

Correspondence

TO THE EDITOR, *British Journal of Venereal Diseases*

Trimethoprim in a selective medium for isolation of gonococci

Sir,

A selective medium for the isolation of *Neisseria gonorrhoeae* based on a medium described by Kellogg *et al*¹ was developed at St Mary's Hospital Medical School, London, (C A Ison, personal communication) using a "cocktail" of antibiotics (VCNT) as recommended by Phillips *et al*.² This medium has been adopted with slight modifications at the Middlesex Hospital, London. The agar concentration was increased from 1.0 to 1.2% (w/v); the concentration of vancomycin was reduced from 3 to 2 µg/ml; the concentration of trimethoprim was reduced from 5 to 2.3 µg/ml; and amphotericin B at 1.5 µg/ml was substituted for nystatin. The concentrations of vancomycin and trimethoprim were reduced because a small proportion of *N gonorrhoeae* is sensitive to the higher concentrations.^{3,4}

It became apparent that not all strains of *N gonorrhoeae* were cultivable on this medium, as a negative culture result was obtained in some patients who were con-

sidered to have gonorrhoea on the basis of a Gram-stained smear. To determine whether the presence of trimethoprim in addition to the other antibiotics was the inhibitory agent, we decided to carry out trials of the medium over two three-month periods firstly with trimethoprim and subsequently without.

The results for genital and rectal cultures taken from all patients attending the clinic were analysed separately (table). The extent of overgrowth with *Proteus* on the two variants of the medium was also compared.

A significantly greater proportion of cultures of *N gonorrhoeae* were obtained in the medium without trimethoprim, when the direct smears of urethral discharge in men gave positive results ($p < 0.001$ by the χ^2 test). This was counterbalanced by a greater proportion of positive smear results in this group ($p < 0.05$) so that there was no significant difference in the overall isolation rate.

Among male rectal cultures a significantly higher proportion was also cultured in the absence of trimethoprim when the direct smears gave positive results ($p < 0.001$). There was, however, a slightly higher isolation rate in the medium containing trimethoprim among those cases giving negative smear results. This apparent paradox may be partly explained by the

difficulty in making a definitive diagnosis of gonorrhoea from rectal smears when other organisms are also present. Furthermore, one might expect a higher yield from rectal cultures when the medium is more selective, as this would suppress the normal rectal flora which would otherwise overgrow the gonococci. No significant differences were noted in female genital or rectal cultures.

The presence of trimethoprim at 2.3 µg/ml did not decrease significantly the proportion of cultures overgrown with *Proteus*. Phillips⁵ has stated that less than 5 µg/ml would be ineffective in suppressing *Proteus* completely and our results support that view.

Overall a higher proportion of cases with positive smear results had positive culture results when trimethoprim was omitted but this was counterbalanced by a slightly lower isolation rate among cases with negative smear results. We have tested 605 strains of *N gonorrhoeae* isolated on the medium without trimethoprim for sensitivity to a 2.5-µg disc of this antibiotic and only two strains were sensitive. This would suggest that there is an additive or potentiating effect against some strains when the three antibacterial agents are used together.

We would like to thank Dr R D Catterall and the staff of James Pringle House for

TABLE Comparison of selective media for isolation of *N gonorrhoeae* with and without trimethoprim (T and NT respectively) under the stated categories

| | Men | | | | Women | | | |
|---------------------------------|------------------|------|-----------------|------|------------------|------|-----------------|-----|
| | Genital cultures | | Rectal cultures | | Genital cultures | | Rectal cultures | |
| | T | NT | T | NT | T | NT | T | NT |
| No examined | 5252 | 5331 | 1839 | 1755 | 3064 | 3105 | 243 | 239 |
| Culture + | 336 | 321 | 162 | 138 | 106 | 95 | 22 | 21 |
| Smear + | 374 | 321 | 97 | 73 | 43 | 36 | 8 | 5 |
| Culture and smear + | 297 | 291 | 60 | 64 | 42 | 35 | 8 | 5 |
| Culture - /smear + | 77 | 30 | 37 | 9 | 1 | 1 | 0 | 0 |
| Culture + /smear - | 39 | 30 | 102 | 74 | 64 | 60 | 14 | 16 |
| Culture and smear - | 4839 | 4980 | 1640 | 1608 | 2957 | 3009 | 221 | 218 |
| Overgrown with <i>Proteus</i> * | 50† | 75 | 57‡ | 78 | 49§ | 88 | 5 | 16 |

+ Positive; - negative

*Data available on a reduced number in some cases as indicated

†Out of a total of 3794

‡Out of a total of 1350

§Out of a total of 2240

||Out of a total of 171

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providing the cultures and Ms E M Belsey for assistance with the statistical analysis.

