mg/l) and cefuroxime (MIC 0.32 mg/l). The strain carried plasmids of 3.0MDa and 25.2MDa and the latter was shown to carry the Dutch type *tetM* tetracycline resistance determinant by polymerase chain reaction. Typing studies revealed that the strain belonged to the prototrophic auxotype and the IB7 serovar. The chlamydia antigen assay was negative.

At the end of the course of ofloxacin the patient re-attended the clinic with a persisting urethral discharge. A Gram-stained smear of the discharge revealed intracellular Gram-negative diplococci. Culture of a urethral swab yielded an organism indistinguishable in all respects from the previous isolate. On this occasion the patient was treated with a 2g *stat* IM dose of spectinomycin. On follow up seven days later only a slight discharge was present and both smear and culture were negative for gonococci although polymorphonuclear lymphocytes were seen in the former. He was therefore treated as a case of post-gonococcal urethritis and given a 10 day course of 250 mg oxytetracycline four times daily.

When first introduced ciprofloxacin had exceptional in vitro activity against strains of *N gonorrhoeae*¹⁻³ and consequently has been increasingly used as a first line treatment for gonorrhoea. However, a treatment failure with another quinolone, enoxacin, was reported some time ago by Wagenvoort *et al.*⁴ In the UK, strains with decreased sensitivity (MIC $\geq$ 0.05 mg/l) to ciprofloxacin have been detected since 1989 and treatment failures with ciprofloxacin have been associated with some of these infections.^{5,6} More recently reports from the Philippines and Thailand^{7,8} have revealed strains with ciprofloxacin MIC of >1 mg/l and in the case of the Philippines at least 10% of strains had a ciprofloxacin MIC of $\geq$ 0.25 mg/l. Sentinel studies in the USA have revealed the importation of gonococci with ciprofloxacin MIC of 2 mg/l into Hawaii from SE Asia and also revealed 14% of strains in Ohio to have MICs between 0.13 mg/l and 0.25 mg/l.⁹ In 1994 Birley *et al.*¹⁰ reported the failure of a five day course of twice daily 250 mg doses of ciprofloxacin in a case of gonorrhoea caught in Spain. This infection was also caused by a strain with high-level resistance to ciprofloxacin (MIC 16 mg/l).

Since 1988 216 strains of gonococci with an MIC of ciprofloxacin $\geq$ 0.05 mg/l have been referred to the PHLS Gonococcus Reference Unit and 13 have had an MIC >1 mg/l; none of the strains with reduced sensitivity also had high-level resistance to tetracycline, but 61% were penicillinase producers. Local incidence of ciprofloxacin resistance remains low. In 1994 only 1 of 338 county of Avon isolates was resistant (MIC 1 mg/l); this was not a penicillinase-producer and the infection was contracted in the UK.

This case re-emphasises the importance of culture for cases of gonorrhoea in order to be able to test the antibiotic sensitivities of the organism and thus assist the selection of suitable chemotherapeutic agents. The need for

continued vigilance for ciprofloxacin resistance is reinforced, especially where the patient was infected in the Far East.

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Patients' awareness of changes in the Association of British Insurers' guidelines on HIV testing

In July 1994 the Association of British Insurers (ABI) recommended to its members an alteration to the questionnaires for prospective policy holders. Previously, insurers had requested information on whether the applicant had ever taken an HIV/AIDS test. The revised question asked "Have you tested positive for HIV/AIDS".¹ This alteration was precipitated by a campaign co-ordinated by the Terrence Higgins Trust which cited a study commissioned jointly by the ABI and the Department of Health (DOH) which concluded that possibly tens of thousands of people were being put off taking an HIV test because of such questions.²

This study was performed to assess the awareness of the alterations to ABI policy and their impact on the attitude to HIV testing in patients attending the John Hunter Clinic. Anonymous questionnaires were given to 130 new patients who were invited to complete them during November-December 1994. To assess the influence of the recommendations, and the possibility of applying for life insurance, on future HIV antibody testing a 5 point

Response of patients "aware" of the ABI recommendations

The ABI does not want to know about	Correct	Wrong	Not answered	Total
Negative tests for HIV/AIDS	13	22	0	35
Positive tests for Hepatitis B or C	16	17	2	35
Testing/treatment for any STDs	21	12	2	35

Likert scale was used. One hundred and twenty eight questionnaires were returned completed. Only 35 (27%) stated that they were aware of the ABI recommendations.

