ordinary people would not be expected to regard local authority boundaries as marking their communities and would not consider their culture to be shaped by the "common media" of council affairs. Watkins's community is one of local institutions. While this is undeniably important in influencing health at a local level, these institutions should not be confused with the people who live within the boundary of the local authority: to do so reinforces bureaucratic paternalism, in which bureaucrats look after the population.

One of the great advances in public health in recent years has been the growing recognition that people who live in districts and boroughs have a right to have their views heard by bureaucrats in the health service. This has been coupled with an ethos that encourages people to take more responsibility for their own health. In the light of this, Watkins's image of the doctor "responsible for . . . a community," which itself is eagerly listening for advice on action it can take to improve its health, is a retrograde one. Our challenge for the 1990s should rather be to devise ways of turning the rhetoric of involving and listening to local people into a reality, while avoiding the minefield of "community" ideology.

Watkins's assertion that public health is multi-disciplinary is brought into question by the emphasis in the article on public health doctors and nurses (the doctors' handmaidens?). This vision of the future is all the more remarkable given that the Faculty of Public Health Medicine is currently looking to open its door more widely to non-medical members, who it seems to expect will be largely people with backgrounds in the social sciences, health economics, statistics, and management.

Though I do not wish to be associated with the rampant managerialism that has become a feature of parts of our specialty in recent years, it does public health a disservice to harp back continually to the old days of medical officers of health. It is time for the specialty to look forward, to push aside the curtains of ideology, and to determine what our role really is in these turbulent and uncertain times.

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Eradicating gonorrhoea

No "epidemiological" treatment

EDITOR,—I take issue with Chris Bignell's recommendation that treatment for gonorrhoea should routinely be combined with treatment effective against *Chlamydia trachomatis*.¹ This amounts to epidemiological treatment of chlamydia infection, by which I mean prescribing antibiotics either without doing microbiological investigations or before the results of investigations are known.

It is common American practice to use epidemiological treatment.² British genitourinary medicine, however, condemns epidemiological treatment on the grounds that potent antimicrobials (which may have side effects³) are used without a clear indication. Not all patients with gonorrhoea are also infected with chlamydia.⁴ Sensitive and specific tests for chlamydia exist,⁵ and drugs that are effective against chlamydia should not be used unless *C trachomatis* has been shown to be present.

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More is needed than just treatment

EDITOR,—It is possible to eradicate endemic gonorrhoea from Britain, as Chris Bignell states.¹ In addition to effective treatment, however, other, equally important factors, including health education, effective contact tracing, and the cooperation of the public, are needed. When these factors are not optimum eradication of this disease may prove difficult. I report the experience at the department of genitourinary medicine at Middlesbrough General Hospital, the largest of three genitourinary medicine clinics in Cleveland.

In the six months May to October this year 10 patients (nine men, one woman) were diagnosed as having gonorrhoea. The age range was 17-52, and four patients had acquired the disease homosexually. Two men were asymptomatic; they attended the clinic for HIV tests only but agreed to be screened for sexually transmitted diseases. The female patient was also asymptomatic but was a partner of one of the men with the disease. Results of microscopy and culture showed a correlation for eight men; the remaining two patients were diagnosed on the basis of the results of culture only. One male patient had coincidental chlamydial infection. All the patients were treated with ciprofloxacin; results of tests for *Neisseria gonorrhoea* were negative in the eight patients who returned for follow up.

Contract tracing was successful for only three male patients. The reasons for failure in the six other cases were that two patients gave false names and false addresses; two had had no further contact with their partners; and two could not remember who their partners had been, giving alcohol as the reason for this amnesia.

The *Health of the Nation* sets the target of a 20% reduction in the incidence of gonorrhoea by 1995.² This department has seen a steady decline in the number of cases from a peak of 112 in 1990 to 27 in 1993. Health promotion campaigns and outreach workers have been active in recent years. Eradication of gonorrhoea is possible, but a lot of work is still to be done.

