DISCUSSIONS:
In present study the mean age of the study subject were 30.7 years, 34.8 years and 26.4 years respectively Group a, b and c.

In the study on infectious diseases in Bangladesh, Gibuey et al the mean age of the subject was 27.4 years.

In one study, Bhalla P, Chawala R, Gurg S, et al (2005) studied vaginal discharge in reproductive age women, the majority are between 25-39 years (>30 years of the age 63%) and Nessa S, Waris S et al studies, sexually transmitted infection and reproductive tract infection RTI among hotel based sex workers, in Dhaka, majority 82% of participant were between the age of 18 to 25 years.

In present study out of 120 females having a history of vaginal discharge 82.5% were of age duration between 21-40 years.

In Indonesia (2005), 80% of HIV infection was in age group of 21-40 years. (WHO Bulletin) Mbu E and KongnyuyE et al (2008) in their study HIV infection among pregnant women majority of (58%) were age of 20-29 years. In present study females having history of HIV-I and II infection, maximum age group was 21-40 years shows similar age duration of HIV infection.

In one study Arabpour M and Kaviyanee K et al (2007), in Iran in study of intrauterine infection in women of child bearing age maximum seroprevalence rate was between 25-29 years. Shreevani Jindal N Agrawal A studied, 350 women of child bearing age; the maximum age were of 16-42 years.
In present study, 98% women were in age of 20-35 years having history of habitual abortion and routine antenatal care.

Table: Comparison of predominant symptoms in present study with other studies:

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<tbody>
<tr>
<td>Abnormal vaginal discharge</td>
<td>85.6%</td>
<td>94%</td>
<td>29%</td>
<td>100%</td>
</tr>
<tr>
<td>Lower abdominal pain</td>
<td>60.4%</td>
<td>40%</td>
<td>20.3%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>49.6%</td>
<td>7%</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Dysuria</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Genital Itching</td>
<td>--</td>
<td>55%</td>
<td>--</td>
<td>12%</td>
</tr>
<tr>
<td>Erosion</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>12%</td>
</tr>
<tr>
<td>Genital Ulcer</td>
<td>--</td>
<td>1%</td>
<td>--</td>
<td>0.8%</td>
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</tbody>
</table>

Study of Howker et al found that 94% women reported abnormal vaginal discharge, 40% reported lower abdominal pain, 55% reported genital itching and only 1% shows genital ulcer.

In study of Ruchika Rajan found commonest presentation was vaginal discharge 29% and lowers abdominal pain 20.3% in study amongst married women.

Present study group (a) all females had vaginal discharge and the lower abdominal pain was 27.5%, genital itching was comparatively low (12%) in
percentage rate. Only one female shows (0.8%) the genital ulcer correlates with Howker et al 1999.

Table: Comparison study of Candida Spices:

<table>
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<tr>
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<th>Candida albicans isolated (%)</th>
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<tr>
<td>Jain et al (2007)</td>
<td>21.5%</td>
</tr>
<tr>
<td>Jindal N et al (2007)</td>
<td>74.4%</td>
</tr>
<tr>
<td>Sobel et al (1996)</td>
<td>25%</td>
</tr>
<tr>
<td>Present study</td>
<td>19%</td>
</tr>
</tbody>
</table>

Candida albicans were isolated by Jain et al (2007), Jindal N et al (2007) and Sobel J and Chaim W et al (1996) in women having vaginovaginal infection 21.5%, 74.4% and 25% respectively. Its rate of isolation Candida albicans 19% was in present study co-relating.

Richard L. Sweet noted 5-10% staphylococcus aureus in genital tract infection. Present study shows 10% staphylococcus aureus. Antibiotic sensitivity test was performed.

