Urinary symptoms, sexual intercourse and significant bacteriuria in male patients attending STD clinics

We read with interest the recent paper by David et al.1 on urinary symptoms and bacteriuria among male STD clinic attenders. The authors state that urethritis and UTI cannot be distinguished on clinical grounds and/or urethral smears. We were surprised that no mention was made of the "two glass urine test" as a means of distinguishing pure urethritis from a combined urethritis/cystitis. We found this a useful test—January to July this year 11 men attended our department with a documented UTI; nine of these had a cloudy second catch urine (not due to phosphaturia). We would, therefore, be interested to hear whether the authors can provide details of the two glass urine test results in their patients with both bacteriuric and non-bacteriuric urinary symptoms.

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The authors reply:
Although the "two glass urine test" is a time honored, and a useful test in a hospital clinic, we did not include it in our study. This test in our opinion is subject to observational variation and interpretation. We think that looking under the microscope for quantitative assessment of colony size is less subject to observer variation and is more scientific. In the Cambridge group only nine of the 11 patients with urinary tract infections had a cloudy second urine, while all 13 patients with urogenital tract infection in our study were found to have pyuria.

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Antibiotic treatment for gonorrhoea in the UK

The emergence of resistance to quinolones in Neisseria gonorrhoeae was highlighted in the review by Ison1 and in the report by Abeyewickereme and others.2 However, in the UK quinolones are becoming ever more widely used and have now overtaken penicillin as the drug of first choice. The National Audit of gonorrhoea management questioned all clinics in the UK about cases diagnosed in the first three months of 1995 and received data on 1308 cases. 59% of these reported the quarter. The antibiotics used fell into the following classes: quinolones 48%, penicillins 40%, spectinomycin 3%, others/not recorded 9%. For those patients known to have acquired gonorrhoea outside Europe, and when penicillins producing Neisseria gonorrhoeae (PPNG) was presumably thought to be more likely, the choice (ignoring single use and unspecified drug) was: quinolones 73%, penicillins 23%, spectinomycin 4%.

Ciprofloxacin resistance is still rare in the UK, but in 1995 the highest ever annual total of ciprofloxacin resistant strains was identified by the Gonococcus Genotyping Reference Unit, while PPNG isolates were still below their 1992 figure. The Reference Unit data rely on voluntary reporting with its attendant limitations. The National Audit figures show that antibiotic choice has moved away from penicillin, so it is now particularly important that information monitoring the extent of ciprofloxacin resistance is available to UK genitourinary physicians.

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3 CDR 1996;610-1.

Epidemiology of gonococcal and chlamydial infections in Harrow and Brent

Matondo and colleagues report on gonococcal and chlamydial infections in Harrow and Brent.1 I would agree that it is important to perform such work since it can: "define the extent of the problem in the community" and allow for the development of "a profile of STDs in our catchment population". Sadly, they have done neither of these two since their sampling is limited solely to those using the genitourinary medicine (GUM) clinic at Northwick Park. An earlier study (not mentioned by the authors), also carried out in Brent and Harrow, was able to do both of these.2 This study was conducted to identify and estimate the proportion of female patients suffering from gonorrhoea, trichomonasvias and candidosis, both with and without symptoms, and to examine the failure of seeking care at all. Samples of women in Brent and Harrow were studied in antenatal, gynaecology, family planning, and GUM clinics, and in general practice. This comprehensive approach into numerous health care facilities with multiple agencies, subamples of non-consultants on general practitioner lists, and residents seeking care at STD clinics elsewhere in England, and thus gave a true population incidence and prevalence.

The authors recognise that there are limitations to their study from only sampling attenders at one clinic within Brent and Harrow, but they should not then make claims on a random sample. The asymptomatic nature of many STDs, the fact that even those with symptoms do not always seek care, and that partner notification is not always as effective as one would desire, must mean that people with STDs within the community are potentially not identified by samples taken from clinic attenders. Public health strategy should be based on true population samples, and not limited to attenders at specialist clinics.

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Epidemiological treatment and tests of cure in gonococcal infection: evidence for value

In his otherwise excellent review article, Carne13 and his co-authors in his conclusions of quoting somewhat spurious percentages rather than absolute values. He says that 42%-6% of treatment failures will be missed if tests of cure are not routinely performed on men with gonococcal infection. However, a closer look at these figures shows that out of the original 4897 men, only 183 (3-7%) were treatment failures, of whom only 78 (1-6%) were asymptomatic; 7 (1-6%) of the total would remain infected after treatment if a policy of test of cure for asymptomatic men were not followed; a more meaningful statistic. As Carne himself points out in the article, the cost of identifying each of these very small numbers of cases in America was estimated to be in the range $4900 to $109 800 per case. It might therefore be argued that a more cost effective use of this money would be to