Letters should not exceed 400 words and should be typed double spaced (including the references) and be signed by all authors.

TO THE EDITOR, Genitourinary Medicine

Bone invasion in secondary syphilis

Sir,

We read with great interest the article of Ollé-Goig et al (Genitourinary Med 1988; 64:198-201), which described two cases of bone invasion in patients with secondary syphilis and lamented the scarcity of similar published reports.

In 1985 we published a report of two cases of periostitis in secondary syphilis (J Roy Soc Med 1985;78:721-4), and at that time we could only find three other papers with similar findings.1-3 Both our patients had secondary syphilis with periostitis, but only minimal radiological changes were seen in case 1 and none in case 2, in contrast to the fairly florid changes found in congenital or late syphilis.

The diagnosis of periostitis could be missed in secondary syphilis for several reasons: the bony lesions may be asymptomatic; early syphilitic periostitis and osteomyelitis seldom produce radiological changes;4 and headaches caused by skeletal lesions may be attributed to meningeal involvement. In our patients the diagnosis of periostitis would have been missed if bone scintigraphy had not been carried out; and we think that a higher incidence of bony lesions will be found if this technique is used as a routine investigation in secondary syphilis.

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References

TO THE EDITOR, Genitourinary Medicine

Rising incidence of penicillinase producing Neisseria gonorrhoeae in Paris, France, in 1985-7

Sir,

Penicillinase producing Neisseria gonorrhoeae (PPNG) strains were first isolated in 1976,5 but were not described in France until 1979.6 To evaluate the prevalence of PPNG strains in patients attending the sexually transmitted diseases (STD) centre of Hôpital Saint-Louis (Paris, France), we conducted a prospective study of N gonorrhoeae isolates from all men presenting with uncomplicated gonococcal urethritis in April and May of three consecutive years. We recovered 213 strains in 1985, 216 in 1986, and 114 in those two months of 1987 and studied them for β-lactamase production by a chromogenic cephalosporin test (Cefinase, Bio-Mérieux). The incidence of PPNG strains rose from 9/213 (4.2%) in 1985 to 22/216 (10.2%) in 19867 and 18/114 (15.8%) in 1987. All three groups of men were statistically comparable (χ² test) for age, ethnic group, profession, marital status, sexual orientation, and place and mode of infection. The small number of patients with gonococcal urethritis who attended our centre in 1987 reflects the generally diminishing incidence of gonorrhea in Paris since 1986, probably because of protective measures against infection with human immunodeficiency virus (HIV).

All 18 patients with urethritis caused by PPNG strains in 1987 had been infected in Paris, half of them (9/18) by female prostitutes. The rising incidence of PPNG strains in our centre is of particular concern. Although our population is poor and urban and does not truly reflect the incidence of PPNG strains in the whole country, a spread of PPNG strains is predictable, as it has already occurred in New York city (Sood R, et al, unpublished observation).

Close epidemiological studies of isolates of N gonorrhoeae are recommended and from now on, penicillin as first line treatment for gonococcal urethritis should be abandoned in Paris.

Yours faithfully,
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M Janier*
I Casin†
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References

TO THE EDITOR, Genitourinary Medicine

Non-radioactive DNA probe to identify Neisseria gonorrhoeae

Sir,

We have recently evaluated a non-radioactive DNA probe (Ortho Diagnostic Systems Limited, High Wycombe, Bucks) developed as a culture confirmation test for definitively identifying Neisseria gonorrhoeae. The organisms were inoculated on to a membrane, lysed, and neutralised. The probe was then applied, and the membrane was treated with a conjugate and washed. A chromogen substrate was added for a specified time, and the reaction then stopped in a solution of 1% sodium azide. A positive result was indicated by the development of a blue colour.

We tested a range of Neisseria spp and related organisms, including stock strains and isolates obtained on primary culture from clinical specimens. The reactions were read blind by three workers and graded as being negative, weakly positive, positive, or strongly positive according to the intensity of the colour. Appropriate control organisms were included. As shown in the table, 30 strains of N gonorrhoeae were examined. Most (27) of these gave a positive result. Of the three isolates that gave a negative result, two were negative on initial testing (one of

60
which was in mixed culture), but proved positive when tested again, and the negative result from the third isolate may possibly be accounted for by the use of a limited volume of conjugate. Eleven strains of *N meningitidis* were tested, seven of which were non-reactive. Of the four that showed weak colour changes, two were tested again, when one gave a similar result and the other result was interpreted as positive by only one of the three workers. Four other *Neisseria* spp proved non-reactive. Two isolates each of *Moraxella* spp and *Branhamella catarrhalis* were recorded as giving negative results, although three of them showed a weak colour change when read again five to 60 minutes after the test was completed.

Although we tested a limited number of isolates, the DNA probe performed satisfactorily in most cases. Some isolates were, however, identified incorrectly. False negative results could possibly be accounted for by one of the technique steps, such as inadequate inoculum size; false positive results are less readily explained. Our overall impression of the test was that it was relatively simple to perform and was completed within 10 minutes. The timing and temperature appeared to be critical, however, which led to a need for extremely good organisation of the work or for two people to perform the test. Furthermore, the colour reaction was weak in many instances, which led to difficulty in interpreting the result. The improvement of the methodology to overcome these limitations will make the probe available as an additional test to identify rapidly *N gonorrhoeae* from primary cultures. Further evaluations, including cost consideration, are necessary to assess the role for this test in routine clinical laboratories.

We thank the staff of the department of genitourinary medicine for their assistance in this study, and Ortho Diagnostic Systems Limited for supplying the kit.

Yours faithfully,

M S Sprott
A M Kearns
M W Neale

<table>
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<th>Organism</th>
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<th>No giving reaction</th>
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<td></td>
<td>Negative</td>
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<tr>
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<td>1</td>
</tr>
<tr>
<td><em>N elongata</em></td>
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<td>1</td>
</tr>
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<td><em>Moraxella</em> spp</td>
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</tr>
<tr>
<td><em>Branhamella catarrhalis</em></td>
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Non-radioactive DNA probe to identify Neisseria gonorrhoeae.

M S Sprott, A M Kearns and M W Neale

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