Other Gram negative bacilli like Escherichia coli, Klebsiella spp. and Proteus spp. were further identify by IMViC test, sugar fermentation test. Antibiotic sensitivity test was performed. Aspergillus niger detecting in 3 case (2.5%) studied on bases of culture in females. Among these one had no response to antibiotic treatment.
Table 4C: Vaginal discharge verities in present study include Homogenous white (HWD) (25%), greenyellow frothy (GYF) (3.3%), Curdy white (CWD) (33.3%) and Mucopurulent discharge (MPD) (20.8%). Maximum was Curdy white discharge (CWD).

Table 6a and 6b: shows the results and the co-relation of the homogenous white discharge with laboratory diagnosis of vaginosis on basis of gram stain. The sensitivity of homogenous white discharge to detect bacterial vaginosis infection was 75% and the specificity 87.5%. The positive predictive value (PPV) of HWD to find positive cases was 60% while negative predictive value (NPV) was 93.3%.

Table 7a: shows out of 27 isolated Candida Spp. 23 were germ tube test positive and they were identified as Candida albicans. So the Candida albicans was the commonest species isolated and the remaining 4 isolates were further identified by Carbohydrate assimilation and fermentation test.

Table 7b: shows the co-relation of Curdy white discharge and the lab diagnosis of Candida on basis of gram staining. The sensitivity of CWD to detect the Candida was 96.2% and the specific 84.9%. The Positive predictive Value (PPV) was 65% and Negative predictive Value (NPV) was 98.7%.

<table>
<thead>
<tr>
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<th>Trichomonas vaginal Infection %</th>
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<tr>
<td>P Madhibvanan K Krupp et a (2008)</td>
<td>8.2%</td>
</tr>
<tr>
<td>Nessa K Waris Set al (2004)</td>
<td>4.3%</td>
</tr>
<tr>
<td>Nagaraja P (2008)</td>
<td>1.5%</td>
</tr>
<tr>
<td>Present study</td>
<td>2.6%</td>
</tr>
</tbody>
</table>
Madhivanan P, KruppK et al (2008), Nessa K Waris et al (2004) and Nagaraja P et al (2008) detect Trichomonas vaginalis microscopically 8.2%, 4.3% and 1.5% respectively. These results correlate present study (2.5%).

Table 8: Out of 120 cases of vaginal discharge in eleven cases showed more than 30 pus cells/hpf which is indirectly suggestive of Chlamydia infection. Among these only 3 cases (2.5%) showed Chlamydial inclusion body in Giemsa stined Mbu T, Kongnyuy E et al (2008) reported Chlamydia trachomatis 38.4% in their studies.

Table 9: Total 250 females having a stronger family history or any related symptoms were first diagnosed by Rapid methods Combaid and Immuno comb (screening test) confirmed by ELISA Test most of were of HIV-I type and some were HIV-I and II types. 230 out of 250 patients had HIV-I and II infection (Reactive) patients HIV I and II non-reactive were only 20.

HbSAg (Australia Antigen) and VDRL test were carried out, the rate of infection was 0.8% and 2% respectively.

The HIV non-reactive females have an infection of Herpes prognitalis Herpes simplex Molluscum contagiosum, Condyloma lata Condyloma accuminatum perianal ulcer itching over the genital and leucorrhea were diagnosed clinically. No genital wart female was diagnosed clinically.
Chaudhray U, Goel N et al (2007) reported the VDRL positive 5.2% and genital wart 11.6% in their study. E Mbu E, Kongnyuy E et al (2008), in their study syphilis with HIV in pregnant women in Cameroon, U.K.

Ding Y, Detels Ret al (2005) found genital ulcer 11.1% and genital wart 10.8% in female sex workers in Zhengzhou China in their survey. In United State, Net J, Mitchell L reported syphilis 43% in black women and 24% in hispanic women.

In present study HIV reactive HIV females had family history of HIV I &II reactive husband, non-reactive and expired due to HIV I & II were 36.8%, 32% and 33.2% respectively.

Table 9 c: CD4/CD8 test was carried out only in 38 patients out of 230 HIV individual. The reason for small number of test may be as follow

1) Tet carried out only to knwn te progress and severity of diaseas
2) It's high coast may be obstratic factor.
3) Patient may be relaxant to undergo obstetric procedure.

