Group 3.—In this group of 30 patients who ceased attending after one to seven months only the following three showed any signs of infection.

Case 1.—The patient, aged 23, was infected two weeks before. He attended the clinic on four occasions between Dec. 23, 1946, and March 3, 1947. On admission he was found to have a typical gonococcal urethritis and penicillin was given. He absented himself for a month, and when he returned he was found to be still discharging freely. A second injection of penicillin was given, and he then disappeared for a further month, only to return again with a right-sided epididymitis and orchitis. A third injection of penicillin was given, followed by a course of sulphathiazole. When he turned up a fortnight later his discharge had gone and his testicle was less swollen though still tender. Since that time he has ceased attending altogether.

Case 2.—A youth aged 16 years 11 months had a typical gonococcal urethritis associated with phimosis and balanitis. He did not attend until two weeks after his first injection, and was then showing much purulent discharge. The second injection of penicillin cleared up the gonococcal inflammation of the urethra, but he still had a mild degree of balanitis. This showed no evidence of being gonococcal. He ceased attending after 11 weeks' treatment.

Case 3.—A man aged 31, who had served in the Army in the East, attended for 10 weeks, and when he ceased attending had been free from discharge for a long time. His urine, however, still showed some pus cells. His general health was poor. He had been a prisoner of war in Japanese hands and had had pellagra, beriberi, and dysentery.

Group 4.—The following two cases are still attending at the clinic.

Case 1.—A man aged 21 had typical gonococcal urethritis. The discharge and all other signs and symptoms cleared up in 24 hours. His gonococcal flocculation reaction, however, was positive.

Case 2.—A man aged 26 had had gonorrhoea in the early part of 1946. He had a typical gonorrhoeal discharge, which cleared up in a week after an injection of penicillin. His urine still shows some pus cells.

Comments

To analyse case records at a V.D. clinic is difficult and unsatisfactory. In the first place I feel that the patients' statements are often open to doubt. In the second place—and this is the main trouble—such a large percentage of patients cease attending before their surveillance is complete. However, from the facts and figures that emerge from this analysis I can say that penicillin given intramuscularly in an oil-wax suspension is the treatment of choice for gonorrhoea to-day. Its advantages are obvious. Easy to give, it causes no appreciable pain or discomfort. The patient is asked to spend the minimum amount of time attending the doctor and loses no time at his work. His discharge is quickly dried up, and if he co-operates he is certain of a quick cure. It is to be specially noted that complications such as orchitis, epididymitis, and vesiculitis are now very rarely met with.

As I said at the start, there are a few disadvantages: (1) It is almost too efficient. The patient gets well so quickly and so easily that some are tempted to run further risks. No longer is the cure worse than the disease. (2) As is already known, penicillin can mask and delay the onset of primary syphilis. (3) Because of this the necessity for repeating the Wassermann test over a period of months is unfortunate. So many patients fail to realize the importance of having more than one blood test.

I would like to express my thanks to my colleagues, Dr. H. Sheasby and Dr. J. Rebeiro, for their help in preparing this paper, and also to acknowledge much assistance given me by Mr. R. D. Vanstone, the clerk to the clinic.

Medical Memoranda

Penicillin, Beeswax, and Allergy

The following two cases of allergy occurring in general practice are described to illustrate the severity of reaction to penicillin and the possibility that some component of the beeswax-oil suspension, other than the penicillin, was the exciting factor.

CASE 1

A man aged 58 complained of persistent boils, and as no previous treatment had allayed the condition it was decided to give a course of penicillin. Injections of 250,000 units in distilled water were given twice daily on June 16 and 17, 1947, and one on the 18th. The patient then defaulted. However, the furunculosis improved considerably.

On June 25, the ninth day after the first injection of penicillin, I was asked to see the patient. He stated that while driving home that day he had felt itching, first of the left foot where his boot-laces pressed, and then of the right foot in the same situation. He felt very drowsy and could hardly keep awake to drive the car home. Within half an hour he began to itch all over. He also complained of severe pain behind the sternum and of severe indigestion. An examination showed the body to be covered with large urticarial weals about the size of the palm of the hand. The feet, hands, and face were swollen. This condition persisted for seven days in spite of treatment with "benadryl," 50 mg. thrice daily, later increased to 100 with adrenaline, 10 min. (0.6 ml.), twice daily. After seven days the condition gradually subsided, but during this time the itching was intense and the patient had only very fitful sleep with the aid of morphine.

CASE 2

The patient, aged 33, was the wife of an ardent bee-keeper, and she helped with the manipulation of the bees from time to time. At first the patient had little reaction to stings until the summer of 1941, when she was stung on the lip. This became very badly swollen. In the summer of 1944 she was stung on the leg. The leg became very swollen, and she stated that the sites of previous stings also became swollen. In February, 1947, she had a small carbuncle on the face, which was treated with penicillin, 150,000 units, in distilled water, given eight-hourly for five days. This cleared up the carbuncle. On Oct. 25 a carbuncle began to develop on the chin, and next day injections of 250,000 units of penicillin in wax-oil suspension were started. These were given twice daily into each buttock alternately at the "site of election." The injections were continued until the morning of Oct. 29, six injections in all being given. On Nov. 2, the eighth day after the first injection of penicillin, the patient began to feel the site of the old bee-sting on the leg itching and a weal developed. Within half an hour the sites of injection of penicillin on both buttocks became itchy and red. For a week the sites of the injections were covered with a ring of urticaria and there was considerable swelling of the underlying tissues. During the same period the site of the old bee-sting on the leg was irritated and became swollen from time to time. The patient also averred that the taking of honey led to an increase in the local symptoms of allergy shortly thereafter. All symptoms were controlled to some extent by benadryl.

COMMENTARY

Case 1 is described to illustrate the severity of the allergic reaction to penicillin. The patient avers that he had never before had penicillin in any form whatsoever.

The second case is the more interesting in that it would seem more likely that the local allergic reactions were due to some component of the beeswax suspension. This is deduced from the facts that the bee-sting on the leg was re-activated. The other interesting factor is that the patient was quite definite that the ingestion of section-honey caused an increased irritation of both the site of the bee-sting and the sites of penicillin injection. It may be argued that the sting of a bee has no relation to beeswax. The firm which produced the beeswax was contacted. They stated that the beeswax used in the suspension is the natural product, but that in their opinion it is impossible for formic acid or other component of a bee-sting to be present in the wax. On the other hand, a well-known naturalist, who is also a bee-keeper, is of the opinion that it is quite possible for formic acid to be present in nectar and that natural beeswax could quite easily be polluted with nectar.

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