LEADING ARTICLE

PHARYNGEAL GONORRHOEA

K V Ratnam

SING MED J. 1988; 29:97

Pharyngeal gonorrhoea as compared to gonorrhoea in the other usual sites poses special problems in diagnosis and treatment. Increasing indulgence in orogenital sexual practices among heterosexuals has necessitated the physician to be cognizant of its peculiarities.

The prevalence of gonococcal infection of the pharynx in a recent study in a cohort of women, heterosexual men and homosexual men was 6.8%, 4.2% and 27.3% respectively [1]. It is extremely infrequent in patients without genital gonorrhoea. Throat symptoms were found in 7% of women, 21% of heterosexual men and none in homosexual men in this group. Although various authors have reported different results, most agree that the homosexuals and heterosexuals who practise orogenital sex like cunnilingus and fellatio are at highest risk and that the majority are asymptomatic.

Importance of its detection is controversial as spontaneous cure within 12 weeks nearly always occurs[2]. Its role in transmission of disease is currently thought to be minor. However pharyngeal infections with PPNG in particular may have serious consequences as N. meningitidis frequently coexists in these patients and could result in transfer of Beta lactamase plasmids to the meningococcus[3]. In view of this high N. meningitidis carriage rate in most populations, diagnosis of gonococcal pharyngitis requires culture for confirmation and identification of PPNG strains by the usual methods. The culture should be taken from both Tonsillar crypts and the posterior pharyngeal wall.

Treatment of oropharyngeal gonorrhoea poses a special problem. It has been known that pharyngeal infections even with penicillin sensitive N. gonorrhoeae are difficult to treat. The reason for this is unclear. In this issue of the SMJ, a treatment regime using a 3-day course of Ampicillin resulted in a 97.2% of cure rate. However, this treatment has the drawback of being useless for PPNG strains and there may be compliance problems. CDC (Atlanta) recommends a single dose of 250 mg Ceftriaxone in PPNG endemic areas[4]. Single dose Spectinomycin has an unacceptable failure rate. Some workers would recommend a three-day course of a cephalosporin or even a single dose of 9 Bactrim tablets to produce a satisfactory cure. In MRH it is recommended that the CDC guideline be followed. Whatever the regimes, cases of pharyngeal gonorrhoea should be strictly followed for relapse.

In view of the possible risk of disseminated gonorrhoea with pharyngeal infection, should all cases of genital gonorrhoea be screened for pharyngeal involvement? A more rational and cost effective approach would be to do pharyngeal culture in all those with a history of orogenital sex regardless of symptoms and treatment should be more aggressive than in other sites with close follow up. In short pharyngeal gonorrhoea is still an enigma.

Middle Road Hospital
Middle Road
Singapore 0718

K V Ratnam, MBBS, Senior Registrar

REFERENCES

1. Sulaiman MZ, Bates CM, Bittiner JB, Dixon CA, Slack RC: Relapse of pharyngeal gonorrhoea to single dose penicillin treatment. Genitourinary Med 1987; 63(2):92–4.
2. Sexual Transmitted Diseases. KK Holmes. Per. Ander Mardh, P Fredrick Sparling and Paul J Weisner Macgraw Hill 1984.
3. Int J Dermat 1987; 26(4):206–14. Vinendar N S, Stivastava. Gonorrhoea and the story of Resistant Neisseria gonorrhoeae
4. CDC MMWR 1987; 36 Suppl Antibiotic resistant strains of N. gonorrhoeae. Policy guidelines for detection, management and control.