Although, the final analysis are pending preliminary evidence from the most recent national family health survey (NFHS-3) demonstrated that with an HIV prevalence of 0.97 (0.7-1.25) in Andhra Pradesh and 1.13 (0.92-1.44) in Manipur these two states continued to have the highest prevalence of HIV infection among the six high burden state in India (Andhra Pradesh, Manipur, Uttar Pradesh, Karnataka, Maharashtra and Tamilnadu).

Heterogoneity of epidemic and geographic variation is further evidence by up to three fold higher rates of HIV infection 0.97 (0.7-1.25) in Andhra Pradesh when
compared with the neighboring and also industrialized southern state of Tamilnadu 0.34 (0.18-50). In case of Andhra Pradesh men who have sex with men (MSM) prevalence rate of HIV infection have risen from 6.5% in 2005 to 10.25% in 2006 at the once sentinel surveillance site in the state (personal communication APSACS/PHMI SandM officer Askhya Mishra, September 30, 2007).

The HIV/AIDS epidemics is increasingly affecting women and young girls especially were heterosexual sex is the main mode of transmission out of the estimated adults living with HIV 38.4% was females.

Women are less educated, more over worked, under paid and the financially dependent upon men. They failed to make use of protective measures (Condom) which are male driven and also they lack the power to negotiate with their partner. Ironically they are faithful but are infected by their single partner.

The greatest boon of the nature to women is the capacity to conceive and the greatest curse is her inability to control the same.

Zalava-Velazque Guzman-Marini et al (1989) analyzed 100 women and found 47% of them had IgM antibodies against toxoplasama. Galvan-Remirez Soto Maucilliim et al (1995), found that seroprevalence of toxoplasama varies from 7% to 51.3% in pregnant woman. Chopra S, Arora U et al (2004), reported toxoplasama antibodies in 42.5% Mookerjee N, Goget N et al (1995) Yashodhara P. Ramlakshmi B et al (2001) reported antibodies in 34.5% and 13% respectively. In present study, toxoplasama IgM antibodies detected in 15.4 (20 females from 130 total women) seropositivity was nearly co-related with Yashodhara P. Ramlakshmi B et al (1995).
Yashodhara P et al (2001), Kishore J. et al (2003), Turbandkar D et al (2003) found Rubella IgM antibodies positive in 6.5%, 10.38% and 26.8% respectively. In study of Singh M, Arora S et al (2009) reported 3.6% Rubella reactivity and Singla N Jindal N et al (2003) higher positive 10.4%. Present study 6.2% (8 women from 130 totals) women were detected Rubella IgM antibodies positive test. Seropositivity in present study was lower to that of 10.4% found by Singla N et al (2003).

CMV IgM antibodies were 7.8% reported by Sighs Arora S et al (2009) but the seropositivity of 8 - 27% CMV with Bed Obstetric History (BOH) and 13-20% in a symptomatic pregnant women by Kaur R Chopra N et al (2005) and Tubarkar D, Mathur M et al 2003.

In present study, seropositivity of the CMV was 11.5% (15 women out of 130 totals) nearly correlate with results of 13-20% Kaur Chopra et al 2005, and Tuborkur D. Mathur D. et al (2003).

McCaughtry M, Genevera S et al reported HSV seropositivity 4.3% from the sample of women attending the gynec clinic with history of herpes and non-herpes (vaginitis, moniliasis and trichomoniasis etc.)

Higher seropositivity of HSV 26% noted in samples of genital ulcer diseases GVD at the sexual transmitted diseases Pune by Risbud A and Chan Tuck K. et al (1999). 26% from 110 infected women were HSV cultured and 46% of 70 women detect HSV seropositivity by PCR in study of Gardella C and Brown Z et al (2005). Only 5.4%, (7 women out of 130) women detect positive HSV IgM in
present study. The result correlates with seropositivity of HSV found by ML McCaughtry G Eneveras et al, but lower than others.

