

LETTERS TO THE EDITOR

Continuing high prevalence of penicillinase-producing *Neisseria gonorrhoeae* at a central London hospital

Penicillinase-producing *Neisseria gonorrhoeae* (PPNG) in the UK has been declining since 1984¹ and accounts for only 4–6% of gonococcal infections at some centres in London.² We reviewed the proportion of PPNG among gonococcal isolates obtained from patients attending our genitourinary medicine clinic since 1981.

Production of β -lactamase in *N gonorrhoeae* isolates was detected by activity on a chromogenic cephalosporin (Nitrocephin, Oxoid). Duplicate isolates from the same patient were excluded.

Although the total number of cases of gonorrhoea has declined from a peak of 486 in 1986 to 128 in 1994, the proportion of PPNG remains elevated. PPNG accounted for over 5% of patient isolates in 10 of the last 12 years and for over 10% in 1993 (21 of 158 isolates) and 1994 (15 of 128 isolates). The notes of all patients from whom PPNG was isolated in 1993 were reviewed. Thirteen patients were probably infected abroad (Africa 7, West Indies 3, Southeast Asia 2, South America 1) and their contacts accounted for a further four cases. No obvious overseas factor was noted in four patients.

At our hospital, PPNG accounts for a higher proportion of gonococcal infections than has been reported elsewhere in London. We believe this is because a large number of patients seen at our clinic have a history of

travel to countries with high PPNG rates. This survey illustrates the value of local laboratory and epidemiological surveillance. It also emphasises the importance of eliciting a detailed history of foreign travel in all patients suspected of having gonorrhoea as an unacceptable number of treatment failures will occur if penicillin is used as first line therapy for all cases.

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- 2 Sherrard J, Barlow D. PPNG at St Thomas' Hospital—a changing provenance. *Int J STD AIDS* 1993;4:330–2.

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Importation into the UK of a strain of *Neisseria gonorrhoeae* resistant to penicillin, ciprofloxacin and tetracycline

We report here what we believe to be the first isolation of a strain of penicillinase-producing *Neisseria gonorrhoeae* with high-level resistance to ciprofloxacin and tetracycline.

On the 3 February 1995 a 35 year old divorced male travelled to Angeles City in the Philippines on business. Here he had sexual contact with a local prostitute. He subsequently travelled to Australia by which time he had developed a bloody urethral discharge. He was prescribed 500 mg of tetracycline with 500,000 units of nystatin ("Mysteclin") orally twice daily for 14 days. On return to the Philippines his urethral discharge was still present and he was prescribed 300 mg rosoxacin (a 4-quinolone) *stat* orally. The patient returned to the UK at the end of February with the urethral discharge still present. The patient had no UK sexual contacts since January. He was examined at his local genitourinary medicine clinic where intracellular Gram-negative diplococci were seen in a smear of the discharge. Urethral swabs were taken for culture and chlamydia antigen assay. He was prescribed 500 mg of ciprofloxacin *stat* and a 10 day course of ofloxacin (400 mg daily) was started.

The urethral swab taken at this time yielded oxidase-positive Gram-negative diplococci after 48h incubation on New York City medium at 37°C in 5% CO₂. This organism was identified as *N gonorrhoeae* by the carbohydrate utilisation and Phadebact Monoclonal GC tests. The strain was demonstrated to be β -lactamase positive and found by agar dilution antibiotic sensitivity testing to be resistant to penicillin (minimum inhibitory

