

Azithromycin v oxytetracycline for the treatment of non-specific urethritis

EDITOR.—Single dose azithromycin 1 g rather than multidose tetracyclines or erythromycin over several days for the treatment of chlamydial infections is becoming more widespread as patient acceptability and improved compliance outweigh cost considerations. However, in men, treatment is often initiated on the basis of microscopic evidence of urethritis before the chlamydial result is available. Relatively few studies report the efficacy of azithromycin in the treatment of non-gonococcal non-chlamydial urethritis (NSU),^{1,3} but recently published evidence based guidelines for the management of NSU recommend either doxycycline 100 mg twice daily for 7 days or azithromycin 1 g immediately.⁴

In this genitourinary medicine clinic azithromycin became first line treatment for all proved or suspected chlamydial infections from 1 April 1998. This retrospective study assessed the efficacy of azithromycin for the treatment of NSU compared with oxytetracycline 250 mg four times daily for 7 days, the previous first line treatment regimen for men with microscopic urethritis in whom no Gram negative diplococci were evident.

The outcome of all men with NSU diagnosed between 1 April 1998 and 30 September 1998 (treated with azithromycin) was compared with those diagnosed between 1 April 1997 and 30 September 1997 (treated with oxytetracycline).

NSU was defined as the presence of at least five polymorphonuclear leucocytes (PMNL) in five or more fields on microscopy of a urethral smear, negative culture of *Neisseria gonorrhoea* after direct plating onto modified New York culture medium and negative chlamydial screen on ELISA testing (Syva) of a urethral swab.

"Cure" was defined as either resolution of symptoms or clearing of previously positive two glass urine. A repeat urethral smear was not examined routinely.

"Treatment failure" was defined as persistent PMNL on microscopy of a urethral smear taken because of ongoing symptoms or persistent positive two glass urine test, with possibility of reinfection denied.

The results (see table 1) demonstrate that azithromycin is as effective as oxytetracycline in curing NSU, and produces fewer treatment failures, possibly owing to better compliance with single dose therapy. Compliance with multidose regimens might be expected to be less good in asymptomatic patients, but with no satisfactory "test of cure" this was difficult to ascertain. Overall, there was a 25% non-attendance rate for follow up, biased towards the asymptomatic patients and those treated with oxytetracycline.

Table 1 Comparative age, symptoms, and response to treatment of the two groups

	1997, oxytetracycline	1998, azithromycin
Number treated	76	52
Median age (range)	28 (18–63)	25 (16–54)
No with symptoms (%)	35 (46)	25 (48)
No cured (%)	29 (38)	27 (52)
No treatment failures (%)	6 (8)	0
Outcome uncertain*	41 (54)	25 (48)
Symptomatic dna	8/35 (23)	4/25 (16)
Asymptomatic dna	13/41 (32)	7/27 (26)

*Originally asymptomatic with clear two glass urine; did not reattend (dna); possibly reinfect.

The results of the two glass urine test did not differ significantly between the two groups but overall was positive in 70% of symptomatic patients compared with only 47% asymptomatic ($p < 0.01$). Its low sensitivity and specificity⁴ are likely to be even lower in asymptomatic patients. Default from follow up occurred more frequently in the asymptomatic patients, but was less evident in the azithromycin treated group, who had a lower default rate overall, as previously reported.⁵

In conclusion, although the numbers are small, it would appear that azithromycin is an effective treatment for NSU, and can be given at the time of initial diagnosis, pending the chlamydial result. Financial considerations preclude the use of azithromycin as first line treatment for NSU in many centres, but better compliance resulting in fewer treatment failures, and fewer wasted appointments from defaults may counter the economic argument.⁵

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Sexually transmitted infections in elderly people

EDITOR.—Jaleel *et al* recently presented the incidence of sexually transmitted infections and other conditions among elderly people attending a genitourinary medicine clinic.¹

We, in our genitourinary medicine department at Royal Berkshire Hospital, Reading, studied the reasons for attendance of elderly people and compared them with the younger age group. Data were collected from patients aged 60 and above who attended the clinic between January 1998 and December 1998. Randomly selected sex matched people aged 20–35 years are taken for comparison.

A total of 68 elderly people attended the clinic. The mean age was 66.5 years (range 60–83); 61 (90%) were male and seven (10%) were female. Forty one (60%) attended for STI screening and 27 (40%) attended for non-STI management. In the younger age group 60 (88%) attended for STI screening and eight (12%) attended for non-STI management ($p < 0.001$). Sixteen (24%) older attendees had an STI compared with 35 (51%) in the younger age group (see table 1). Of the 16 older attendees with suspected STIs 11 (68%) waited over 2 weeks between symptom recognition and clinic attendance. Of 31 symptomatic attendees in the younger age group 10 (32%) waited over 2 weeks for symptom recognition and clinic attendance ($p < 0.001$).

Table 1 Diagnoses of older and younger clinic attendees

	Older clinic	Younger clinic
(No of patients)		
STIs		
NSU	7	21
Latent syphilis	3	
Genital herpes	2	1
Genital warts	1	11
Gonorrhoea	1	2
<i>Trichomonas vaginalis</i>	1	
HIV	1	
Other conditions		
Erectile dysfunction	15	1
Balanitis	9	1
Lichen sclerosus	1	
Zoon's balanitis	1	
Genital psoriasis	1	1
Genital ectopic sebaceous glands		1
Genital skin tag		1
Inguinal hernia		1
Genital sebaceous cyst		1
Miscellaneous (hepatitis B vaccination)		1

Many elderly people maintain heterosexual and homosexual activity. Therefore this age group is at a risk of all sexually transmitted infections.² In our study, a smaller percentage of older attendees had STIs compared with previous studies.^{1,3} However, the number of older patients who attended for non-STI management are comparable. The delay between symptom recognition and healthcare presentation is a feature of STI related illness behaviour. The delay behaviour among individuals with suspected STIs is age specific, with longer latency periods experienced by people over the age of 50.⁴ This finding was seen in our study as well.

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Tertiary syphilis

EDITOR.—I read Dr Reed's letter on tertiary syphilis¹ with interest.

The regimen he describes for the treatment of early syphilis—arsenic, bismuth, and round the clock aqueous penicillin, was used in our hospital from 1946–8² although daily penicillin in beeswax was also used. It was unclear how much inactive penicillin K was in the commercial product used. The penicillin regimen used here was higher than in Lincoln (40 000–75 000 units 3–4 hourly). There were 10 treatment failures (re-infections) out of 275 patients described.²

Treponema pallidum remains viable in the CSF even after adequate clinical treatment^{3,4}