LETTERS TO THE EDITOR

Health of the nation and gonorrhoea

In the 1992 Government White Paper "Health of the Nation" [1](HoN), HIV/AIDS and Sexual Health was identified as one of the five Key Areas. One of the targets in this Area is to reduce the incidence of gonorrhoea among men and women aged 15–64 years by at least 20% by 1995.

In late 1992, we reviewed the episodes of gonorrhoea seen in this clinic between 1990 and 1992 and found a 54% reduction from 63 new cases per 100 000 population of 15–64 year olds in West Berkshire in 1990, to 29 new cases per 100 000 in 1992. No change in our practice had occurred during this time, and we consistently aim to provide accurate diagnosis, adequate treatment, tests of cure, contact tracing and health education of patients with gonorrhoea, and we also attempt recall of patients who default. Although we have an appointment system, patients wanting urgent appointments are usually seen on the same day.

The Department of Health Handbook[2] states that good quality surveillance data is essential for the accurate monitoring of trends and also suggests that studying local genitourinary medicine (GUM) clinic figures may give a poor indication of the success of the local STD prevention strategies. Have we missed cases? In 1992 the local microbiology laboratory was fully computerised, and by cross referencing their data we noted that all cases of gonorrhoea diagnosed by the microbiology department of this hospital, but from samples taken outside this clinic, were subsequently referred to this clinic for further management. Although other cases in the community may have been treated without having had diagnostic tests, the data we have suggest that there may be a real reduction in the number of episodes of gonorrhoea.

The emerging resistance pattern of *Neisseria gonorrhoeae* has not been highlighted as a potential threat to the future sexual health of the Nation. In 1991 14% of our isolates were resistant to penicillin and in 1992 this had gone up to 21%. Details are set out in the table. Recent Communicable Disease Report Weeklys also show an increase in the number of penicillin-resistant cases of gonorrhoea. If the number of cases of gonorrhoea is decreasing (as we hope) then the increasing trend in gonococcal resistance is even more alarming. Also only 30% of patients with gonorrhoea in 1991 and 24% in 1992 accepted the offer of HIV testing. It may be appropriate for more patients with sexually transmitted diseases to consider HIV testing.

Table Annual episodes and penicillin sensitivity of gonorrhoea at this clinic per 100 000 population of West Berkshire, aged 15–64

	Total no	Sensitive to penicillin mic ⩽0·64 mg/l	Resistant to penicillin (CMRNG) mic ⩾1·25 mg/l	PPNG
1991	151	130 (86·1%)	2 (1·3%)	19 (12·6%)
1992	90	71 (78·9%)	4 (4·4%)	15 (16·7%)

CMRNG = Chromosomally mediated resistant *N gonorrhoeae*
PPNG = Penicillinase producing *N gonorrhoeae.*

The lag in collating data from KC60 reports (that is, statistics on diagnoses in GUM Clinics for the Department of Health) is significant and if monitoring is to be done by GUM clinics, as suggested in HoN, more up-to-date figures will be essential. For the future, we shall continue to monitor all gonorrhoea cases on a monthly basis, but at this stage we hope more current surveillance data from other regions will be made available promptly, if we are to work towards having a sexually healthy population in this nation.

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1 Secretary of State for Health. *The health of the nation: a strategy for health in England.* London: HMSO, 1992 (Cm 1986).
2 Department of Health. *The health of the nation. Key area hand book: HIV/AIDS and sexual health.* Department of Health: January 1993.

Severe genital ulceration in two females following self-treatment with podophyllin solutions

We report two cases of severe genital ulceration in female patients prescribed podophyllin for self-treatment of genital warts.

Case 1: A 36 year old woman was diagnosed by her general practitioner (GP) as having genital warts. She was given a prescription for 10% podophyllin for self-application. Apparently, the only instruction she was given was to wash off the solution after four hours. The chemist dispensed a 50% podophyllin solution in error. The patient subsequently applied the solution to the warts on a daily basis, using her fingers as applicators. After three days of treatment she developed ano-genital chemical burns which caused retention of urine and resulted in a four day hospital admission during which she required urinary catheterisation and opiate analgesia. She subsequently made a full recovery.

Case 2: An 18 year old women was diagnosed by her GP as having perianal and vulval warts. The patient was prescribed a solution

of 10% podophyllin for self-treatment, apparently without any instructions. After a week of twice-daily application to the warts and failing to wash off the podophyllin, she developed severe vulval inflammation which resulted in her calling out an emergency cover GP and subsequently being referred to our department. Secondarily infected vulval ulceration was treated with oral flucloxacillin, simple analgesia and saline baths. In the medium-term follow-up the patient has reported a persistent burning sensation and discomfort in the vulval region which has prevented sexual intercourse.