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Open access for screening is vital

EDITOR,—We wish to respond to Chris Bignell's editorial on gonorrhoea.¹ History has shown that gonorrhoea is difficult to eradicate but can be controlled at a low level. New remedies may inspire false confidence and attitudes towards this and other sexually transmitted diseases.² While effective gonococcal treatment is available, control must depend more on diagnostic methods, notification of partners, health education, and widespread screening, especially in areas of high prevalence. Even in areas of low prevalence, such as Stockholm, 57% of cases during 1987-9 were

considered to have been acquired endemically; this figure, however, was decreasing while imported cases remained constant.³ The short incubation period of *Neisseria gonorrhoeae* and asymptomatic infections will lead to the spread of imported cases into the indigenous population, so that endemic infection is maintained. Immunisation against gonococcal infection in the future may be possible but is hampered by the rapid antigenic variation of the organism.

Cases of gonorrhoea detected outside departments of genitourinary medicine may not be reported nationally and do not appear in the Department of Health's statistics. In one study patients seen by general practitioners accounted for a quarter of the cases of gonorrhoea. Only 54% were subsequently referred to the local genitourinary medicine department.⁴ This is relevant because the *Health of the Nation* uses gonorrhoea to indicate the sexual health of the nation.

Not all genitourinary physicians would agree with Bignell that gonococcal treatment should routinely be combined with effective treatment against *Chlamydia trachomatis*. If this policy was adopted then all partners should also be given epidemiological treatment for both organisms, which would lead to overtreatment.

Finally, to keep gonococcal infections under control it is vital to maintain an open access system of screening for sexually transmitted diseases and to ensure that all patients with gonococcal infection are referred to genitourinary medicine clinics.

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Initial management of suspected meningococcal infection

Parenteral benzylpenicillin is vital

EDITOR,—The seasonal upsurge in meningococcal infections is expected shortly. C S Nanayakkara and R Cox ask whether there is sufficient evidence to justify the chief medical officer's advice to general practitioners to give benzylpenicillin to patients with suspected meningococcal disease and whether there is a clear role for adjunctive steroid treatment in meningococcal disease.¹

A meta-analysis of recent trials has shown that dexamethasone given with or before the first dose of antibiotics in bacterial meningitis reduces the incidence of neurological or audiological sequelae.² There were too few patients with meningococcal meningitis, however, for any firm conclusions to be drawn on the value of steroids in this subgroup.

Patients with meningococcal meningitis but without septic shock have an excellent prognosis and a low rate of residual neurological deficits, which makes controlled trials of steroids difficult. Most infectious diseases units give dexamethasone to all children with turbid cerebrospinal fluid or with clear clinical signs of bacterial meningitis shortly before the first hospital dose of antibiotics. The pathophysiology in meningococcal and other types of bacterial meningitis is similar, and dexamethasone has reduced inflammation and residual

damage in both clinical studies and animal models of meningitis.

Diagnosing meningococcal meningitis in the community may be extremely difficult. General practitioners should not give dexamethasone in the home as many patients would be treated inappropriately. There have been no placebo controlled trials of dexamethasone to support its use in meningococcal septic shock, but trials of steroids in adult patients with other forms of Gram negative sepsis have shown no benefit.³

We stand by our recent recommendation that general practitioners should give parenteral antibiotics before admission to all patients suspected of having meningococcal disease.⁴ In all five health districts that participated in a study there was a trend towards increased survival when benzylpenicillin was given before admission, with greatest benefit in the patients who were most ill—those with a haemorrhagic rash.⁵

We therefore endorse the chief medical officer's advice. During the winter general practitioners should ensure that they carry benzylpenicillin among their emergency drugs. If they see a patient in whom they suspect meningococcal disease, especially if a rash is present, they should give a dose, ideally intravenously, before urgently arranging admission to hospital. Admitting paediatricians can remind general practitioner colleagues over the telephone of the value of this treatment. Whether or not benzylpenicillin is given, immediate transfer to hospital is the next urgent priority.