Yours faithfully,

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TO THE EDITOR, *British Journal of Venereal Diseases*

Penicillinase-producing gonococci in the Netherlands

Sir,

The number of infections with strains of penicillinase-producing *Neisseria gonorrhoeae* (PPNG) in the Netherlands has risen progressively from one in 1976 to 273 in 1979.¹ This trend has continued during 1980, when 475 such infections were reported. From January to August of this year (1980) they formed 3% of all strains of

References

1. Kellogg DS, Peacock WL, Deacon WE, Brown L, Pirkle CI. *Neisseria gonorrhoeae*. I Virulence genetically linked to clonal variation. *J Bacteriol* 1963;**85**:1274-9.
2. Phillips I, Humphrey D, Middleton A, Nicol CS. Diagnosis of gonorrhoea by culture on a selective medium containing vancomycin, colistin, nystatin, and trimethoprim (VCNT). A comparison with Gram staining and immunofluorescence. *Br J Vener Dis* 1972;**48**:287-92.

gonococci isolated in Amsterdam; in the following months this proportion rose to 18.3% in December.

The proportion of infections in women in 1980 (28%) is about the same as in 1979 (25%) but the proportion of Dutch cases (65%) is higher than in 1979 (45%) but about the same as in 1978 (62%). The proportion of PPNG infections contracted outside the Netherlands decreased from 11% in 1979 to 9% in 1980. Most of the locally acquired infections were contracted in Amsterdam (58% in 1979 and 68% in 1980) followed by The Hague (17% in 1979 and 12% in 1980). Contact tracing often remains unsuccessful; many men were

3. Platt DJ, Gerken A. Inhibition of gonococci by a selective medium: disparity between isolates from sexual partners (letter). *Br J Vener Dis* 1979;**55**:65.
4. Taylor E, Phillips I. Assessment of a selective medium for the isolation of *Neisseria gonorrhoeae*. *Br J Vener Dis* 1979;**55**:183-5.
5. Phillips I. Gonorrhoea (letter). *Lancet* 1970;**i**:674-5.

infected by prostitutes in Amsterdam who were heroin addicts.

Yours faithfully,

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Reference

1. Bijkerk H. Penicillinase-producing gonococci in the Netherlands. *Br J Vener Dis* 1980;**56**:243.

TO THE EDITOR, *British Journal of Venereal Diseases*

Monosymptomatic hypochondriacal psychosis

Sir,

For some time now I have been interested in studying patients who present with a false conviction of disease, abnormality, or alteration in a single part of the body or a single organ system. This solitary delusional belief, unaccompanied by other features of psychotic disturbance, does not relate to any distinct cerebral pathology and is not the most prominent manifestation of a clear-cut primary pathological disorder of mood (severe depression or anxiety). For perhaps understandable reasons these patients tend to be referred to general physicians or surgeons, dermatologists, venereologists, plastic surgeons,

parasitologists, and dental surgeons rather than to psychiatrists.

I am presently collecting data on such patients. To do this, the responsible physician/surgeon completes a fairly straightforward questionnaire on the personal and family history of such patients, the specific nature of their complaint and its evolution, and their therapeutic history. If any of your readers believe they may have encountered such an individual relatively recently and would care to assist me in this exercise, I invite them to contact me with a view to obtaining further information on this project. I would, of course, preserve the anonymity of the patients concerned and the information acquired would be used for my own personal research purposes.

It might serve to jog the memories of your readers if I remind them that such patients may present to dermatologists or parasitologists with a complaint of skin

infestation by parasites, worms, or insects (parasitophobia); to venereologists with a complaint of venereal infection (venereophobia, syphilophobia); to plastic surgeons with a complaint that a facial feature (commonly the nose) is misshapen or ugly; to surgeons/gastroenterologists with a complaint of bowel blockage or degeneration or an evil smell emanating from the gastrointestinal tract or both; to dental surgeons with a complaint of malocclusion or other dental abnormality; and to almost any physician/surgeon in one of many unspecified ways.

I would like to thank you for allowing me the use of your columns for this purpose.

Yours faithfully,

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