LETTERS TO THE EDITOR

Ciprofloxacin resistant *Neisseria gonorrhoeae* in the UK

Ciprofloxacin has been shown to be highly active against *N gonorrhoeae* and 100% cure rates for uncomplicated genital infections have been reported from single 250 mg doses,^{1,2} and this activity has been reported to be retained against penicillin resistant strains.^{3,4} In consequence ciprofloxacin is now regarded as an effective alternative to the penicillins, and suitable for use when infection with penicillin resistant strains is likely, either in treatment failures or in patients returning from areas with a high incidence of antibiotic resistant gonococci.

Unfortunately in those parts of the world where this drug is used extensively (especially if other quinolones were used in the past) increased levels of resistance of up to 0.5 mg/l have been observed.⁵ In-vitro work^{6,7} has shown that strains becoming resistant to one quinolone have increased resistance to other members of the group.

We report what we believe to be the first recognised isolation in the United Kingdom of a strain of *N gonorrhoeae* showing significantly reduced sensitivity to ciprofloxacin.

A 44 year old man with a urethral discharge presented to a general practitioner on his return from Thailand. Erythromycin was prescribed with no improvement. The patient then attended the local Department of Genitourinary Medicine and was treated with spectinomycin 2g. He then defaulted and was lost to follow-up. A strain of *N gonorrhoeae* was isolated from the urethral pus. After local examination it was sent to the PHLS Gonococcus Reference Unit (GRU) at Bristol. Here it was confirmed to be a penicillinase-negative chromosomally resistant strain of *N gonorrhoeae* (CMRNG) sensitive on disc testing to erythromycin and requiring the following minimum inhibitory concentrations (MIC):—benzylpenicillin 1.25 mg/l; cefuroxime 0.64 mg/l; tetracycline 4 mg/l; spectinomycin 32 mg/l.

Most notable in this isolate was the MIC of 0.1 mg/l for ciprofloxacin.

All 1086 isolates of *N gonorrhoeae* received by the GRU in 1988 were tested against ciprofloxacin. Their median MIC was 0.0032 mg/l (range 0.0016–0.05 mg/l). Sixty-six of these were CMRNG and in this group the median MIC for ciprofloxacin was 0.0064 mg/l (range 0.0032–0.0125 mg/l). Thus the strain isolated in Grimsby was almost 10 times more resistant than the most resistant CMRNG isolate previously tested at the GRU.

The recognition of strains of *N gonorrhoeae* with high MICs for ciprofloxacin must raise a note of caution in the use of single dose ciprofloxacin in the treatment of uncomplicated genital gonorrhoea, especially in patients where possible penicillin resistance may make this a favoured regime.⁵

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Male genital ulcerations in Paris (France): Absence of correlation between clinical aspect and microbiological data.

Between November 1986 and June 1987, 75 consecutive male patients (mean age 35 years) consulting for genital ulceration at the STD clinic of Hôpital Saint-Louis, participated in a prospective study for an aetiological evaluation.

In each patient the following pathogens were searched for in the ulceration: *Treponema pallidum* (dark field examination), *Haemophilus ducreyi* (Gram smear and culture), *Chlamydia trachomatis* (culture), *Neisseria gonorrhoeae* and common bacterial pathogens (Gram stain and culture), *Herpes simplex virus* (culture). Sera were tested for the presence of antibodies against *T. Pallidum*, *C. trachomatis* and HIV 1.

The results are shown in the table. They reflect the urban-poor population consulting at our clinic, consisting mainly of migrants from Central Africa (35.4%), French Caribbean (37.1%) and Maghreb (16.1%), mostly heterosexual (94%) and having sex with female prostitutes in Paris (81%). These epidemiological data explain the persistence of chancroid which is endemic in Paris, mainly in black migrants.¹

Herpes is also a major cause of genital ulceration in our experience although it is still more frequently reported in Sheffield.² We have excluded from this study cases of recurrent herpes simplex whose diagnosis was clinically evident (vesicles).

In 17.3% of the cases no pathogen was found, as compared with 10% in Sturm's³ and 27% in Mabey's⁴ studies.

We studied the predictive value of clinical parameters (induration, location, size, number of the ulceration—lymph node enlargement, size and pain) and did not find any correlation with the three major etiologies: syphilis, chancroid and herpes.

Moreover, in 26 patients out of 62,

Table Male genital ulcerations, Hôpital Saint-Louis, Paris. 75 cases. November 1986–June 1987

Chancroid	24 (32.08%)
Primary syphilis	19 (25.3%)
Herpes	19 (25.3%)
No pathogen	13 (17.3%)