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Correspondence

TO THE EDITOR, *British Journal of Venereal Diseases*

Failure of pirampicillin in treating chlamydial infections

Sir,

It has hitherto been customary to use ampicillin in the treatment of acute salpingitis and acute epididymitis. In recent years it has become clear that *Chlamydia trachomatis* infection may be an important factor in these diseases,[1] [2] but to our knowledge no report on the efficacy of ampicillin in the treatment of chlamydial infections has been published, although the in vitro activity of ampicillin against *C trachomatis* (MIC 0·25 mg/l) indicates possible efficacy.

We treated 15 patients who had chlamydia positive non-gonococcal urethritis with pivampicillin (500 mg by mouth three times daily for seven days), pivampicillin being an ampicillin which is almost completely absorped. Urethral specimens were cultured for *C trachomatis* on days 10 and 17 after the start of treatment. Of the 14 patients who completed the study, seven became chlamydia negative, while seven still harboured *C trachomatis* in the urethra. Of the seven treatment failures, three were negative at the first follow up, while in two only one inclusion was found in the cell cultures, probably indicating suppression of the infection. All seven were positive at the second follow up, but denied the possibility of reinfection.

The results are unfavourable when compared with the effect of tetracyclines and erythromycin in similar treatment regimens.[4] The role of *C trachomatis* in the aetiology of acute salpingitis and acute epididymitis necessitates a re-examination of present treatment guidelines. In addition, the frequent association of *C trachomatis* and *Neisseria gonorrhoeae* should influence the choice of treatment for gonococcal disease.

Yours faithfully,

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TO THE EDITOR, *British Journal of Venereal Diseases*

Herpes Vaccine

Sir,

Considerable publicity has recently been given to the Ac NFU_1 (S^-) MRC herpes vaccine for the prevention of genital herpes. The scientific evidence to support the efficacy of this preparation is, however, extremely limited. During the past nine months the *British Journal of Venereal Diseases* has carried two articles about drug trials with the vaccine.[1] [2] The first considered a vaccination programme in consorts of patients with herpes, and the only controls were patients seen at the clinic before the vaccination programme. No attempt was made to show that the groups were similar in regard to the number of patients with primary or recurrent infection, the viral type, the antibody status of patients and consorts, or the frequency and type of sexual activity. In addition the "control" group consisted of only 20 patients, whereas the treatment group contained 60 patients. The authors made no attempt to analyse the results statistically.

The second study considered a vaccination programme in patients who had suffered a first attack of herpes. Historical controls were used from the same department and also from a sexually transmitted disease (STD) clinic at another centre. No attempt was made to show that the groups were similar in regard to age, sex, severity of the first attack, and antibody status. In addition 38% of all isolates were not typed. The authors did not state how long after the first episode patients were vaccinated or if the initial examination was given at the same time in all patients. As in the first study, no attempt was made to analyse the results statistically.

The authors dismiss viral type as a possible explanation for the difference in rates of recurrence between vaccinated and control patients, and referred to our work to argue this point. However they misquoted and misrepresented the work of the Middlesex Hospital. The correct information is as follows: five (45%) out of 11 Type I patients compared with 14 (82%) of 17 Type II patients had recurrences at six months following treatment in a double blind placebo controlled randomised study of intravenous acyclovir ($p<0·05$). At 12 months all Type II and 59% of the Type I patients had had recurrences ($p<0·02$).[3] Corey *et al* in a long term follow up study of untreated patients in Seattle have confirmed that patients with Type II infection have recurrences more frequently than those with Type I.[4]

A final aspect of these studies that warrants consideration is the possibility that vaccination may enhance subclinical infection, thus increasing the possibility that vaccinated patients may transmit the disease without knowing it. In neither of the two studies were patients screened to assess asymptomatic viral shedding. The only way to assess whether vaccination has any effect in preventing or modifying genital herpes is to conduct double blind randomised placebo controlled studies. Until such studies are undertaken the clinical efficacy of the Birmingham vaccine remains completely unproved.

Finally, it should be pointed out that the vaccine does not have a product licence from the Committee on Safety of Medicines (CSM), and patients should be discouraged from being vaccinated until the manufacturers have obtained such a licence.

Yours faithfully,

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