of the urethral meatus, together with marked vulval oedema and a white vaginal discharge. Twenty four hours later the swelling had increased in size to approximately 2 × 2 × 1 cm and was extremely tender. The swelling was thought to be a periurethral abscess and she was admitted to hospital. Under anaesthetic the lesion was incised, but only a small amount of fluid was obtained. Bacterial and fungal cultures were negative. A small biopsy was taken, with the clinical summary of 'periurethral abscess'; microscopy showed a mild acute inflammatory infiltrate of neutrophils in the epithelium and underlying tissue, and was at this stage considered non-specific.

The diagnosis remained uncertain, and the lesion resolved over the next two days without further treatment. Following a practice meeting, the suspicion that this might be a case of orf was discussed with a histopathologist, and the biopsy material was reviewed. The sections showed ballooning and reticular degeneration of the superficial epithelium; some cells were vacuolated and few eosinophilic inclusion bodies were seen. Tissue was recovered from the paraffin block and processed for electron microscopy. Some particulate matter was seen, but the preservation was too poor to allow their definite identification as orf particles. Although the histopathological findings were consistent, and even strongly suggestive of orf, they were not definite enough to allow final confirmation. Nevertheless, these findings were analogous with those of orf in skin biopsies, and are therefore consistent with the clinical diagnosis of the same infection in the urethra.

Human infection was first reported in 1879,[1] and virological studies have confirmed the transmission of the disease from sheep to man.[2] The pox virus responsible for the infection is resistant to drying and freezing, and can remain viable for long periods on objects with which the infected animal has been in contact. This explains the reported cases of viral inoculation from inanimate objects such as farm buildings, wool and pastures.[3]

Infection from human to human is rare, and only three cases have been described — a nurse who had changed the dressings of a patient with orf,[4] the child of an infected mother,[5] and a farmer's wife who developed a lesion on her cheek.[6]

A literature review revealed only one report of autoinoculation with the orf virus: this was in a seven year old American girl who had perianal orf, and was later found to have a resolving digital lesion.[7] The case reported here is similar, but is the first description of orf infection in the urogenital tract, and is the first British report of autoinoculation of the orf virus.

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Primary ciliary dyskinesia

Sir,

I am sure that many general practitioners are unfamiliar with the condition primary ciliary dyskinesia (also known as immotile-cilia syndrome)[1] as indeed I was myself until recently. As a cause of 'chestiness' in children, its diagnosis has therapeutic consequences and we should, therefore, be aware of its existence when a child presents with a recurrent, productive cough.

In primary ciliary dyskinesia the cilia of the respiratory tract move poorly or not at all, leading to accumulation of mucus which readily becomes infected. Unless prompt action is taken in the form of physiotherapy with postural drainage and treatment with bronchodilators and antibiotics, the child may enter adulthood with bronchiectasis. The effects of the poor mucociliary clearance thus resemble those of cystic fibrosis. In addition, there may be deafness and, in males, infertility (because the forward motility of the spermatozoa is impaired).

The incidence of the condition is thought to be about one in 20 000,[1] so that there may be approximately 3000 cases of primary ciliary dyskinesia in the United Kingdom. Only 37 cases are known (Polak C, personal communication), and the explanation for this discrepancy is probably that clinicians do not think of the condition. They do not, therefore, arrange the diagnostic test, which is electron microscopy of a nasal brush biopsy.

General practitioners should know that there is a primary ciliary dyskinesia family support group which is a source of information about research into, and the management of, this potentially disabling condition.

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Journal publication times

Sir,

While it would be inaccurate to describe myself as an avid reader of the *Journal*, it is nevertheless true that I look at it at regular intervals. I always feel inferior when reading the correspondence columns since I can never remember the article to which the letter relates. It then occurred to me that this was because it took so long for letters to be published that any correspondence was outdated before a discussion could be generated.

Being of an enquiring mind, and well versed in audit I undertook a survey of the June 1991 and June 1992 issues of the *Journal* to examine publication times (Table 1). For the June 1991 issue, seven papers were published; the mean submission date was July 1990 and the mean acceptance date was November 1990. For the June 1992 issue, seven papers were published; the mean submission date was May 1991 and the mean acceptance date was October 1991. Thus, articles in the *Journal* reflect the state of general practice research some 13 months earlier, even if it is accepted that the research itself needed to be carried out and the paper written.

Regarding letters to the editor, 15 letters were published in June 1991; 11 were in reference to articles previously published in the *Journal*. Eight referred to articles published three months earlier, and one each to articles published four and five months earlier. One letter referred to papers published in both the February and March issues of the *Journal*. Nine letters were published in June 1992; two referred