

LETTERS

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Use of antibiotics and antifungal agents in herpetic gingivostomatitis

Sir,
Despite its falling incidence, herpes simplex infection remains common.¹ Most primary infections, which may be asymptomatic,² are acquired in childhood, where they manifest as gingivostomatitis. The incidence of herpes virus infections is higher in deprived areas.³

A retrospective review of 43 cases of gingivostomatitis among children admitted to a regional infectious diseases unit over a 24 month period suggests that general practitioners are uncertain about the diagnosis and treatment of this condition. While our sample may be biased, it suggests that current practices should be reviewed.

The 43 cases were clinically similar, and of the 25 which were investigated virologically, 22 had positive cultures for herpes simplex virus. An obvious prodrome, lasting between one and three days, was noted in only eight cases. Four patients had been unwell in the week leading up to admission (two with gastroenteritis and two with chest infections). Treatment prior to hospitalization consisted of: nystatin (five patients), amphotericin (one), aminopenicillin (ampicillin, amoxycillin or co-amoxiclav) (nine), erythromycin (four) and aminopenicillin plus nystatin (five). Two of the five patients who received acyclovir prior to admission had received antibiotics beforehand. In the three instances when an antibiotic had been prescribed for prodromal symptoms it was erythromycin. This is likely to represent the choice of antibiotic for 'pyrexia of unknown origin', and it seems unlikely that erythromycin increases the incidence of ulceration. Bacterial culture grew light growths of normal oral flora, and occasional light growths of yeasts.

From discussion at the time of admission, and because nystatin was the commonest therapeutic agent prescribed prior to admission, it appeared that many of the cases were being misdiagnosed as thrush or bacterial stomatitis. At the time of presentation all of the children had

painful mouths (often present before ulceration), displaying typical shallow, grey-white, based ulcers in the anterior part of the mouth, and 23 had secondary lesions. The greyish-white ulcers are quite distinct from the white raised lesions which are the usual sign of candidiasis in children. The latter are confined to mucosal surfaces and are less associated with systemic illness. Many children have light growths of candida on oral swabs, as did a number in this series. We did not use antifungal agents in these circumstances and had no problems with thrush.

Only five children had received acyclovir prior to admission, without obvious benefit. Our policy is to give acyclovir in the first two days of illness (except for very mild lesions), though there is no conclusive evidence to show benefit at present.⁴ Certainly treatment probably needs to be given very early. No children required intravenous fluids or had late complications.

Herpetic gingivostomatitis may be diagnosed on clinical grounds,⁵ and if confirmation is required, herpes simplex virus is easily cultured. Thrush should be easily distinguishable, and if treatment for possible bacterial stomatitis is desired, penicillin V is active against all normal pathogens, and is less likely to cause adverse events than many agents.

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Testicular self examination: evaluation of an educational leaflet

Sir,
With optimal management, more than 90% of patients who present with advanced anaplastic germ cell tumours of the testis¹ can probably be cured. Those failures that do occur are usually in patients with very bulky disease and high tumour marker concentrations at presentation.² Most of those with stage 1 disease will require no further treatment after the initial orchidectomy.³ Delays in diagnosis are largely due to the failure of patients to report testicular abnormalities promptly.⁴ These delays are associated with a greater frequency of poor prognostic characteristics.⁵ It is therefore preferable that testicular cancer is diagnosed early.

The Yorkshire Regional Cancer Organization has prepared a leaflet (published by McCormack Ltd, Leighton Buzzard) which describes the purpose and technique of testicular self examination. We have evaluated its effects on knowledge of testicular cancer among students of the University of Bradford and on attendances at the university student health service.

Testicular self examination leaflets were made available to students when they collected their grant cheques over a period of two terms. Consultations for scrotal complaints in the student health service were recorded by the medical officers there during the terms. The following term, a questionnaire was administered to a random group of male students in order to assess what proportion had seen the leaflet and what they knew of testicular cancer. The interviews were conducted by students recruited for this purpose. Student health service consultations after the survey were monitored as before.

Interviews were carried out with 720 men, 33.1% of the male students in the