We were unable to assess the biology of the Neisseria gonorrhoeae strains responsible for infections in Malawi. It was not possible in our clinical setting to study chromosomal resistance or PPNG strains because of the unavailability of required supplies in the hospital bacteriological laboratory. Indeed, we knew of the probability of the presence of resistant strains of Neisseria gonorrhoeae but could do little else but continue treatment with the only antibiotics available, topical tetracycline and systemic penicillin.

Many eyes in our series which were lost due to endophthalmitis from Neisseria gonorrhoeae had already sustained corneal perforation from corneal ulceration at the time the patients were admitted to hospital. Others who presented with severe gonococcal keratocconjunctivitis went on to corneal perforation during hospitalisation despite tetracycline and penicillin treatment, lending credence to the supposition that Neisseria gonorrhoeae resistant strains were present. We would have switched our therapy to spectinomycin or one of the newer cephalosporins had any of these drugs been available.

Not only in Rwanda is gonococcal antimicrobial resistance a problem, as Drs Kestelyn and Meheus write, it is also a great concern in Kenya, where penicillinase-producing and beta lactamase plasmid-containing strains complicate therapy. We have documented the periodic problem of epidemic gonococcal keratoconjunctivitis in adults in Malawi by probable, but unproved, penicillinase-producing and plasmid-containing strains. Almost certainly this spectacular epidemic adult blinding infection has occurred in other African nations.

Drs Kestelyn and Meheus have noted the World Health Organisation's treatment recommendations for ocular gonococcal infection. The Centre for Disease Control (CDC) recommends spectinomycin 2-0 g intramuscularly or ceftriaxone 250 mg IM for patients with venereal gonorrhoea which has persisted after one of the non-spectinomycin regimens has failed or for proved PPNG strains, followed by tetracycline 500 mg p.o. q 6 h x 7 days or doxycycline 10 mg p.o. q 12 h x 7 days. Patients who cannot tolerate tetracycline may be treated with spectinomycin 2-0 g IM followed by erythromycin 500 mg p.o. q 6 h x 7 days. For gonococcal ophthalmia in adults the CDC recommends hospitalisation and treatment with aqueous penicillin G, 10 million units intravenously daily for five days. For PPNG infections cefoxitin 1-0 g IV or cefotaxime 500 mg IV q 6 hours daily or ceftriaxone 1-0 g IM daily are recommended. The CDC does not recommend the use of topical ocular antibiotic preparations.

Improved chemotherapy for resistant Neisseria gonorrhoeae offers hope for preventing ocular destruction and blindness in patients with advanced infection. Until governments and international health agencies are able to improve health care systems and provide sufficient and appropriate pharmaceuticals for developing nations, however, destructive gonococcal keratoconjunctivitis will probably increase and will become a more significant cause of irreversible blindness.

References
1 Burnham RC, et al. Antimicrobial susceptibility testing and phenotyping of Neisseria gonorrhoeae isolated from patients with ophthalmia neonatorum in Nairobi, Kenya. Antimicrob Agents Chemother 1983; 28: 3: 393–6.
2 World Health Organisation. Morbidity and Mortality Weekly Report. 1985; 34 (45), 18 October.

Book review

Parsons' Diseases of the Eye. 17th edn. By Stephen J. H. Miller.. Pp. 384. £19-50. Churchill Livingstone: Edinburgh. 1984.

The seventeenth edition of this well-known text book, produced under the guidance of Sir Stephen Miller, is a worthy successor to previous editions. Perfection is, of course, impossible in a book of this type, attempting as it does to describe far more than is implied in its somewhat modest title. There is indeed a section entitled 'Diseases of the eye,' but there are seven others, covering anatomy and physiology, optics, examination and therapeutics, disorders of motility, diseases of the adnexa of the eye, symptomatic diseases of the eye, and preventive ophthalmology.

When one considers that some major textbooks require between 10 and 20 sizeable volumes to cover the same ground, one realises what a difficult task, both in selection and compression, the author of a single ophthalmological textbook has. The danger with a book of this sort is that it falls between two stools: it may be too complex for the undergraduate medical student or general practitioner but too condensed for the practising ophthalmologist. This book, however, and this paperback edition in particular, is aimed specifically at the student. One takes that to mean the postgraduate beginning a career in ophthalmology, usually in the first years of an ophthalmic residency. It will also be useful to certain general practitioners, practising in remote places, who have to be relatively self-sufficient in basic ophthalmology.

This is a valuable addition to the venerable line of editions of 'Parson's.' The text is clear and eminently readable and the numerous line illustrations from our foremost ophthalmic illustrator blend well with excellent photographs of macroscopic and microscopic subjects.

REDMOND J H SMITH

Note

Cataract

The New Orleans Academy of Ophthalmology will hold its 36th Annual Symposium on 'Cataract in the Nineties' on 14–17 February 1987 at the Hyatt Regency Hotel, New Orleans. Details from Emily Busby (Executive Secretary), New Orleans Academy of Ophthalmology, Eye, Ear, Nose & Throat Hospital, 145 Eliz Place, Room 203, New Orleans, LA 70112, USA.