversely affect not only the diagnostic processing, but also infection control surveillance. While reviewing how surgical wound infections were investigated in the laboratory, with particular attention to the phage typing of *Staphylococcus aureus* from wounds associated with prosthetic implants, and cardiac, vascular and general surgery we suspected that many specimens, often from general practice, labelled simply as 'wound swab', should have been included in this group. The term 'wound swab', as employed by laboratory users, covers a wide variety of lesions, ranging from both surgical and traumatic wounds to pressure sores and ischaemic ulcers.

A survey was undertaken of the first 100 specimens submitted to the laboratory between 25 May and 25 June 1994 that were labelled 'wound swab' with inadequate clinical details. Doctors who had submitted poorly filled in request forms were telephoned in order to discover if the swab was from a surgical wound and, if so, the details of the operation and the name of the surgeon.

Of the 100 specimens 47 were from general practice, 40 were from two acute hospitals and the remaining 13 were from miscellaneous health care facilities. A total of 38 specimens (14 of which were from general practice) were from operation wounds, 14 of which were orthopaedic procedures and four were from cardiac operations.

In four of the 38 specimens, the telephone information radically affected the laboratory interest in the outcome. In two cases enterococci were isolated, and required sensitivities as they originated from wounds following orthopaedic implants. The other two specimens grew *Staphylococcus aureus,* which were phage typed, and were given a wider range of susceptibility tests since they originated from orthopaedic implants.

Thirty four of the 38 specimens would have required further testing had a significant pathogen been isolated. Of particular interest were the four cardiac surgical cases. They were transferred from the regional centre outwith the area. It would have been useful to know this information from the outset, since major centres often have endemic organisms with wide ranging antibiotic resistance, for example, methicillin-resistant *Staphylococcus aureus* and high resistance enterococci, both of which are unusual in this area. Methicillin-resistant *Staphylococcus aureus* in particular may pose problems, as it may not perform well in routine screening for coagulase production by commercial kits and may be misidentified.

Surgical wound infection is likely to be used as a measure of quality of care and all doctors, whether from hospital or general practice, must have the patience to give adequate details on the request form if there is to be any prospect of collecting meaningful statistics and of improving treatment of patients.

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Chlamydia trachomatis

Sir,

We were interested to read the paper by Dryden and colleagues demonstrating a 5% prevalence of *Chlamydia trachomatis* infection in urine specimens from men and women aged 16–57 years, with a much higher rate in the 16–20 years age group.[1] We assume that this represents a symptomatic population, but as many infected individuals, particularly women, are asymptomatic, we would like to present the results of a small study (funded by a grant from the Scottish Home and Health Department) designed to estimate the prevalence in asymptomatic women.

Over a three month period in 1992, 10 general practices from a number of areas in Fife Health Board were asked to enter patients into the study. All women aged between 15 and 40 years attending the practices for routine cervical cytology were asked to participate. Women complaining of a vaginal discharge were excluded. Following the taking of the cervical smear, an endocervical swab was taken using a plastic shafted cotton tipped swab (Medical Wire and Equipment company). This was placed in chlamydia transport medium (Northumbria Biologicals) for chlamydial testing at Fife area laboratory. The specimens were examined by a centrifuge-enhanced direct immunofluorescent monoclonal antibody (Microtrak®, Syva) for the presence of elementary bodies.[2]

Five specimens from 287 women (1.7%) were positive for *C trachomatis.* There were no infections in women between 30 and 40 years of age, making the prevalence of infection 3.5% (5/145) in women aged less than 30 years. In none of the chlamydia positive patients was the smear reported as inflammatory (four were negative and one was borderline). None of the five women with chlamydia infection was using a barrier method of contraception.

This study demonstrates an unexpectedly low prevalence of chlamydial infection among asymptomatic women attending for routine cervical cytology compared with 9% and 12% reported in other studies.[3,4] However, in keeping with other studies those women with infection were in the younger age group and were not using barrier contraception.[5] The presence of an inflammatory smear was not a useful criterion in 'targeting for testing' in this and other studies.[3,4]

General practitioners are ideally placed for screening asymptomatic women, although it is possible that those at high risk of infection do not attend their general practitioner for cervical smears but have smears done elsewhere, for example, family planning clinics, or do not have smears done at all. We recommend that screening for chlamydial infection be considered in a selected population on the basis of age and contraceptive method, regardless of the presence or absence of symptoms. Close cooperation between general practitioners, practice nurses and genitourinary medicine services will allow