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Chief medical officer's guidelines are right

EDITOR,—We regard as unconvincing the evidence to support C S Nanayakkara and R Cox's concluding comments in their letter on the initial management of suspected meningococcal infection.¹ The incidence of *Haemophilus influenzae* type b infection has decreased since the introduction of the immunisation programme. In Birmingham it decreased from 19.8 per million population for the year October 1991 to September 1992 to 2.0 per million for the year October 1993 to September 1994. The figure compares this with the incidence of meningococcal disease over the same period.

Meningococcal infection will therefore increase as a proportion of the total number of cases of meningitis, particularly in childhood. Meningococcal disease may also present as septicaemia, which has a much worse prognosis. Thus the most appropriate management of infection with *Neisseria meningitidis* will become even more important. The role of dexamethasone in the early treatment of

meningococcal infection is unclear and remains under review. Most studies agree, however, that in suspected meningococcal disease antibiotics should be given as soon as is appropriate.^{2,4} Even Peltola—cited by Nanayakkara and Cox—urged prompt management.⁵

Number of cases of meningitis due to *H influenzae*, meningococcal meningitis, and meningococcal septicaemia per million population, October 1991 to September 1994 (source: Birmingham Communicable Disease Unit)

In the future, when a general practitioner is presented with a case of meningitis the cause is more likely to be *N meningitidis* than *H influenzae* type b. Nanayakkara and Cox present insufficient evidence to support the statement that early use of benzylpenicillin by general practitioners may be inappropriate or even harmful. Indeed, general practitioners would need to consider whether withholding benzylpenicillin in order to administer dexamethasone would do more harm than good to their patients.

The chief medical officer's current guidelines on meningococcal disease are based on the scientific data available. Their use should be encouraged by all doctors involved in the early management of the disease.

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On the spot treatment needed

EDITOR,—C S Nanayakkara and R Cox's letter highlights the confusion that exists between meningococcal meningitis and meningococcal septicaemia.¹ Life threatening meningococcal disease presents not as meningitis but as septicaemia, often with a rash.² Giving penicillin before admission to hospital may decrease the mortality from meningococcal disease;³ penicillin should

therefore be given to those most at risk of dying—that is, those with septicaemia characterised by a purpuric rash. Information and publicity about meningococcal disease should focus on septicaemia, characterised by a petechial or purpuric rash, rather than on meningitis.²

In a recent prospective study in Merseyside the most important factor affecting whether children with meningococcal disease received penicillin before admission was the admitting doctor's diagnosis. When meningococcal disease was diagnosed 26 (84%) of 31 children were given penicillin. Of the 19 children diagnosed as having meningitis, however, only three (16%) were given penicillin ($P < 0.0001$, Fisher's exact test). To increase the numbers of children given penicillin before admission, attention should focus on meningococcal disease and not meningitis.

There is little evidence that children with bacterial meningitis benefit from antibiotics before admission,⁴ although they may benefit from dexamethasone given with, or before, the first dose of antibiotic.⁵ There is no evidence supporting the use of dexamethasone in meningococcal septicaemia, and antibiotics should not therefore be withheld before admission from those with a purpuric rash because steroids are unavailable.

The rapid progression of meningococcal septicaemia requires immediate antibiotic treatment to be given by the first doctor to see the patient. Penicillin should thus be recommended before admission for patients with meningococcal disease presenting with a petechial or purpuric rash. Such on the spot treatment might help reduce the mortality from this devastating infection.

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Authors' reply

EDITOR,—F A I Riordan and colleagues highlight the clinical confusion that exists between meningococcal meningitis and meningococcal septicaemia. We would be interested to learn the outcome of the prospective study on Merseyside, particularly in those children in both groups who did not receive penicillin before admission.

The authors emphasise that numbers of children given penicillin before admission could be increased if attention was focused on meningococcal disease, not meningitis. We agree that meningococcal disease presenting clinically with a petechial or purpuric rash requires penicillin before admission. But this distinction is not made or emphasised in the advice given by the chief medical officer¹ or the Communicable Disease Surveillance Centre.² Confusion may still exist in the indications for penicillin before admission in children without a rash, who may still have serious meningococcal disease.