References

Csonka, G. W. (1965). Non-gonococcal urethritis. *British Journal of Venereal Diseases*, **41**, 1–8.

Holmes, K. K., Johnson, D. W., and Floyd, T. M. (1967). Studies of venereal disease. III. Double-blind comparison of tetracycline hydrochloride and placebo in treatment of nongonococcal urethritis. *Journal of the American Medical Association*, **202**, 474–476.

Lassus, A., Perko, R. L., Stubb, S., Mattila, R., and Jansson, E. (1971). Doxycycline treatment of nongonococcal urethritis with special reference to T-strain mycoplasmas. *British Journal of Venereal Diseases*, **47**, 126–130.

Prentice, M. J., Taylor-Robinson, D., and Csonka, G. W. (1976). Non-specific urethritis. A placebo-controlled trial of minocycline in conjunction with laboratory investigations. *British Journal of Venereal Diseases*, **52**, 269–275.

Simopoulos, J. Ch. (1977). Tetracycline treatment for non-specific urethritis. *British Journal of Venereal Diseases*, **53**, 230–232.

Yours faithfully,

D. Taylor-Robinson,
M. J. Warrell,
G. W. Csonka

TO THE EDITOR, *British Journal of Venereal Diseases*

Sir,

Anal canal versus rectal wall sampling

In Dr Deheragoda's paper (Deheragoda, 1977) he reached the conclusion that rectal wall sampling should be confined to first visits and to patients with symptoms, but he does not seem to be justified by the results. Such information as he gives regarding male and female patients suggests that each year his department will miss up to 20 cases of gonococcal proctitis. Imitation of his proposals nationally and internationally, at a time when selective media and productive sampling of the rectum and pharynx are improving the control of gonorrhoea, would appear to be retrograde. Now that β-lactamase producers threaten serious problems it would not seem to be in the best interests of public health to miss cases of rectal infection.

Dr Deheragoda's recommendation engenders in me a sense of *déjà vu*. Many of us have spent much of our lives trying to bring doctors to a recognition that vaginal sampling is not the best way to diagnose gonococcal endocervicitis. It was said of high vaginal samples what is now said of anal canal samples—'they are reliable, easy to perform, and not distressing to the patient'.

I hope most sincerely that the department of genitourinary medicine at Charing Cross Hospital will dissociate itself from these ideas and continue to be one of the United Kingdom's leading departments.

Reference

Deheragoda, P. (1977). Diagnosis of rectal gonorrhoea by blind anorectal swabs compared with direct vision swabs taken via a proctoscope. *British Journal of Venereal Diseases*, **53**, 311–313.

Yours faithfully,

R. S. Morton

TO THE EDITOR, *British Journal of Venereal Diseases*

Hepatitis B antigen and antibody in a male homosexual population

Sir,

Coleman *et al.* (1977) are to be congratulated on their detailed study of the incidence of hepatitis B antigen and antibody in the serum of 600 male homosexual patients, but it is difficult to accept their conclusion that there was little correlation between these indices of infection by the hepatitis B virus and a previous history of hepatitis, jaundice, or liver disease. The figures which they give can be compounded into the following table, which demonstrates a very strong correlation indeed between serological evidence of hepatitis B infection and a positive clinical history:

	History of jaundice, hepatitis, or liver disease	*No history*	*Total*
HBs Ag or IOEP-detectable HBs Ab	10	54	64
Neither	18	518	536
Total	28	572	600

$\chi_1^2 = 19{\cdot}34 \quad P < 0{\cdot}0005$

Furthermore, the authors state that the sera of 85 patients negative for HBs Ag and HBs Ab by routine methods were tested for antibody by radioimmunoassay (RIA) and three of them were found to have both antibody and a history of jaundice or hepatitis. If this proportion is representative of the whole series, it follows that among the 536 patients who were negative for HBs Ag and immunoosmoelectrophoresis—detectable HBs Ab there may well have been as many as 19 in whom the presence of RIA detectable HBs Ab coincided with a history of jaundice or hepatitis.

These 19, together with the 10 patients with a positive history and positive routine tests are sufficient to account for all the 28 patients in the series with a history of jaundice or hepatitis, so that it is likely that serological evidence of hepatitis B infection would have been found in every patient with a positive clinical history if the whole series had been tested for antibody by RIA. Finally, if the results of RIA testing of part of the series are extrapolated to the whole series it may be calculated that 42% of these men, almost all of whom had in all probability been exposed to the virus, probably had serological evidence of infection, and 11% of these had had a clinically apparent infection. This shows the extent to which the virus is dangerous, at any rate when acquired by homosexual means, and this to me is the main interest of this informative series.

Reference

Coleman, J. C., Waugh, M., and Dayton, R. (1977). Hepatitis B antigen and antibody in a male homosexual population. *British Journal of Venereal Diseases*, **53**, 132–134.

Yours faithfully,

P. H. Renton

National Blood Transfusion Service,
Roby Street,
Manchester M1 3BP

Notice

MSSVD Student Prize

The paper that won the MSSVD Student Prize competition in 1977 appears on page 160. This was the first year of this competition. The judges had great difficulty in choosing one of the seven entries, but used the following criteria:

1. The observations on which the report was based, appeared to have been made by the entrant alone.
2. The methods used to make the observations were of a high standard.
3. The report was clearly and concisely written.

It is hoped that by publishing these criteria future entrants will be helped.