usually transmitted diseases were performed. A provisional diagnosis of gonorrhoea was made, and the patient was treated with a single oral dose of 250 mg of ciprofloxacin followed by a two week course of Detcloc twice daily. He reported an intermittent sexual relationship with a known female partner, who was seen one week later at this clinic. She denied any other recent sexual contacts, and after careful testing (including rectal and throat swabs) was found to be free of genital infection.

Culture of the male patient’s urethral swab yielded an organism of the moraxella group, but unfortunately the organism was not kept for further study. Chlamydia ELISA and gonococcal cultures were negative. At a review visit three weeks after commencing treatment, he was found to be clinically and microbologically cured. He gracefully accepted an explanation about the nature of his infection, and volunteered the information that he was exposed to many unusual germs in the course of his work as a fitter at a pharmaceutical factory. The Occupational Health Doctor at this factory confirmed that *Moraxella urethralis* (recently renamed *Oligella urethralis*) was currently being studied. Category 2 precautions were being taken by staff handling the organism, but our patient was merely carrying out maintenance work in the department. It is possible that his hands may have become contaminated during work, and that he subsequently transferred the organism to his penis duration urination.

Organisms of the moraxella group can be found as normal inhabitants of the mucous membranes of the respiratory and uro-genital tracts. They rarely cause disease although *M. lacunata* is a recognised cause of eye infection and other species are occasionally reported as a cause of serious systemic infection.

*Moraxella urethralis* is found almost exclusively in the urogenital tract of man. It is generally considered to be a non-pathogenic member of the normal mucosal flora at this site although isolates from blood cultures have been reported. It includes some of the strains formerly called *Mima polymorpha var oxidans*. Differentiation in the laboratory from other *Moraxella* spp can be difficult and is not often attempted in a routine diagnostic laboratory. The possibility of a causative role in acute gonorrhoea was made for this organism many years ago although changes in taxonomy make interpretation of these earlier reports difficult.

It is suggested that the acute urethritis in this patient was caused by the *Moraxella* sp isolated from the clinical specimens taken at presentation, given the lack of other identifiable causes, the response to treatment and the documented microbiological cure. The possibility of another unidentified pathogen being responsible cannot be dismissed. The lack of infection in the reported sexual contact and the occupational exposure also raises the intriguing possibility that this infection was occupationally acquired.

Effective control of gonorrhoea requires that treatment and contact tracing of suspected gonorrhoea is commenced immediately on the basis of clinical and microscopy findings, before definite laboratory confirmation has been obtained. However, other organisms with a similar morphological appearance can also cause acute urethritis, and an erroneous diagnosis of venereal disease could be a very serious matter. There are several recent reports of urethritis caused by *Meningococcus* and this case indicates that moraxella could also be a cause. It is policy in our clinic to use the expression “suspected gonorrhoea” until a firm diagnosis has been established.

Microbiologists and genitourinary physicians have a responsibility to advise all staff working in their laboratories and clinics about the potential hazards and the appropriate precautions. This advice should include the need for staff to wash their hands before and after visiting the lavatory.

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Podophyllotoxin—is it user friendly?

Topical podophyllin has been standard treatment for ano-genital warts for many years. Self therapy may lead to local and systemic side effects. The active agent podophyllotoxin has been purified, in a stable form, and is marketed as a safe home treatment for male genital warts. We have encountered two cases where problems have resulted from home therapy.

Patient 1 presented with prepuceal warts and was prescribed podophyllotoxin 0.5% twice daily for three days weekly. Routine screening for other sexually transmitted diseases was negative. He defaulted from follow up but was referred three months later by the general surgeon having been admitted with a possible strangulated right inguinal hernia. He had been unable to follow the podophyllotoxin application instructions. After the first application, his prepuce became swollen and took one week to subside. This was then repeated with the same response. After about 10 weeks applications, he had an excessive reaction taking him to A & E where cephadrine was prescribed. The following day his general practitioner arranged his admission. The surgeons noted severe balanoposthitis and referred him to us after commencing intravenous amoxyclillin-clavulanic acid. He had secondarily infected podophyllotoxin burns with associated right inguinal lymphadenopathy. Once settled further treatment to the warts was by cryotherapy.

Patient 2 had been prescribed podophyllotoxin 0.5% by his general practitioner, either with instructions being misunderstood or not given and he had misinterpreted the product informa-

Letters to the Editor
MATTERS ARISING

Sexual assault of men: a series

We read with interest the recent paper by Hillman et al. This prompted us to review our own experience. Eight men, alleging recent sexual assault, presented to our department within the last three years. The victims ranged in age from 10 to 25 years (mean 16 years). Six of eight patients attended within three months of the assault (range two days to 18 months).

Referrals were arranged by general practitioners (GPs) in two cases, Accident and Emergency departments in two cases and a social worker in one case. Four of the eight assaults were reported to the police.

The assailant was known to two of the victims. One case involved multiple assailants. HIV/AIDS anxiety was a prominent symptom in three patients. Oral and/or anal penetration took place during seven of the eight assaults. Sexual orientation was unknown for six victims and in five of these the assault was their first sexual experience. One patient considered himself to be heterosexual. One man had been exclusively heterosexual prior to the assault, but had had a number of both male and female partners thereafter. Voluntary intercourse had occurred in two patients after the rape and before presentation. Alcohol was reported to be a factor in only one assault.

Three patients had a sexually transmitted infection. These were scabies, rectal chlamydia and rectal gonorrhoea. The patient with rectal gonorrhoea was seen 18 months after the incident and had had a number of partners in the intervening period. All patients were investigated according to standard guidelines. Three patients attended only once. For the other five, average follow-up time was three months. HIV and hepatitis B serological testing were negative in five patients at three months from the time of the assault.

One case is particularly worthy of mention as it involves an infection not heretofore reported in the context of male sexual assault. A 15 year old boy was referred to us by his GP complain-