Present studied for Toxoplasama, Rubella, Cytomegalovirus and Herpes simplex virus were causative agents more or less association with epidemiological factor, age, socioeconomical status and parity and causes of intrauterine infection and abortion.

At present there is no hard evidence that bacterial or viral infection can causes recurrent abortion. An impressive incidence of antichlamydial antibody has been reported in women with 3 or more spontaneous abortion but it is not certain whether this is the association with Chlamydia trachomatis or whether this is the marker of different immune response in women with recurrent abortion

Reason for low seropositivity of TORCH in present study may be following:

a) The test is carried out only in patient who had clinical bed history.

b) The cost of TORCH test also influence in investigation rate as it is one of the costlier serological test.

c) Patient may be reluctant to undergo test procedure.

Human being exposed to the number of organism, the cause of infection depends upon the number of factor e.g. pathogenecity of the organism, the host susceptibility and the immune reponse. Pattern of infectious diseases vary throughout the world depending upon factors such as environmental, weather, economic factor, nutrition, behaviorer and the local heath care system. It is essential that every clinician is aware of regional diseases pattern for the effective
diagnosis treatment and control of infection within their own practice of medicine.

The incidence of sexually transmitted diseases is increasing in large scale. In case of AIDS initial thoughts to be a disease of specific population segment (Haitians hemophiliacs, heroin addicts, homosexual). It is now recognized to have more complexity (social group and demographic). The appearance of AIDS, in changing over the time increasing with incidences among the females and the pediatric population in world, as well as the MSM (men who have a sex with men, encompasses the highest risk homosexual and bisexual male population).

The incidence of sexually transmitted diseases is increasing in large scale is also because of the advanced diagnostic technique. In recent time laboratory advanced technology newer technology and the knowledge regarding the causative organism are predisposing factor in higher incidences.

Patients are educated ready to convince for the diagnostic procedure also their approach is regarding the investigation, particularly in favour to know the positive, in recent time compared to past.

The patient comparatively to have a good financial status and also government and non-government institute carried out, the investigation at lower cost or free of charge and also private laboratory routinely carried out the test.

As a result of genital tract infection, in female facing the following effects.
As female working in their routine house work or in other than house work (in job), such type of genital tract infection responsible for disturbances in their routine life. Malaise or weakness and other symptoms may interfere with her responsibility in case of females. Genital tract infection may lead to effect on her pregnancy and its outcomes. Unhealthy child, premature delivery, still birth, and infertility may be because of her genital tract infection. As in present time such type of gynaec as well as obstetric complication may result in psychological effects.

Phychological effects may be due to some social reasons also. Genital tract infection such as HIV may disturb her, and because she has HIV infection, breast feeding is not advisable, a fear of HIV in her new born, ultimately lead to sever pspsychological depression.

As she has HIV infection in some cases social rejection from the society or because of HIV infection, she is not able to attending the social activity or social function or gathering. Such type of events may precipitate her mental status.

Depression because of genital tract infection HIV is a serious problem when HIV infection diagnosed in women and also in her family member (husband and kids'). It is difficult to treat as antiretroviral drug are so costly. In some cases her husband may die because of HIV infection and the only source of earnings she lost. Financially, to achieve the source of infection, she works hard even though she has had a HIV infection.
In HIV individual weakness and other opportunistic infection e.g. tuberculosis may found comparatively in higher rate. Diarrhoea and weight loss are also common in HIV individual. Health conscious is important to maintain.

Because of costly medicine and the expensive medication, economical status of the family also disturbed. For the females (housewife) all the medical financial, social and the chances of opportunity infection as well as routine infection (weakness) for her health or infection in their kids (particularly HIV) may lead to affect health status of her.

In day to day newspaper there are articles about the suicidal cases in HIV individuals.

Government and other private institute (Non Govt. Organization) are ready to provide medical treatment and source of income to maintain, their life easy.