CORRESPONDENCE

August, 1950.

Sir,—Dr. W. V. Macfarlane's excellent article in the June, 1950 issue of this Journal questions the necessity for a six months' observation period after treatment of gonorrhoea with penicillin. There must be many who have been thinking along the same lines. As regards complications, most workers will agree that this factor does not justify the prolongation of surveillance beyond the usual three months. Complications requiring a more prolonged surveillance will arise within this period or should be found at tests of cure three months after treatment.

The Ministry of Health's recommendation of March, 1945, (Memorandum V.21), was concerned with the masking of syphilis by treating gonorrhoea with penicillin, and it was doubt on this point which wisely led them to advise an extended observation period. It is the practice in most clinics in Gt. Britain to complete tests of cure for gonorrhoea about three months after treatment. Observation thereafter is limited to clinical and serological examination to exclude syphilis. Hence, the relevant issue in this discussion is whether the time has now come when we can safely conclude from the known facts that concomitantly-acquired syphilis will always become manifest within three months of standard treatment for gonorrhoea.

Dr. Macfarlane has made out an excellent case for reducing the observation period to three months for certain patients under his care, but I believe his conclusion to be unjustified in so far as it is intended to have a more general application. More precise knowledge is required on various and variable factors before such a conclusion is justified. The most important factor is that of dosage in the treatment of gonorrhoea. Dr. Macfarlane's admirable moderation in this respect cannot be accepted as standard practice. Doses considerably in excess of 300,000 units are the rule rather than the exception. Further, there is a tendency in dealing with a non-toxic product for the nurse or orderly to err on the generous side, thus the dose given is more likely to be greater than less than that prescribed. The more popular penicillin products are not easily measured precisely. Cases of gonorrhoea, particularly in the female, are commonly treated with doses of penicillin three or four times greater than that prescribed by Dr. Macfarlane. Numerous cases are treated outside the clinics, or attend the clinics after empirical diagnosis and

treatment with an unknown quantity of penicillin. There can be no room for argument that the danger of masking syphilis increases with the dosage of penicillin given for the treatment of the gonorrhoea.

Other unknown factors affect the individual case and must be taken into consideration before a general principle can be formulated. For instance, the size of the concomitant treponemal inoculum, the time interval between concomitant syphilitic infection and treatment for the gonorrhoea, the time and dose factor in cases of re-treatment for relapse or failure, and penicillin treatment for any other condition during the observation period. I suggest, therefore, that, although Dr. Macfarlane may be justified in reducing the observation period for certain selected cases from his clinic, venereologists would be ill-advised to advocate such a reduction as a general measure. I believe it is the duty of venereologists to impress on all who treat gonorrhoea, whether in the clinics or privately, that syphilis and gonorrhoea may be acquired simultaneously, that our knowledge of the various factors at work is at present insufficient to enable us to relax our rigid standards of surveillance, that the dosage of penicillin in the treatment of uncomplicated gonorrhoea should be kept to a minimum consistent with a reasonable cure-rate, and that when doses much in excess of this are considered necessary for the treatment of complications, the dose and treatment schedule should be similar to that for primary syphilis.

There is one other point arising from Dr. Macfarlane's excellent article on which I must take issue. He maintains that the gonococcus was not instrumental in causing epididymitis in the majority of patients who developed this complication subsequent to penicillin treatment [for acute gonorrhoea] since in those patients bacteriological and clinical success not only immediately followed penicillin therapy but was maintained over a varying period, usually weeks.

Surely any case of epididymitis occurring after gonorrhoea and within the period of surveillance must be ascribed to the gonococcus unless some other organism can be definitely incriminated.

I am,
etc.,
A. E. TINKLER.

Mawnan, Cornwall.