

## Correspondence

TO THE EDITOR, *British Journal of Venereal Diseases*

Sir,

**Pityriasis versicolor of the penis**

Five cases of pityriasis versicolor of the penis have been found among 70 men investigated in detail as part of a survey. Only one previous report of involvement of this site has been found in the literature, that of Blumenthal (1971) where the patient was a negro with hypopigmented lesions on the penis and of the right cubital fossa. This superficial fungal infection of the skin is not uncommon in any part of the world, with an incidence in England of between 0.5% to 1% of all skin diseases (Adamson, 1949) but as high as 50% of the population in tropical areas (Vanbreuseghem, 1950; Marples, 1950). The higher incidence in tropical areas is attributed to the high degree of body perspiration, but hereditary and familial factors are probably important also. The extent and degree to which the skin is affected is certainly much greater in hot countries, as was shown in this series and that of El-Hefnawi *et al* (1971) in Egypt.

The responsible organism is *Malassezia furfur*, which is considered by many authorities to be a form of the lipophilic yeast, *Pityrosporum orbiculare* found in normal skin. Examination of scales in a 10% solution of potassium hydroxide shows clumps of thick-walled spores, often like bunches of grapes, and short branches of mycelium. Confirmation may be made by Wood's light, which is also useful in determining the extent of the skin affected.

The five patients investigated comprised two Sudanese, two Indians, and one Palestinian. Their ages ranged from 23-35 years, and all were engaged in clerical work. All had extensive skin involvement, and only two mentioned penile lesions as part of their symptoms. The skin appearances on the penis were

typical, with discrete, circinate, finely-scaling, hypopigmented areas. Elsewhere on the body there was frequently confluence of lesions to produce very large areas, and this feature was noted in many of the total number of patients. Four of the five patients with penile involvement complained of mild irritation compared with 15 out of the whole series of 70, and this may be an important factor in relation to involvement of the penis. The duration of the condition varied from one and a half to seven years and had been recurrent in three patients.

The patients were seen during a six-month period, which suggests that this site for the condition is not as rare as was previously considered; either it is being missed, not sought, or diagnosed as another condition.

Our patients were treated with baths twice daily followed by applications of two different antifungal preparations. Treatment was successful, and there were no recurrences at the time of writing. This emphasises the importance of finding and treating all affected areas at the time this fungus disease is diagnosed.

Yours faithfully,

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TO THE EDITOR, *British Journal of Venereal Diseases*

Sir,

**Anal canal versus rectal wall sampling**

Dr Deheragoda's work (Deheragoda, 1977) showed that repeated proctoscopy of homosexual men is unproductive. Dr Morton clearly does not believe this, but he has produced no facts to refute the findings (Morton, 1978). His criticism that 20 cases of gonorrhoea would be missed each year by this department if the recommendations were followed is erroneous. The study found that 96% of cases were detected by anorectal swabbing, and that 94% of male anorectal gonorrhoea was diagnosed on the first examination. Thus, in men, 6% of cases would not have been examined by proctoscopy at their second examination, but 96% of them would nevertheless have been diagnosed by direct swabbing, which leaves a diagnostic failure rate of 4% of 6%, or of about one in 400. Although our department is the second largest in the country, we have yet to see 8000 cases of anorectal gonorrhoea in a year.

Yours faithfully,

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