These cases illustrate some of the potential problems of prescribing podophyllin solutions for self-treatment in female patients. Podophyllin solutions are toxic and can cause chemical burns even when used with due care. Rare but serious systemic effects have been reported, usually following ingestion or application of large volumes of podophyllin to damaged epithelial surfaces; these include possible fetal malformation[1 2] and intra-uterine death.[3] The confusion over the strength of the podophyllin solution in the first case illustrates the hazards of writing prescriptions for non-standardised solutions. Furthermore, podophyllin is not licensed for self-treatment in the UK.

In a small verbal survey which we conducted at a recent scientific conference, of 33 consultant genitourinary physicians questioned, 31 said that they would never prescribe podophyllin for female self-treatment; all cited the difficulties in accurate application and the risk of conception during treatment as their principle reasons. The two physicians who said that they would prescribe podophyllin, did so only with the provisos that there were few, non-mucosal warts and that the patient must be judged to be highly dependable in following instructions for application.

We believe that all patients presenting to their GPs with genital warts should be referred to a department of genitourinary medicine unless the GPs can screen for other sexually transmitted infections, treat, test for cure and contact-trace as appropriate. We would discourage the prescription of podophyllin for self-treatment by female patients. For those women unwilling or unable to attend either a genitourinary medicine clinic or their GP's surgery for treatment, podophyllotoxin 0·5% is a safe, effective alternative.[4 5]

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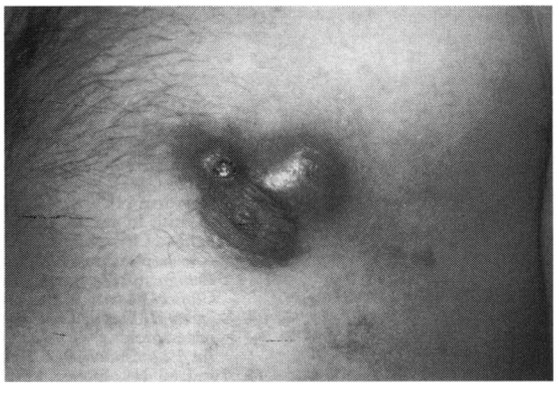
1 Karol MD, Conner CS, Watanabe AS, Murphrey KS. Podophyllum: suspected teratogenicity from topical application. *Clin Toxicol* 1980;**16**:283–6.
2 Cullis JE. Congenital deformities and herbal 'slimming tablets'. *Lancet* 1962;**ii**:511–2.
3 Chamberlain MJ, Reynolds AL, Yeoman WB. Toxic effect of podophyllin application in pregnancy. *BMJ* 1972;3:391–2.
4 Baker DA, Douglas JM Jr, Buntin DM, Micha JP, Beutner KR, Patsner B. Topical podofilox for the treatment of condylomata acuminata in women. *Obstet Gynecol* 1990;**76**:656–9.
5 Greenberg MD, Rutledge LH, Reid R, Berman NR, Precop SL, Elswick RK. A double-blind, randomized trial of 0·5% podofilox and placebo for the treatment of genital warts in women. *Obstet Gynecol* 1991;77:735–9.

Periareolar breast abscess due to *Pseudomonas aeruginosa* in an HIV antibody positive male

Breast abscesses in men are rare and there are no reports of such infection in men who are HIV antibody-positive. We present a case of an HIV-infected man who developed two periareolar abscesses due to infection with *Pseudomonas aeruginosa*. A 33 year old bisexual man presented with a week's history of pain in the left breast. There was no history of nipple-piercing. He had been known to be HIV antibody-positive for 13 months following the diagnosis of oral hairy leukoplakia, oral pseudomembranous candidiasis and perianal herpes simplex, at which time he had a CD4+ lymphocyte count of 85/mm³. His current medication was zidovudine 200mg t.d.s, and co-trimoxazole 960mg o.d.

On examination he was thin and apyrexial and there was a small erythematous area above the nipple of the left breast which on palpation was tender, non-fluctuant and indurated. There was no associated lymphadenopathy. Investigations showed a CD4 + lymphocyte count of 43/mm³ and a granulocyte count of 1·6 × 10⁹/l (normal 2·0–7·5). A diagnosis of periareolar cellulitis was made and treatment with erythromycin 500 mg b.d. commenced. Three weeks later a 4 cm² abscess developed and malodorous pus was obtained by needle aspiration. Culture of the pus grew *P aeruginosa* and treatment was changed to ciprofloxacin 500 mg b.d. After approximately five weeks of ciprofloxacin the abscess, which since aspiration had drained freely via the aspiration site, had largely resolved. However, a second periareolar abscess developed, adjacent to the first (fig).



Left nipple and adjacent abscesses.