

LETTERS TO THE EDITOR

Acquisition of pharyngeal gonorrhoea via sweets passed by mouth

I would like to report two cases of oropharyngeal gonorrhoea in twin children in whom the transmission occurred via sweets passed from their infected sister. A 16 year old girl, victim of multiple rape, attended the GUM department in Coventry for a check up. Throat culture grew penicillin sensitive *Neisseria gonorrhoeae* while cervical and urethral Gram stained smears and cultures were negative. A swab taken from the cervix for *Chlamydia trachomatis* was also positive. The patient received treatment for both infections and tests after treatment were negative.

The mother was worried as the patient had the habit of exchanging sweets with her twin sisters (sweets were passed by mouth). On the doctor's advice, the twin sisters of the patient, who were 2½ years old, were brought to the clinic by their mother. Throat cultures for *N gonorrhoeae* from the twins were positive. Both were treated with penicillin and tests after treatment were negative. When the cultures were found to be positive, the mother brought the rest of her children to the clinic. Throat cultures for gonorrhoea from the mother, 14 year old boy, and 6 and 4 year old girls were all negative. The raped girl denied having direct oral contacts with her twin sisters.

Non-sexual transmission of gonorrhoea seems to be extremely rare in adults. Only one case of non-sexual transmission of genital *N gonorrhoeae* is documented in adults¹ and in another transmission possibly occurred through an inflatable doll.² Non-sexual acquisition of gonococcal infection occurs more often in infants and children.^{3,4} Transmission of pharyngeal gonorrhoea is usually oro-oral or through oro-genital sex or fellatio. Transmission of pharyngeal gonorrhoea without direct oral contact has not been studied. The susceptibility of *N gonorrhoeae* to drying is a major factor in limiting the non-sexual transmission of this organism.³ Gonococci can survive for up to 24 hours on a towel when periodically rinsed with warm, physiological saline.⁵ Gonococci were recovered from a wide variety of hard and soft materials for up to 3 days⁶; therefore, the risk of transmitting pharyngeal infection through contaminated food or utensils is theoretically possible. This might have implications in suspected child abuse cases. To the best of my knowledge, no case of pharyngeal transmission of gonorrhoea has been documented through exchanging sweets or chewing gum.

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An unusual presentation of vulvar carcinoma: a traumatic aetiology?

The aetiology of vulvar carcinoma in the elderly is poorly understood. Risk factors such as human papilloma virus (HPV) infection, cervical dysplasia, and cigarette smoking, which predict the development of disease in the younger population, do not seem to correlate with disease in the elderly. We present the case of a patient with vulvar carcinoma of the clitoris and a history of a black ant bite to the affected area, suggesting a potential traumatic or viral aetiology.

A 75 year old nulligravid female was referred for the treatment of carcinoma involving the clitoris. She initially presented with a 4 month history of itching and burning of the clitoris, and attributed her symptoms to a black ant bite several months previously. On review there had been a significant weight loss, of 15 lb, during this period. Her last pelvic examination had been in 1945, and there was no family history of gynaecological malignancy.

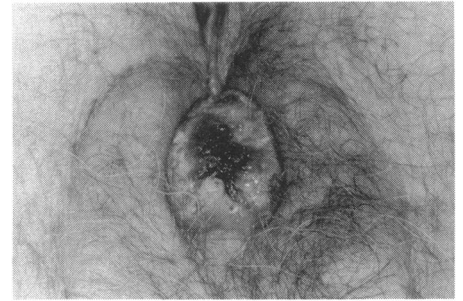
Physical examination revealed a lesion of the clitoris, irregular and ulcerated in areas with central necrosis (fig). Shotty inguinal lymphadenopathy was also seen. Biopsy specimens were consistent with keratinising epidermoid carcinoma. The patient subsequently underwent a radical vulvectomy with bilateral groin dissection. The tumour measured over 5 cm in diameter, and 0/33 regional lymph nodes were positive for metastatic disease. After almost 5 years of follow up, no evidence of recurrence was detected.

Vulvar carcinoma is traditionally a disease of the elderly, most often developing in the seventh and eighth decades.¹ Although the overall incidence (between one and two per 100 000) suggests that it is a fairly rare disorder, this rate increases with age. In one study a peak incidence of 20 per 100 000 after the age of 75 was reported.²

Recent literature has focused on the rising number of younger women with vulvar carcinoma.³ Preliminary studies have linked several risk factors to the development of disease in this population, including HPV, cervical dysplasia, and smoking. In contrast, these risk factors do not seem to be significant predictors of disease in the elderly, suggesting a different disease process in this population. Further evidence to suggest that distinct subsets of this disease exist is that tumours in the younger population tend to be more poorly differentiated and more prognostically unfavourable.²

Our elderly patient had the unique presentation of carcinoma with an antecedent history of an insect bite to the clitoris. We have, therefore, suggested the possibility that this irritating event served as the impetus for tumour formation.

Vulvar irritation has been previously associated with development of cancer, particularly in patients with a history of vulvar lichen planus and other types of chronic irri-



Clitoral carcinoma, irregular and ulcerated in areas with central necrosis.

tation.² Although the mechanisms by which lichen planus cause malignant degeneration are not known, it is thought that inflammation and the presence of continued epithelial renewal may be of importance.⁴ It is, therefore, plausible that an event such as a bite could result in a similar process.

Another way to relate a bite to tumour formation is by direct causation. There are published reports of tumour growths which are thought to be related to insect bites. Dermatofibromas, common benign cutaneous tumours, are thought to result from mechanical irritation of residual arthropod tissue deposited in the skin after a bite. Other associations between insect bites and subsequent tumour formation include the development of multiple primary cutaneous plasmacytomas⁵ reported in one case, and a second case in which a clear cell acanthoma of the lower extremity developed at the site of previous insect bites.⁶ In the latter example, the authors suggested the possibility of introduction of an epidermotropal virus into the tissue by an insect bite, causing tumour growth to occur.

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Genital *Chlamydia trachomatis* infection in women in a Nigerian hospital

Chlamydial infections are common in many developing countries, yet they are neither well recognised nor correctly treated in many instances.^{1,2} *Chlamydia trachomatis* infection is now well established as a cause of non-gonococcal urethritis in men and as a cause of cervicitis and pelvic inflammatory disease