and transport medium to the cell culture, where the antigen has to multiply in the cytoplasm of the McCoy cells. Positive chlamydia culture is registered if intracytoplasmic inclusions are seen in the McCoy cells. Several factors may, however, affect the vitality of the chlamydial elementary bodies. Some of the most critical points are the collection of samples, the toxicity of the swabs, temperature during transport, transport time, growth medium, and bacterial contamination of the cell culture. Optimum conditions for all these factors are essential for chlamydial antigen to be recovered. The two other test systems are based on identifying non-vital antigen, which means that these factors are less important for the monoclonal antibody test and the enzyme immunoassay. False positive results of cell culture may occur by misreading iodine stained epithelial cells as chlamydial inclusions, but may also be caused by contamination with charcoal particles from charcoal swabs or infection of the cell culture medium with bacteria, viruses, or mycoplasmas.

As all the methods available for testing for urogenital chlamydial infection give an appreciable number of false positive or negative results, it is important that discrepancies between test results, clinical manifestations, and responses to antibiotic treatment should lead to repeat testing and contact tracing.

Yours faithfully,

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TO THE EDITOR, *Genitourinary Medicine*

Acute syphilitic myelitis in a young man

Sir,

We read with great interest the paper of Lowenstein, Mills, and Simon (*Genitourin Med* 1987;63:333-8) concerning a man aged 26 who had acute syphilitic myelitis. Two years ago we published a report of a similar case, among other early manifestations of neurosyphilis.¹

Our patient was a man aged 17 seen in 1982 with flaccid paraplegia of rapid onset. Analysis of the cerebrospinal fluid (CSF) showed a protein concentration of 1.06 g/l and white cell count of $180 \times 10^6/l$ with a differential count of 85% lymphocytes and numerous plasma cells. His serum in the Venereal Disease Research Laboratory (VDRL) test was positive at a titre of 1/16 and in the fluorescent treponemal antibody absorbed (FTA-ABS) test at a titre of 1/6400. His CSF FTA-ABS test result was positive at a titre of 1/100.

Despite treatment with penicillin and non-reactive CSF at the end of treatment, his paraplegia evolved towards spasticity. Two months before the onset of the neurological manifestations, the patient had had a transient non-pruritic rash on the trunk consistent with roseola. Acute syphilitic myelitis classically belongs to the tertiary stage. Onset during the secondary stage may have been caused by concomitant HIV infection.

Yours faithfully,

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Reference

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TO THE EDITOR, *Genitourinary Medicine*

Prescribing policies for gonorrhoea in the United Kingdom

Sir,

We seek the courtesy of your columns to report the findings of a survey of prescribing policies for β -lactamase (penicillinase)

producing *Neisseria gonorrhoeae* (PPNG) strains in the United Kingdom, which was carried out by the British Co-operative Clinical Group.

During 1986 self administered postal questionnaires were distributed to all consultant physicians working in genitourinary medicine clinics in the United Kingdom. Information was sought about the numbers of PPNG strains isolated in each clinic during the last quarters of 1982 and 1985. In addition, responding clinicians were asked to indicate their choice of antibiotics in different clinical situations during those periods. We received 127 replies, of which six were incomplete. This represented a response rate of 61% (127/209). The table summarises the choices of antibiotics.

We identified three changes between responses for 1982 and 1985, which comprised a drop in the mean number of isolates in each clinic from 1.64 in 1982 to 1.18 in 1985 (not a significant difference), a slight (not significant) shift away from penicillin towards the use of spectinomycin in all clinical situations, and a slight (not significant) shift towards the use of cephalosporins for patients infected overseas.

In general, patterns of prescribing showed little change between heterosexual men, homosexual men, and women. It was interesting that penicillin remained the drug of first choice of four fifths of responding clinics, but spectinomycin was the first choice for treatment failures and for those infected overseas. Very few responders reported the use of either new antibiotics, such as quinolones, or of mixed antibiotic regimens.

Although PPNG strains are now endemic at a low level in the United Kingdom, the continued reliance upon cheap antibiotics in the standard treatment of gonorrhoea contrasts with the situation in many developing countries where PPNG strains predominate and necessitate more expensive single or combination antibiotics in routine treatment.

Most clinics routinely use an antibiotic active against PPNG strains as the first line treatment of gonococcal infections acquired overseas. This may be one factor accounting for the falling incidence of PPNG strains in the United Kingdom.

Yours faithfully,

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