Correspondence

TO THE EDITOR, British Journal of Venereal Diseases

Sir,

Chlamydia culture service

We read with interest the paper by J R Willcox et al1 advocating a routine chlamydial isolation service. They found that almost 40% of Chlamydia trachomatis-positive female patients had no history of contact with a patient with urethritis and therefore would not have received antichlamydial therapy. Kinghorn and Waugh2 have recently published similar data. The results of previous series,3 4 however, have suggested that chlamydia are rarely found in the absence of a history of contact with either nongonococcal urethritis (NGU) or gonorrhoea.

We are conducting a study of unselected female patients attending two venereal disease clinics. So far, C trachomatis has been isolated from 50 (21%) of 241 patients, a figure compatible with those of other studies.1-4 Of these 50 patients, 40 had a definite history of contact with a man suffering from NGU, gonorrhoea, or an unspecified urethritis, and another two women had an infection with Neisseria gonorrhoeae and can therefore be presumed to have had a contact in the above categories. Only eight (16%) chlamydia-positive patients therefore had no contact history at all. If our study is analysed in terms of diagnostic categories, 25 (31%) of 81 contacts of NGU and 15 (33%) of 44 contacts of gonorrhoea were chlamydia-positive but only eight (7%) of 116 patients with no contact history were chlamydia-positive.

In the absence of a chlamydial isolation service, at present only those patients who have a history of contact with NGU are considered for antichlamydial therapy. It has, however, been suggested5 that women with gonorrhoea or with a history of contact with gonorrhoea should receive a treatment regimen which is effective against chlamydia in the absence of any simple screening test for the diagnosis of postgonococcal cervicitis. Our results suggest that if all women with a history of contact with NGU or gonorrhoea or with an infection with N gonorrhoeae had received antichlamydial therapy, only a small proportion of chlamydia-positive patients would have remained untreated.

There thus seem to be two possibilities in dealing with the reservoir of female chlamydial infection in the community: either a routine chlamydial isolation service analogous to that for N gonorrhoeae is set up for every clinic or therapeutic regimens are designed which will eradicate a large proportion of chlamydial infections. Although others1 2 may feel that their results indicate that laboratory assistance is essential for treatment, our results lead us to believe that institution of such therapeutic regimens would be a justifiable course of action. We do not believe that it would be cost-effective with present chlamydial isolation techniques to set up a routine service and we would favour the restriction of chlamydial isolation to epidemiological and other studies.

We would like to thank Drs G Csonka and J Nabarro for access to patients under their care.

Yours faithfully,
D Taylor-Robinson
P E Munday
Clinical Research Centre,
Watford Road,
Harrow,
Middlesex HA1 3UJ

References

TO THE EDITOR, British Journal of Venereal Diseases

Sir,

Effect of probenecid on amoxycillin

In common with many other doctors, I find the mathematics of clinical pharmacology difficult and would be grateful for some clarification of the information in the paper by Barbhaiya et al4 about the effect of probenecid on amoxycillin. They say that the AUC was taken as a measure of relative absorption of amoxycillin in the presence and absence of probenecid, and they found it to be increased with probenecid. This would seem to imply that amoxycillin is better absorbed when probenecid is present, although it is not obvious why the AUC differences could not be simply due to the change in excretion. Or is it "relative absorption" a technical term meaning "absorption relative to metabolism/excretion"?

It is well known that probenecid delays the excretion of penicillins, but while the prolonged concentrations obtained can be accounted for by this alone, the mechanism causing increased concentrations is less clear. It has been shown that delayed excretion is insufficient to account for the extent of the increased serum concentrations, but the suggestion is that probenecid interferes with the distribution of the antibiotics in the body rather than increasing their absorption.2-4 The implication of this is that although impressive serum concentrations are obtained, these are achieved at the expense of antibiotic in the tissues.

In view of the clinical results, this is obviously not a critical factor in the single-dose therapy of urethral gonorrhoea, but it could be important in other situations such as the treatment of gonococcal salpingitis.

The relationship between serum and tissue concentrations of amoxycillin seems to be similar to that of ampicillin,5 and it has been shown that the concentration of ampicillin in the Fallopian tubes is only one-quarter of that in the serum.6 It must be at least a possibility that the addition of probenecid would further lower the concentrations in the Fallopian tubes, exactly the opposite of the effect that might have been expected.

Yours faithfully,
Kevin Woodcock
Special Clinic,
King Edward VII Hospital,
Windsor

References