A CLINICAL TRIAL OF TINIDAZOLE IN URO-GENITAL TRICHOMONIASIS

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SUMMARY

Trichomonas vaginalis parasitizes the male and female urogenital tract.

The classical clinical signs are not always present, and specific lesions of the vaginal wall and of the cervix must be sought for by colposcopy, and the organisms must be looked for in the adnexal glands, since it is from these sites that relapses occur.

Nitro-imidazole compounds have proved effective over the past twenty years, with metronidazole at their head, which, however, requires long-term treatment.

A new imidazole derivative, tinidazole, has been shown to be effective at lower doses.

Our own clinical experience has confirmed this effect in human therapeutics.

We have treated 52 women suffering from trichomonal vaginitis, using tinidazole in a single oral dose of 2 g. The partner was also given concurrent treatment, at the same dose, in 32 cases.

The result was good in all cases from the first week, and was confirmed 4 to 6 weeks later, with the exception of three cases, in whom a second single course treatment was necessary.

A certain number of organisms associated with trichomonas vaginalis were sensitive to tinidazole. Associated candidiasis, present in 9 cases, was cured in 4.

Clinical tolerance was satisfactory. There were, however, a few side-effects, mainly affecting the alimentary tract.
In any infective gynaecology practices, vaginitis due to trichomonas vaginalis is still very common, with an incidence of about 10% and, according to different authors, follows or precedes mycotic vaginitis. Non-preferential association with pathogenic organisms is usual, and the tendency for the normal flora to disappear should be emphasized.

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The incidence of infection is higher in practices confined to prostitutes, indicating the venereal origin of the infection (the seventh venereal disease). The organism has, however, been shown in swimming-pool water, so that this may also present a route of infection.

The obvious clinical signs, with copious frothy, foul-smelling leucorrhoea and painful and itching vaginitis, are not always seen. It is necessary to be able to observe the condition of the vaginal mucosa by colposcopy, with its numerous small areas where the surface epithelium is abraded, and plaques of oedema. Cytology shows lymphocytic and serious infiltration and cellular dysplasia, and may even show nuclear anomalies. Schyler's Lugol test usually shows infection of the cervix, with the yellowish-white spots described by Joseph MAGENDIE, but there may in addition, in advanced stages, be leucoplasia with cellular metatypes, which are regarded as pre-malignant changes. The parasite has been found on the inflamed endometrium and in pyosalpinx. Trichomonas may shelter in the adnexal glands of SKENE and BARTHOLIN, and these locations are the origin of relapses.

Apart from the fact that copious itching leucorrhoea results in the pathological state of dyspareunia, the lesions in the cervical epithelium and the uterine mucosa due to trichomonas vaginalis may compel the gynaecologist to carry out more searching investigations.

Invasion of the urinary tract is common, and occurs via the urethra, the meatus of which is one of the favourite haunts of the parasite.

In the male, infection is more discrete, and there are many healthy carriers. The parasite may lodge in the balano-praeputial fold without producing clinical signs, but may on occasion provoke urethritis and less often a prostatitis.

**TREATMENT**

In the treatment of uro-genital trichomoniasis, attention should be paid to the severity of the manifestations of the acute stage, the occult, latent character of the chronic stage, and of the risk of re-infestation from a non-treated partner.

The nitro-imidazoles have proved their trichomoncidal activity over twenty years, with metronidazole (FLAGYL) at their head, but this substance has to be given for long periods, both orally and topically.