the techniques and the patients studied. A clinical trial was, therefore, set up to test the effectiveness of cryosurgery in the treatment of genital warts in men and women, with particular attention being paid to the technique and to patient acceptability.

Of 103 patients (69 men and 34 women) treated with cryosurgery 60 (39 men and 21 women) had been previously unsuccessfully treated with either podophyllin, electrocautery, or curettage, with a mean of 14.0 attendances.

Other diseases as well as genital warts were treated before or at the time of the patients first attendance for cryosurgery. Of the 103 patients treated, 31 were excluded from the study because they were unavailable for follow up, and one was excluded because of treatment failure.

Of the 71 patients studied, 49 (69 %) were cured after three or less cryosurgical sessions—that is, two weeks’ treatment for patients attending weekly (Table). However, 10 (50 %) of the 20 patients who had anal warts (with or without genital warts) needed more than three sessions. In those patients with anogenital warts five men and two women with anorectal warts were treated using a proctoscope. In five (7%) patients the warts recurred after apparent cure, but the recurrences were minor and responded rapidly to further treatment. Non-specific balanoposthitis occurred in one man after treatment.

The method of treatment was acceptable to patients. Ninety-one (88.3 %) of the 103 patients in the trial attended during treatment was completed, although 20 of these did not attend for follow up. Discomfort and pain from thawing were reduced to a minimum by not freezing excess normal tissue. Also staging of treatment was more comfortable for the patient, although it meant additional treatment sessions in some instances.

Thus with careful attention to technique cryosurgery can be used successfully to treat genital warts, and it is acceptable to patients. The most important aspects appear to be accurate freezing of affected tissue by using two freeze-thaw cycles and KY jelly (Johnson and Johnson Ltd) to ensure adequate contact between warts and cryoprobe. The use of the Key Med variable-size chisel-tipped cryoprobe is an additional refinement.

The great advantage of cryosurgery is that it can be used as often as required where warts are extensive and where new lesions appear in untreated sites: both of these are common problems in the management of genital warts. Furthermore, there is no scarring, and local anaesthetics, such as Anugest cream (Warner), are only necessary with extensive vulval or anal warts. Cryosurgery was also effective in treating those warts which were difficult to manage by other methods such as, intrameatal, vaginal, cervical, anorectal, and vulval warts in pregnancy.

A further assessment of the value of cryosurgery as a primary treatment for genital warts by a comparative trial with other methods, such as podophyllin, is envisaged.

I am very grateful to Key Med (Key Med House, Stock Road, Southend-on-Sea) for the loan of the Key Med MT600 cryosurgical equipment. I also thank the consultant staff of the department for allowing me to study patients under their care and all the staff who helped to organise the appointment clinic.

Yours faithfully,

M. J. Balsdon
Royal South Hants Hospital,
Bullar Street,
Southampton

Table Mean number of attendances for cryosurgery before cure

<table>
<thead>
<tr>
<th>Site of warts</th>
<th>No. of patients</th>
<th>Mean number of attendances before cure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>With previous treatment and cryosurgery (41 patients)</td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td>2.4</td>
</tr>
<tr>
<td>Penile</td>
<td></td>
<td>2.8</td>
</tr>
<tr>
<td>Anal or anogenital</td>
<td>13</td>
<td>8.2</td>
</tr>
<tr>
<td>Intrameatal</td>
<td></td>
<td>4.0</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td>2.2</td>
</tr>
<tr>
<td>Genital</td>
<td></td>
<td>4.2</td>
</tr>
<tr>
<td>Anal or anogenital</td>
<td>7</td>
<td>4.2</td>
</tr>
<tr>
<td>Total attendances</td>
<td>4.1</td>
<td>2.3</td>
</tr>
</tbody>
</table>

TO THE EDITOR, British Journal of Venereal Diseases
Comparison of three- and six-day clotrimazole treatment for vaginal candidosis

Sir,

In view of the popularly held belief that patients comply better with short rather than long courses of treatment, and since Masterton et al. (1977) reported good results in candidal vaginitis using a three-day course of clotrimazole, we decided to carry out a short study to compare the efficacy of a three-day course of clotrimazole (Canesten) pessaries (two inserted at night) with that of a six-day course (one inserted at night).

Forty-seven patients were included in the trial and were assessed four weeks after starting treatment. The initial diagnosis of candidosis was based on microscopic examination, but follow-up assessment included microscopy and culture (Sabouraud’s medium).

The results are given in the Table. The success rates for three- and six-day courses of clotrimazole were not statistically significantly different ($\chi^2 = 1.35$, and $P = 0.025$).

Recently it has been stressed that the success of any course of treatment depends on good patient compliance (Macnair et al., 1978). As the default rate was low and very similar for both the three- and six-day courses of treatment, it can be concluded that there was no significant difference in compliance between the two groups of patients.

Moreover, the results show that there is no therapeutic advantage in giving a less concentrated course (one pessary nightly for six nights) over giving the shorter or more concentrated three-day course. Nevertheless, Hurley (1975) advocates longer courses as a prophylactic.
measure against relapse. In view of this the standard treatment that we have adopted in this clinic is to give two clotrimazole (Canesten) pessaries for vaginal insertion at night for six consecutive nights.

J. D. H. Mahony
M. R. Girgis
St Giles’ Hospital, London

TO THE EDITOR, British Journal of Venereal Diseases

Sarcoptes scabiei infestation treated with malathion liquid

Sir,

We have recently carried out a preliminary study evaluating the use of 0.5% malathion liquid in the treatment of sarcoptes scabiei infestation. Treatment was given
and followed up in 30 cases, all of which were included in the study. Diagnosis was
made by the demonstration of the mite from the burrows. Malathion 0.5% would appear to be an alternative treatment for scabies (Merck Index, 1976).

A total of 127 consecutive male and female patients with clinical characteristics of sarcoptes scabiei infestations were examined for the presence of mite and ova. Mites were demonstrated in 41 of these patients by the following technique. Burrows seen on the hands were moistened by liquid paraffin and gently scraped with a blunt scalpel. The scrapings were spread on a glass slide, covered with a glass cover, and examined under the low power of the microscope for mites and ova.

After diagnosis 0.5% malathion liquid was prescribed and the patients were instructed to have a hot bath, thoroughly

References


Table Clinical findings in the 30 cases of sarcoptes scabiei studied

<table>
<thead>
<tr>
<th>Examination</th>
<th>No. of cases seen</th>
<th>Burrows</th>
<th>Mites</th>
<th>Papules</th>
<th>Scratches</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>At initial visit</td>
<td>30</td>
<td>30 100</td>
<td>30 100</td>
<td>30 100</td>
<td>29 97</td>
<td>0 0</td>
</tr>
<tr>
<td>At one week</td>
<td>20</td>
<td>1 5</td>
<td>1 5</td>
<td>9 45</td>
<td>7 35</td>
<td>6 30</td>
</tr>
<tr>
<td>At two weeks</td>
<td>16</td>
<td>0 0</td>
<td>0 0</td>
<td>3 19</td>
<td>2 12</td>
<td>12 75</td>
</tr>
<tr>
<td>At three weeks</td>
<td>23</td>
<td>3 13</td>
<td>2 9</td>
<td>5 22</td>
<td>5 22</td>
<td>16 70</td>
</tr>
<tr>
<td>At final visit</td>
<td>30</td>
<td>3 10</td>
<td>3 10</td>
<td>5 17</td>
<td>5 17</td>
<td>20 67</td>
</tr>
</tbody>
</table>

References

Comparison of three-and six-day clotrimazole treatment for vaginal candidosis.
J D Mahoney and M R Girgis

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