1995, this problem has been rectified in data from Scottish GUM clinics. Scotland is now in a unique position in the UK, in that we now collect statistics on individuals (with all due attention to preserving anonymity, by using unique identifiers), rather than diagnostic events. This change has led to the introduction of sexual behaviour in GUM clinic attenders in Scotland compared with a control population (in a nearby family planning centre) and we hope that similar developments will be possible in the future, as a result of this fundamental improvement in the methodology of our data collection.

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Urinary symptoms, sexual intercourse and significant bacteriuria in male patients attending STD clinics

We read with interest the recent paper by David et al.1 on urinary symptoms and bacteriuria among male STD clinic attenders. The authors state that urethritis and UTI cannot be distinguished on clinical grounds and/or urethral smears. We were surprised that no mention was made of the "two glass urine test" as a means of distinguishing pure urethritis from a combined urethritis/cystitis. We find this a useful test— from January to July this year 11 men attended our department with a documented UTI; nine of these had a cloudy second catch urine (not due to phosphaturia). We would, therefore, be interested to hear whether the authors can provide details of the two glass urine test results in their patients with both bacteriuric and non-bacteriuric urinary symptoms.

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The authors reply:
Although the "two glass urine test" is a time honoured practice at some private house clinics, we did not include it in our study. This test in our opinion is subject to observational variation and interpretation. We think that looking under the microscope for qualitative assessment of change in white cells is less subject to observer variation and is more scientific. In the Cambridge group only nine of the 11 patients with urinary tract infections had a cloudy second urine, while all 13 patients with urinary tract infection in our study were found to have pyuria.

LOAY DAVID DAN NATIN

Antibiotic treatment for gonorrhoea in the UK

The emergence of resistance to quinolones in Neisseria gonorrhoeae was highlighted in the review by Ison2 and in the report by Abeywickere and others.3 However, in the UK quinolones are becoming ever more widely used and have now overtaken penicillin as the drug of first choice.

The National Audit of gonorrhoea management questioned all clinics in the UK about cases diagnosed in the first three months of 1995 and received data on 1303 cases, 51% of all reported in the quarter. The antibiotics used fell into the following classes: quinolones 48%, penicillins 40%, spectinomycin 3%, others/not recorded 9%. For those patients known to have had urinary tract infection outside Europe, and when penicillin producing Neisseria gonorrhoeae (PPNG) was presumably thought to be more likely, the choice (ignoring single use and unspecified drugs) was: quinolones 73%, penicillins 23%, spectinomycin 4%.

Ciprofloxacin resistance is still rare in the UK, but in 1995 the highest ever annual total of ciprofloxacin resistant strains was identified by the Gonococcus Reference Unit, while PPNG isolates were still below their 1992 figure.3 The Reference Unit data rely on voluntary reporting with its attendant limitations. The National Audit figures show that antibiotic choice has moved away from penicillins, so it is now particularly important that information monitoring of the extent of ciprofloxacin resistance is monitored in UK genito-urinary physicians.

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Epidemiological treatment and tests of cure in gonococcal infection: evidence for value

In his otherwise excellent review article,1 Chris Carne makes the classic mistake in his conclusions of quoting somewhat spurious percentages rather than absolute values. He says that 42-6% of treatment failures will be missed if tests of cure are not routinely performed on male gonococcal infection. However, a closer look at these figures shows that out of the original 4897 men, only 183 (3-7%) were treatment failures, of whom only 78 (1-6%) were asymptomatic; therefore only 127 (1-6%) of the total would remain infected after treatment if a policy of test of cure for asymptomatic men were not followed; a more meaningful statistic. As Carne himself points out in the article, the cost of identifying each of these very small numbers of cases in America was estimated to be in the range $4900 to $109 800 per case. It might therefore be argued that a more cost effective use of this money would be to...
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