Correspondence

Letters should not exceed 400 words and should be typed double spaced (including the references) and be signed by all authors.

TO THE EDITOR, *Genitourinary Medicine*

Low dose oral ofloxacin to treat gonorrhoea in Hong Kong

Sir,
Penicillin resistant gonococci are now common in the Far East.^{1 2} In Hong Kong, 50% of all new male patients with gonorrhoea are infected by penicillin resistant strains.³ In an attempt to find a simple, safe alternative to penicillin, we undertook a trial of oral ofloxacin.

Ofloxacin is one of the new quinolone antibiotics. Quinolones have high in vitro activity against gonococci, and both norfloxacin and ciprofloxacin have been used successfully to treat uncomplicated urethral gonorrhoea in men.⁴⁻⁷ Ofloxacin has an MIC against gonococci of 0.1 g/l, which is superior to that of norfloxacin but slightly inferior to that of ciprofloxacin.⁸

During 1986, 104 consecutive men attending the British Military Hospital, Hong Kong with untreated urethral gonorrhoea were treated with a single 300 mg dose of ofloxacin by mouth. Gonorrhoea was diagnosed on the basis of finding intracellular Gram negative diplococci in the urethral smears or by culture (Gibco GC selective medium). All the men were instructed to abstain from further intercourse and re-examined on days 7 and 21. Treatment failure was defined as the persistence of gonococci in the urethral samples either on microscopy or culture when patients had abstained from further sexual intercourse. Postgonococcal urethritis was defined by more than 10 polymorphonuclear leucocytes per high power field ($\times 1000$) in the urethral discharge in the absence of gonococci and further intercourse.

Of the 104 men, 103 were followed up for 21 days. Of these, 98 (95%) were cured. None of the five treatment failures had had further intercourse during follow up. Three still had evidence of gonorrhoea on day 7, whereas two were apparently cured on day 7 but had clinical and bacteriological relapse by day 21. All were cured by spectinomycin. Thirty eight men (37%) had developed post-gonococcal urethritis by day 21. None had had further intercourse. No drug side effects were reported.

It appears that, even in areas where penicillin resistance is common, a single 300 mg

dose of ofloxacin provides a simple and effective treatment for gonorrhoea in men. Despite evidence that the drug is active against chlamydiae and *Ureaplasma urealyticum*, a single 300 mg dose appears to confer no protection against post-gonococcal urethritis.^{5 8} (and Tolman EC, *et al*, unpublished observation) Ofloxacin is now being used as first line treatment for gonorrhoea at the British Military Hospital, Hong Kong.

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References

- 1 Ng WS, Chau PY, Ling J, Echeverria P, Rockhill R, Arnold K. Penicillinase-producing *Neisseria gonorrhoeae* isolates from different localities in South East Asia. Susceptibility to 15 antibiotics. *British Journal of Venereal Diseases* 1983;59:232-6.
- 2 Wang FH. B-lactamase-producing gonococci in Hong Kong. *British Journal of Venereal Diseases* 1980;56:270.
- 3 Henderson A, Mifsud E, St Martin G, Flindell C. Ampicillin resistant gonorrhoea in Hong Kong. *Genitourin Med* 1986;62:402.
- 4 Anonymous. Quinolones—a paradoxical adolescence. *Lancet* 1986;i:837-8.
- 5 Aznar J, Caballero MC, Lozano MC, de Miguel C, Palomares JC, Perea EJ. Activities of new quinoline derivatives against genital pathogens. *Antimicrob Agents Chemother* 1985;27:76-8.
- 6 Crider SR, Colby SD, Miller LK, Harrison WO, Kerbs SBJ, Berg SW. Treatment of penicillin-resistant *Neisseria gonorrhoeae* with oral norfloxacin. *N Engl J Med* 1984;311:137-40.
- 7 Hart CA, How SJ, Hobson D. Activity of ciprofloxacin against genital tract pathogens. *British Journal of Venereal Diseases* 1984;60:316-8.
- 8 Bailey JMG, Herpleston C, Richmond SJ. Comparison of the vitro activities of ofloxacin and tetracycline against *Chlamydia*

trachomatis as assessed by indirect immunofluorescence. *Antimicrob Agents Chemother* 1984;26:13-6.

TO THE EDITOR, *Genitourinary Medicine*

Use of slide latex agglutination test for rapid diagnosis of vaginal candidosis

Sir,
We read with interest the recent paper describing a new slide latex agglutination test for rapid diagnosis of vaginal candidosis.¹ For comparison, we present a study in which we compared the slide latex agglutination with microscopy and culture for detecting pathogenic *Candida albicans* in vaginal swabs from 100 unselected women attending a genitourinary medicine clinic.

Eighteen women had vulvovaginal candidosis (characteristic symptoms of candidosis confirmed by either microscopy or culture). The sensitivity, specificity, and overall correlation were 78%, 90%, and 88% for slide latex agglutination, 56%, 100%, and 92% for microscopy and 100%, 94%, and 95% for culture (table). Compared with culture the sensitivity, specificity, and overall correlation for slide latex agglutination were 61%, 88%, and 82% respectively.

Of the nine women who had false positive slide latex agglutination test results, *Ureaplasma urealyticum*, *Mycoplasma hominis*, and *Gardnerella vaginalis* were isolated from four, and *Trichomonas vaginalis* and human papillomavirus were identified in two. *G. vaginalis*, *T. vaginalis*, and papillomavirus, however, have been found not to cross react with the latex, and cross reactivity studies on genital mycoplasmas are planned in the near future (Ryder P, Marketing Manager, Mercia Diagnostics Limited, personal communication).