This study demonstrated that only a minority (27%) of genitourinary medicine (GUM) attendees were aware of the new ABI recommendations of July 1994. If these recommendations were intended to make HIV antibody testing more acceptable, it failed at the first hurdle. Even in those patients who thought they knew of the changes, less than 40% correctly indicated that insurers no longer wished to know about negative HIV antibody test results. Amongst the minority of patients who correctly indicated that insurers did not want to know about negative HIV antibody tests there was a slight increase in their likelihood of undergoing HIV antibody testing, compared with those who wrongly answered this question (table). From this study it would appear that the correct message from the ABI failed to reach the majority (90%) of GUM attendees. If the ABI and the DOH wish to remove barriers to the uptake of HIV antibody testing a greater effort must be made to inform adequately the general public. This could be achieved through posters and leaflets in GUM clinics, GP surgeries and family planning clinics.

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2 Surgeon D. Insurers inconsistent over HIV. *BMJ* 1993; 306:1495-8.

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How much sexually transmitted disease is not seen by genitourinary physicians?

At present the majority of national data used in the UK to study the epidemiology of sexually transmitted disease (STD) are provided by the quarterly returns made by genitourinary medicine clinics. Thus far it has been widely assumed that the trends of infection apparent in clinic attenders will reflect those in the community at large. It is likely, however, that a significant number of individuals either never present to the medical services or else only see their general practitioner (GP) who may not refer them on to a specialist clinic. Thus the recent decline in bacterial

STDs could have partially resulted from changes in referral patterns. One of the recommendations of the recent Health of the Nation report was to improve surveillance of STDs at a community level.

We have recently carried out a study looking at GP referrals of men presenting with urethritis in the Lothian region of Scotland as a pilot for a national study. A random selection of 51 GPs selected from the 537 on the Lothian Health Board GP Mailing List were sent a questionnaire enquiring about the number of patients they saw with urethral discharge and their management. Specifically they were asked whether they took swabs for *N gonorrhoea* and *C trachomatis*, if an antibiotic was prescribed, whether the patient was referred to the local genitourinary medicine clinic and what attempts at contact tracing were made.

Forty four (86%) GPs responded. Thirty eight of these, who answered the question, had seen an average of two cases of urethritis over the past year (range 0-6). Six GPs (16%) had not referred their last patient to the local genitourinary medicine clinic. Of these six GPs, three had taken urethral swabs for gonorrhoea and two for chlamydia. All six had prescribed an antibiotic, a tetracycline derivative in four cases and penicillin in one (one GP did not specify which antibiotic was prescribed). None of these six practices were more than 10 miles from the local genitourinary medicine clinic. Contact tracing had been attempted in two cases and successful in one.

Twenty-five of the 37 GPs (68%) who answered the question on which tests were taken had taken a swab for *N gonorrhoeae* while 27/37 (73%) had taken chlamydial swabs. Extrapolating this to the whole of Lothian would have resulted in 749 swabs having been sent to the local bacteriology laboratory for gonococcal culture over a 1 year period. It is estimated, however, by the laboratories in Lothian that they only received 120 male urethral swabs from GPs in 1994.

It seems likely that around 16% of male urethritis presenting to GPs in our region may not be seen in a genitourinary medicine clinic. The associated implications for accurate diagnosis, appropriate management, contact tracing and public health control are obvious but it remains unclear why GPs are reluctant to refer such patients. It would also appear that GPs may overestimate the number of swabs that they take from such patients. As part of an ongoing larger study covering all of Scotland we hope to assess some of the possible factors such as patient refusal, lack of knowledge amongst GPs and geographical variation.

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