course of chronic hepatitis D in our cohort of HIV-immunosuppressed patients, and we postulate that high replication of the delta virus and the presence of HCV co-infection, in conjunction, could explain this worse outcome. MONTSE DE POULPALA VICENÇ SORIANO JAVIER G. SAMANIEGO ANA ENRIQUEZ FERNANDO MUNOZ JUAN GONZALEZ-LAHOZ Department of Infectious Diseases, Gastroenterology, and Microbiology, Instituto de Salud Carlos III, Madrid.

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Spontaneous loss of PPNG resistance plasmids

The Scottish Neisseria gonorrhoeae Reference Laboratory Annual Report for 1992 highlighted one of the points made in the study on gonococcal epidemiological data from Stockholm, Sweden. A small cluster of penicillinase-producing Neisseria gonorrhoeae (PPNG) infection in Central Region, Scotland, demonstrated spontaneous loss of plasmid encoding during the process of clinical assessment, screening and treatment. Patient 1 who attended on 17 August 1992 with minor vulvodynia (and who had had a hysterectomy in 1986) was found to have a gonococcal infection with a PPNG isolate of serovar IB-1/Bopst. Her partner, who was contact traced on 2 September 1992 and reported a casual contact in Tenerife, was also shown to be infected with a IB-1/Bopst PPNG isolate. It is of interest that the casual contact originated from a Scottish Health Board Area (Fife) adjacent to Central Region. Patient 3 (no connection with nos 1 & 2) attended with urinary symptoms on 10 September 1992 with positive microscopy and a IB-1/Bopst non-PPNG isolate was reported. His partner was contact traced on 11 September 1992, had complained of cystitis over a five month period, and a IB-1/Bopst PPNG (showing a weak reaction in the chromogenic cephalosporin test) was isolated; the culture was later shown to contain both penicillin sensitive and penicillin resistant IB-1 isolates. A repeat culture from the same patient received one week later was found to be IB-1/Bopst non-PPNG. All of the PPNG isolates carried 2-6, 3-05 and 24-5 MDa plasmids, were non-requiring (NR) on auxotyping and had a ciprofloxacin MIC of 0-06 mg/l. The non-penicillinase isolates were also auxotype NR with a ciprofloxacin MIC of 0-06 mg/l. There were no other IB-1/Bopst strains isolated in Scotland during 1992.

As all patients were contact traced, the cluster of infection was contained with the added bonus of demonstrable spontaneous loss of β-lactamase plasmid during surveillance. This report also highlights the importance of national surveillance. It is unlikely that the probable source of infection in Tenerife, who originated from Fife, has returned to Scotland with an infection as this would have been detected through the Scottish Neisseria gonorrhoeae Reference Laboratory.

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Disseminated infection due to penicillin resistant gonococci—is it still rare?

Penicillin resistant gonococci have only rarely been implicated in disseminated gonococcal infection. Two reports attributed two separate cases of gonococcal arthritis to penicillinase producing organisms but these cases were not well documented. In neither case was the organism cultured directly from a disseminated site and the relation of the arthritis to the gonococcal infection was presumptive, being based on positive throat or urethral cultures. However, five cases of gonococcal arthritis due to penicillinase producing organisms that were cultured directly from infected joints have been reported. As an addition to these cases, we describe a case of gonococcal arthritis due to penicillinase producing organisms, based on culture from the infected joint. A 25 year old West Indian woman was admitted to the orthopaedic department in September 1993 with a history that following return from Jamaica, she was suffering from flitting joint pain affecting particularly her