Table Comparison of three methods of detecting pathogenic *Candida albicans* in vaginal swabs (n = 100)

	Slide latex	Microscopy	Culture
True positive	14	10	18
False positive	9	1	5
True negative	74	82	77
False negative	3	7	0
Sensitivity	78%	56%	100%
Specificity	90%	100%	94%

Definition of true positive: positive test in a patient with vulvovaginal candidosis.

Correspondence—Book review

Although we agree that slide latex agglutination is rapid and simple to perform, we think that its value in a genitourinary medicine clinic is not yet proved.

Yours faithfully,
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Reference

- 1 Rajakumar R, Lacey CJN, Evans EGV, Carney JA. Use of slide latex agglutination test for rapid diagnosis of vaginal candidosis. *Genitourin Med* 1987;63:192–5.

TO THE EDITOR, *Genitourinary Medicine*

Aetiology of urinary symptoms in sexually active women

Sir,

We agree with the caution expressed by Dr Feldman and colleagues (*Genitourin Med* 1986;62:333–41) in ascribing the aetiology of urinary symptoms in women to any pathogen isolated from the genital tract. We conducted a prospective clinical and microbiological study of 15 women presenting to a department of genitourinary medicine with dysuria and frequency of micturition in the absence of vaginal infection. Initial urine specimens were obtained by suprapubic aspiration (SPA) in six cases. Ethics committee approval had been granted for this project.

Appreciable bacteriuria ($>10^5$ colony forming units (cfu)/ml) was found in urine specimens from five patients, one obtained by SPA. Coliforms (*Escherichia coli*) were present in three specimens, *Proteus spp* in one, and a mixed infection, including *Staphylococcus epidermidis*, in one. Herpes simplex virus was isolated from vulval sores, which had not been noticed by the patient, but not from the urethra, cervix, or urine of the patient with a mixed urinary infection.

Of 10 women found to have unremarkable bacteriuria, five underwent SPA. *Staph epidermidis* was isolated in small numbers (1.5×10^2 cfu/ml and 1.0×10^2 cfu/ml) from two patients, being a constituent of the urethral or periurethral flora in one.

A mixture of organisms was present in the midstream specimens of urine (MSSU) of four of five women with unremarkable bacteriuria. *Staph epidermidis* was isolated in all cases and was a constituent of the urethral

or periurethral flora in one. Diphtheroids and *Bacteroides spp* were present in two MSSUs, the former organism being a constituent of urethral or periurethral flora in both and the latter in one patient.

Mycoplasma hominis and *Ureaplasma urealyticum* were not isolated from any urine specimen obtained by SPA. *M hominis*, however, was present in six of 10 MSSUs and *U urealyticum* in four of 10 MSSUs. *Chlamydia trachomatis* was not isolated from any urine or genital tract specimen.

Commensal urethral flora were reflected in the MSSU samples obtained from patients with insignificant bacteriuria. *C trachomatis*, *U urealyticum*, and fastidious organisms were not associated with symptoms of frequency and dysuria in women in this study. Human papillomavirus has been described in association with the acute urethral syndrome in a few patients. Additional investigations to include urethroscopy, colposcopy, and biopsy, when appropriate, would contribute to this work together with assessing the role of other non-infectious causes, as suggested by Feldman *et al.*

Yours faithfully,
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Book review

Sexually transmitted diseases by YM Feldman. (Pp 321; £55.) Edinburgh: Churchill Livingstone, 1986.

Yet another volume on sexually transmitted diseases (STD) has appeared to add to the recent growth industry in this subject. I do not think that it will be a success with so many competitors on the market, as it is extremely lightweight and can most charitably be described as good only in parts.

The book is divided into 21 chapters with an additional section containing 35 small colour plates. All contributors except Dr Oriel are or were based in north America,

which means that there is a heavy bias towards America and limited reference to European data on the epidemiology of STD and patterns of sexual behaviour. Each chapter deals with an individual infection, related groups of conditions such as non-venereal diseases of the genitals, and the now standard sections on epidemiology, sexual behaviour, and prevention of infection. It seems curious that the chapter entitled "Gardnerella and Trichomonas vaginitis" is tucked away at the end of the book almost as an afterthought after "the prevention of STD".

My main complaint about this book is its lack of weighting for important conditions yet overemphasis on others. This leads to important omissions. For example, four chapters are devoted largely to homosexually related conditions with lengthy descriptions of amoebiasis and giardiasis, yet there is little more than a passing reference to the acquired immune deficiency syndrome in a chapter on Kaposi's sarcoma and half a page in the section entitled "Homosexuality and Sexually Transmitted Diseases". The chapter on gonorrhoea dismisses disseminated infection in two brief sentences, yet takes two pages to describe the diagnosis of gonorrhoea without describing how *Neisseria gonorrhoeae* is formally identified. Also heterosexual men apparently do not get gonococcal pharyngitis! In a book supposedly aimed at specialists who may at some time encounter STD it is disappointing that the role of an underlying urinary tract infection is not considered as a possible cause in the older man with non-gonococcal urethritis. Although early reference is made to the differences in the microbiology of women with pelvic inflammatory disease (PID) in the United States and Europe, the information provided is limited. The male partners of women with gonococcal PID are advised to be seen, but how about those who are contacts of chlamydial PID? Metronidazole is not even considered as part of the treatment for polymicrobial PID. Only seven day courses of treatment are recommended for vaginal candidosis, and the use of imidazoles or polyenes combined with hydrocortisone when appropriate is again not considered. The association between *Gardnerella vaginalis*, other anaerobic bacteria, and mycoplasmas is not discussed in the final chapter dealing with bacterial vaginosis, and the combination of group B streptococci with *Trichomonas vaginalis* is not considered in the context of persistent trichomonal infection.

My other grouse is a tendency for possibly