

MATTERS ARISING

The diagnosis of prostatitis

Dr Thin's review of prostatitis¹ throws much light on an ill-understood condition. Of particular practical importance is his clarification of the way in which reflux of urine into the prostate occurs, and the part that this may play in the infective process.

However, he states that acute bacterial prostatitis is uncommon. Many years' experience of providing a laboratory diagnostic service to general practitioners in a large health district has convinced me that this condition is far commoner than may be apparent to urologists and other doctors who work in hospital. Specimens of urine with request forms describing the clinical syndrome characteristic of this condition, as described by Dr Thin, are received in the laboratory every week from up to 30 men of all ages. They invariably show gross pyuria and yield common bacterial urinary pathogens, often, but not always, in high counts. High bacterial counts are, of course, the consequence of multiplication of bacteria in the bladder, which acts as an incubator. Men with acute prostatitis do not necessarily also have bladder infection, and in these patients bacterial counts may be low. We have shown that men without symptoms referable to the urinary tract or prostate do not excrete Gram-negative organisms in the urine,² suggesting that the presence of such organisms, in whatever count, should be taken as indicative of infection.

Apart from those with the fever and malaise characteristic of acute prostatitis, urine specimens are also received from a large number of men with dysuria or frequency, many of which show heavy pyuria.³ Some may have chronic prostatitis caused by the common bacterial urinary pathogens; others may have infection with one of the less common pathogens listed by Dr Thin. To this list should be added *Gardnerella vaginalis*,⁴ *Haemophilus influenzae*,⁵ almost certainly *Chlamydia trachomatis*⁶ and possibly *Corynebacterium spp.*⁷ Many of these pathogens are only detected if appropriate culture techniques are used.⁸ Our laboratory procedure is to request a further specimen from all men in whom pyuria is unexplained by overnight culture on Cled agar. This specimen is then cultured on Cled agar and chocolate blood agar for incubation in an atmosphere containing 5% CO₂ for 48 hours, and on nalidixic acid blood agar for incubation anaerobically for 48 hours. If pyuria is still present and all cultures are negative the infection is presumed to be due to *C trachomatis*, mycoplasma or ureaplasmas. As yet, we do not apply techniques for detection of *C trachomatis* in urine, but such techniques have been applied successfully elsewhere.^{9,10}

On the assumption that the very unpleasant condition of chronic prostatitis occurs as a consequence of inadequately diagnosed or treated acute prostatitis, our laboratory reports on urine specimens from men carry a suggestion that the patient should be treated,

in accordance with the sensitivity of the isolate, for 14 days with an agent that achieves therapeutic concentration in the prostate. Such agents include cotrimoxazole, doxycycline and ciprofloxacin; erythromycin may also be used for infections with Gram positive organisms. Treatment with agents such as nitrofurantoin, the penicillins or cephalosporins will merely sterilise the urine temporarily but leave the prostatic focus of infection untouched.

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Declining trends in some STDs in Belgium

Dr Walckiers and her colleagues report interesting trends in some sexually transmitted diseases in Belgium based on data derived from sentinel networks of general practitioners and laboratories,¹ and acknowledge some of the shortcomings of their approach. From the laboratory data it is very difficult to infer the frequency with which infections occur in the population. This is because neither the proportion of infected individuals who present to health facilities, nor the frequency with which those health facilities carry out testing in such individuals are known. For sentinel networks of general practitioners, diagnosis is largely syndromic and information about the occurrence of individual pathogens cannot be derived.

Might I suggest that where both clinical and laboratory sentinel surveillance systems are operating in parallel, the former might, where practical, collect information about practitioners' testing practices both for screening, and diagnosis. Such information would enable the number of infected patients seen by clinicians to be estimated from the number of positive laboratory tests reported. Although such information would tell us nothing about the proportion of all infected individuals who present, it seems reasonable to assume that this proportion is less likely to be subject to rapid variation over time than

testing practices; at least for diseases such as chlamydial and gonococcal urethritis in men. If in addition clinical information could be provided to laboratories concerning whether a test was carried out for screening or diagnostic purposes, then the frequency of occurrence of infections in asymptomatic individuals could also be estimated.

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Choosing equipment for treating genital warts

We read with interest the excellent paper by Anne Scouler which included an update of surgical techniques available for the treatment of recalcitrant warts.¹

We wish to comment that curettage as a treatment modality was not mentioned in this paper. Curettage is very cheap and efficiently removes isolated hyperkeratotic warts which resist chemotherapy.² The equipment consists of a Volkman's spoon, a curette which can be reused after sterilisation. Ethyl chloride spray is used as a local anaesthetic prior to the procedure and bleeding can be easily controlled using silver nitrate sticks or Monsel's solution. It is our experience that patient acceptability equates with that of other destructive methods of wart treatment and healing occurs without scarring.

Care, however is required in order to avoid the potential hazards of ethyl chloride in the work place as it is a potent anaesthetic.³ Occupational safety limits are set at 1000 parts per million for long term use and 1250 parts per million for short term use.^{4,5} Furthermore, as it is a highly flammable substance, the necessary precautions must be taken, such as ensuring that it is not used near a naked flame, in high temperatures or when sparks are likely (near electrical equipment). It should be stored in a cool, dark place at or under 20°C and adequate ventilation ensured when it is used.⁶

Significant toxicity may occur in medical attendants but only after prolonged exposures as there are two case reports in the literature of psychological and neurological symptoms which occurred after daily exposure to ethyl chloride over several months. Both cases resolved spontaneously on withdrawal of exposure.^{7,8}

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