LETTERS TO THE EDITOR

Recurrent periurethral abscess

We report a case of recurrent periurethral abscess in a man, which is rarely seen nowadays.

A 23-year-old single Caucasian heterosexual presented in our clinic in October 1989 with a one week history of a swelling on the ventral surface of the penis. He had no urethral discharge, dysuria, or a past history of STD nor had he had recent antibiotics. The patient had been seen in October 1987 with a discharging penile abscess at the same spot, which spontaneously resolved. Urine after three hours held was clear. Routine tests were negative for pus cells, gonorrhea, chlamydia and syphilis. Pus from the abscess grew *Staphylococcus albus*.

Examination on this occasion was unremarkable except for a multiloculated abscess (fig). Again routine STD tests were negative. The abscess was incised and drained under local anaesthesia. Scanty *S albus* was cultured from the pus. The patient’s consort was untraceable. The abscess had nearly resolved when the patient was reviewed in two weeks following a 10 day course of oxytetracycline 500 mg tds. Final review at three months confirmed a pea-sized nodule at the site of the abscess. The patient’s urinary flow was normal.

Delay in presentation or diagnosis of gonococcal/non-specific urethritis can result in a periurethral abscess. Recurrent periurethral abscess is rare in the younger age group. The average age at presentation is 50 years. Congenital abnormalities of the median raphe, past history of urethritis or periurethral abscess are considered to be risk factors in the development of a recurrent periurethral abscess. The commonest predisposing factor is urethral strictures, and presentation is a penile swelling, usually painless, which may resolve spontaneously. Surgical repair may be required to salvage the urethra in cases of recurrent periurethral abscesses.

Our patient was young and his periurethral abscess preceded an earlier episode. Although he had no clinical or microbiological evidence of urethritis or urethral stricture, he was referred to the urologist to exclude any congenital abnormality which may be a possible cause in this patient.

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Non-gonococcal urethritis in men practising “safe” sex

It has been apparent for some time that orogenital contact is an effective way of transmitting genital pathogens, although less has been written about the association between orogenital contact and the development of non-gonococcal urethritis (NGU). A recent study from Spain suggested that insertive oral sex was a risk factor in the development of NGU. However, this conclusion was reached following statistical analysis of data derived from patients, the majority of whom had practised both anal intercourse in addition to oral sex. With the advent of the Acquired Immunodeficiency Syndrome, many individuals have modified their sexual behaviour to avoid potential infection. Most commonly, such modification involves the avoidance of unprotected, anal or vaginal intercourse. In our clinical practice we have found a large group of men, mostly homosexual, who are practising oral sex as their only unprotected form of sexual contact. We felt that this group provided a unique opportunity to explore an association between oral sex and the development of NGU.

Male patients were selected from the outpatient clinic, who had documented urethritis, and who gave a history of insertive oral sex as the only form of unprotected penile intercourse in the three months prior to presentation. Male patients who gave a history of anal or vaginal intercourse together with oral sex were still recruited if they had used condoms on every occasion for anal or vaginal intercourse (but not for oral sex) with no history of “condom accidents”. The control group consisted of males with the same sexual history who were proven not to have urethritis following investigation. All patients had the following investigations performed;
serological test for syphilis (TPHA), Gram stain urethral smear for microscopy, urethral cultures for Neisseria gonorrhoeae, Chlamydia trachomatis, oral spirochaetes,35 non-sporing anaerobic organisms and Mycoplasma spp. Patients with more than five polymorphs per high powered field (×1000) in the Gram stained smear of urethral discharge were diagnosed as having urethritis.

Fifty one patients were recruited in total. Thirty two had no evidence of urethritis, (28 were homosexual and 43 were heterosexual). Nineteen patients had evidence of urethritis, (17 were homosexual and two were heterosexual). The results of microbiological investigations are listed in table 1. Four patients in the study group had gonococcal urethritis, but no organism emerged as an obvious candidate for the cause of NGU. We were surprised that no patients had evidence of chlamydial infection, and also by the relatively high prevalence of α-haemolytic streptococci in the urethritis and control groups.

We decided to extend the study by examining urethral specimens from a further group of 20 asymptomatic men with particular emphasis on the presence or absence of α-haemolytic streptococci. The results of this are shown in table 2. The α-haemolytic streptococci from all groups were speciated (API 20 strep) and the majority were found to be Streptococcus mitis.

Of the 19 patients with urethritis, 15 had NGU of whom 10 had a previous history of urethritis. The remaining five had no previous history.

From this relatively small study we conclude that orogenital contact can be associated with the development of NGU, although two thirds of the patients with NGU had a previous history of urethritis. Chlamydia trachomatis does not appear to be a common pathogen in this group of patients. Streptococcus mitis, an oral streptococcus whose taxonomy is controversial1 appears from this study to be a common urethral commensal in men irrespective of a history of orogenital contact.

**MATTERS ARISING**

The natural history of human immunodeficiency virus infection

Kelly et al1 stated in a recent report that oral hairy leukoplakia (OHL) was not as important a factor as the presence of oral candida in deciding the timing for anti-retroviral therapy. Although OHL is classified along with oral candida as a manifestation of the secondary infections associated with symptomatic HIV infection (CDC IV-C2),2 there are individuals who have OHL alone, without additional clinical or laboratory evidence of advancing HIV disease. What is the significance of OHL when seen in isolation?

We have studied the prevalence of OHL in a similar cohort of exclusively homosexual/bisexual men studied prospectively since 1982.44 In this cohort, OHL in isolation was not used to classify the subjects as having IV-C2 disease, which was based on the presence of at least two of the CDC indicator diseases.