INTRODUCTION

Trichomonas vaginitis (T.V.) parasite was first described by Donne, in 1836. He found it in the purulent secretions of the genital tract in both men and women. The parasite T.V. is a common cause of infection of the genitourinary tract (Lamie et al., 1979). It is a tetraflagellated motile protozoan and man is the only known host of it (Bard, 1974).

Incidence of infection is unknown because infection is commonly asymptomatic in both sexes. It is claimed however to be present in 10-25% of women in the reproductive years of life and in 12-15% of all men presenting with uretheritis (Catterall, 1972). In Benha, Egypt, T.V. was diagnosed in 39.6% of female outpatients complaining from vaginal discharge (Fahmy et al., 1983).

T.V. is almost always transmitted by sexual contact and it is frequently associated with other venereal disease, especially Candida albicans (Fleury, 1981).

The clinical features of T.V. vaginitis are variable and a clinician may suspect the infection. However, negative clinical diagnosis is unreliable in excluding trichomoniasis (Hughes et al., 1966). Diagnosis is only made with certainity be demonstrating this motile flagellate under the microscope (Fleury, 1981). Microscopic examination of wet smear from vaginal secretions is reliable and was found to be positive in 86-90% of cases (Bard, 1974).

Treatment of T.V. has been simplified since the introduction of Metronidazale and Tinidazole (Bard, 1974). Treatment of T.V. vaginitis by vaccination is a new developing treatment modality (Pavic and Stoikovic, 1983).