1 Dickson NJ, Paul C, Skegg DC, *et al.* Unlinked anonymous monitoring of HIV prevalence at sexually transmitted disease clinics. *NZ Med J* 1993;106:325-7.
2 Dickson, Austin FJ, Paul C, Sharples KJ, Skegg DC. HIV surveillance by testing saliva from injecting drug users: a national study in New Zealand. *J Epidemiol Community Health* 1994;48:55-7.
3 Coutinho RA, van Andel RLM, Rijsdijk TJ. Role of male prostitutes in spread of sexually transmitted diseases and human immunodeficiency virus. [Letter] *Genitourin Med* 1988;64:207-8.

Accepted for publication 26 June 1996

Rapid emergence of 4-fluroquinolone resistance with associated decline in penicillinase-producing *Neisseria gonorrhoeae* in Colombo, Sri Lanka

Penicillinase-producing *Neisseria gonorrhoeae* (PPNG) was first detected in Sri Lanka in 1980¹ and routine testing of gonococcal isolates obtained from patients attending the Central STD Clinic, Colombo for PPNG was started the following year. In 1989, 26% of all isolates were PPNG (table 1). However, since

1992, there has been a sharp decline in PPNG with none detected in 1995. Penicillin was withdrawn from use as first line therapy for gonorrhoeae and single dose quinolone therapy introduced in 1993.

Occasional clinical resistance to quinolones was first detected in late 1994. Antibiotic susceptibility testing facilities were not available on a routine scale in the Central Laboratory of the STD/AIDS Control Programme at that time. As increasing clinical resistance began to surface during the 2nd quarter of 1995, antibiotic susceptibility testing was started in June the same year. Since then, quinolone resistance has varied between 14-50% (table 2).

This rapid emergence of quinolone resistance with decline of PPNG which has also been reported from Hong Kong,² clearly indicates that 4-fluroquinolone is no longer useful as first line therapy for gonorrhoea in Sri Lanka. What next? Cephalosporins appear to be the only alternative but they are expensive. The perennial budgetary constraints present in developing countries have to be taken in to account when selecting an appropriate antibiotic which is effective, reasonably priced, can preferably be administered as a single dose orally, and be also made widely available.

I ABYEWICKEREME
STD/AIDS Control Programme,
Colombo, Sri Lanka
L SENARATNE
V B PRITHIVIRAJ
Central Laboratory,
STD/AIDS Control Programme,
Colombo, Sri Lanka

Correspondence: Dr I Abeyewickereme, STD/AIDS Control Programme, P O Box 567, Colombo, Sri Lanka.

1 Wickramasinghe RSB, Rodrigo HT. Penicillinase producing Gonococci in Sri Lanka. *Ceylon Medical Journal* 1982;27:185-8.
2 Kam KM, Lo KK, Ho Ng KY, Cheung MM. Rapid decline in penicillinase-producing *Neisseria gonorrhoeae* in Hong Kong associated with emerging 4-fluroquinolone resistance. *Genitourin Med* 1995;71:141-4.

Accepted for publication 14 February 1996.

Table 2 4-fluroquinolone resistance in Colombo

Year/ Month	% 4-fluroquinolone resistance
9506	25
9507	14
9508	14
9509	38
9510	50
9511	35
9512	31

Table 1 Penicillinase-producing *Neisseria gonorrhoeae* (PPNG) in Colombo

Year	No of isolates	No Tested for PPNG	PPNG + %
1980	587	22	13.6
1981	282	234	3.4
1982	1232	1232	5.7
1983	1179	1170	10.4
1984	1283	1283	6.1
1985	970	970	8.1
1986	1104	1104	17.1
1987	1021	968	17.5
1988	1271	1142	19.7
1989	1074	1049	26.2
1990	1089	1082	21
1991	752	746	20.5
1992	583	568	9.7
1993	481	475	3.8
1994	281	281	1.8
1995	318	318	0