MATTERS ARISING

The diagnosis of prostatitis

Dr Thin's review of prostatitis throws much light on an ill-understood condition. Of particular practical importance is his clarification of the way in which reflux of urine into the prostate occurs, and the part that this may play in the infective process.

Historically, the term acute bacterial prostatitis is uncommon. Many years' experience of providing a laboratory diagnostic service to general practitioners in a large health district has convinced me that this condition is far more common than may be apparent to urologists and other doctors who work in hospital. Specimens of urine with request forms describing the clinical syndrome classic of this condition, as described by Dr Thin, are received in the laboratory every week from up to 30 men of all ages. They invariably show gross pyuria and yield common bacterial urinary pathogens, often, but not always, in high counts. High bacterial counts are, of course, the consequence of multiplication of bacteria in the bladder, which acts as an incubator. Men with acute prostatitis do not necessarily also have bladder infection, and in these patients bacterial counts may be low. We have shown that men with symptoms referable to the urinary tract or prostate do not excrete Gram-negative organisms in the urine, suggesting that the presence of such organisms, in whatever count, should be taken as indicative of infection.

Apart from those with the fever and malaise characteristic of acute prostatitis, urine specimens are also received from a large number of men with dysuria or frequency, many of which show heavy pyuria. Some may have chronic prostatitis caused by the common bacterial urinary pathogens; others may have infection with one of the less common pathogens listed by Dr Thin. To this list should be added Gardnerella vaginalis, Haemophilus influenzae, almost certainly Chlamydia trachomatis and possibly Corynebacterium spp. Many of these pathogens are only detected if appropriate culture techniques are used. Our laboratory procedure is to request a further specimen from all men in whom pyuria is unexplained by bacterial urine; in Cled agar, the specimen is cultured on Cled agar. If pyuria is still present and all cultures are negative the infection is presumed to be due to Chlamydia trachomatis, mycoplasma or ureaplasma. As yet, we do not apply techniques for detection of Chlamydia trachomatis in urine, but such techniques have been applied successfully elsewhere.1,2

On the assumption that the very unpleasant condition of chronic prostatitis occurs as a consequence of inadequately diagnosed or treated acute prostatitis, our laboratory reports on urine specimens from men carry a suggestion that the patient should be treated, in accordance with the sensitivity of the isolate, for 14 days with an agent that achieves therapeutic concentration in the prostate. Such agents include cotrimoxazole, doxycycline and ciprofloxacin; erythromycin may also be used for infections with Gram positive organisms. Treatment with agents such as nitrofurantoin, the penicillins or cephalosporins will merely sterilise the urine temporarily but leave the prostatic focus of infection untouched.

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Choosing equipment for treating genital warts

We read with interest the excellent paper by Anne Scoular which included an update of surgical techniques available for the treatment of recalcitrant warts.1

We wish to comment that curettage as a treatment modality was not mentioned in this paper. Curettage is very cheap and efficiently removes isolated hyperkeratotic warts which resist chemotherapy.2 The equipment consists of a Volkman's spoon, a curette which can be reused after sterilisation. Ethyl chloride spray is applied to the wart 10-15 minutes prior to the procedure and bleeding can be easily controlled using silver nitrate sticks or Monsel's solution. It is our experience that patient acceptability equates with that of other destructive methods of wart treatment and healing occurs without scarring.

Care, however is required in order to avoid the potential hazards of ethyl chloride in the work place as it is a potent anaesthetic. Occupational safety limits are set at 1000 parts per million for long term use and 1250 parts per million for short term use.3 Furthermore, as it is a highly flammable substance, the necessary precautions must be observed as ensuring that it is not used near a naked flame, in high temperatures or when sparks are likely (near electrical equipment). It should be stored in a cool, dark place at or under 20°C and a adequate ventilation ensured when it is used.4

Significant toxicity may occur in medical attendants but only after prolonged exposures as there are two case reports in the literature of a psychological and neurological symptoms which occurred after daily exposure to ethyl chloride over several months. Both cases resolved spontaneously on withdrawal of exposure.4

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