patients with benign breast disease who show a cyclical pain pattern may respond to 2·5 mg twice daily.

ADVERSE EFFECTS

Nausea is a particularly common side effect and vomiting may occasionally limit the usefulness of bromocriptine. In most patients, however, these symptoms may be prevented by taking the drug with meals and beginning with a low (1·25 mg) dose which is increased gradually over some days to weeks. Dizziness, postural hypotension, and constipation are other common side effects. Gastrointestinal haemorrhage rarely occurs in patients on high doses (over 10 mg daily). Neuropsychiatric side effects are uncommon except in patients with Parkinson's disease.

We thank Dr John Mills for advice on gynaecological aspects of the drugs.

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Communicable Diseases

Penicillinase-producing Neisseria gonorrhoeae in Britain 1982

Prepared by the Public Health Laboratory Service Communicable Disease Surveillance Centre and the Communicable Diseases (Scotland) Unit with the assistance of the Academic Department of Genitourinary Medicine, Middlesex Hospital Medical School.

In an analysis of infections due to penicillinase-producing strains of *Neisseria gonorrhoeae* reported in Britain during 1977-81 McCutchan and his coworkers showed that since these strains first appeared cases had doubled annually, primarily as a result of patients infected abroad.[1] During 1981, however, the number of indigenous cases being reported began to exceed the imported cases, suggesting that the strains had become truly endemic here.

The data for 1982 are summarised in the table. The total for the year was 1033, compared with 433 in 1981. Infection was acquired abroad by 237 patients, 69 more than in the previous year but only 23% of the total, compared with 38% in 1981 and 52% in 1980. Of the 237 patients, 102 had acquired the infection in the Far East (Thailand 51, Philippines 16, Singapore 9, Hong Kong 7), 71 in West Africa (Nigeria 51), and 30 in Europe (West Germany 7, Netherlands 6, Spain 6, France 5). The proportional contribution of these three parts of the world to the total imported infections has changed little in the past three years. The consorts of a further 65 patients were infected abroad.

The infections regarded as indigenous—that is, when both the patient and consort were infected in Britain—show the greatest increase. The total in this category, 519, is 354 more than in 1981. Of these 519 patients, 154 were stated to have contracted the infection in Greater London and a further 157 were reported from laboratories in that area; Birmingham recorded 30 cases, Liverpool 28, Bristol 20, and Leeds 18, and many other areas had smaller numbers of cases. The shift from importation to endemic transmission of penicillinase-producing *Neisseria*

Patients with infections with penicillinase-producing Neisseria gonorrhoeae by age and where contracted, Britain, 1982 (1981 numbers in brackets)

Presumed place of infection	No of reported cases: age in years							Total
	≤15	16-19	20-24	25-34	35-44	≥45	Not stated	
				Men				
Abroad	0 (0)	7 (4)	36 (25)	84 (70)	46 (28)	16 (10)	19 (16)	208 (153)
Britain:								
Consort infected abroad	0 (0)	1 (0)	9 (5)	10 (12)	4 (3)	1 (2)	2 (0)	27 (22)
Indigenous: consort infected in Britain	0 (0)	28 (9)	103 (26)	110 (41)	39 (15)	19 (7)	18 (7)	317 (105)
Not known	0 (0)	3 (2)	13 (4)	11 (4)	9 (4)	1 (1)	74 (7)	111 (22)
Total		39 (15)	161 (60)	215 (127)	98 (50)	37 (20)	113 (30)	663 (302)
				Women				
Abroad	0 (0)	1 (0)	10 (6)	12 (3)	2 (1)	0 (3)	3 (2)	28 (15)
Britain:								
Consort infected abroad	0 (0)	5 (3)	15 (7)	8 (8)	4 (3)	0 (0)	6 (3)	38 (24)
Indigenous: consort infected in Britain	2 (1)	57 (14)	79 (15)	42 (17)	4 (1)	5 (1)	11 (6)	200 (55)
Not known	0 (0)	6 (4)	11 (4)	8 (3)	3 (1)	0 (0)	59 (6)	87 (18)
Total	2 (1)	69 (21)	115 (32)	70 (31)	13 (6)	5 (4)	79 (17)	353 (112)
Sex not stated	0	0	0	0	1*	0	16† (29)‡	17 (29)
Grand total	2 (1)	108 (36)	276 (92)	285 (158)	112 (56)	42 (24)	208 (76)	1033 (443)

*Acquired in Britain; †1 infected abroad, 1 in Britain, 14 not stated; ‡5 acquired in Britain.

gonorrhoeae already discernible in 1981 has clearly become pronounced in 1982. In the remaining 212 reported cases there was no information on presumed place of infection.

As in previous years, infections contracted abroad occurred predominantly in men (7·4:1) whereas indigenous infections were divided more equally between the sexes (1·6:1). These ratios closely correspond to those obtainable from national clinic statistics on imported and indigenous gonorrhoea; the increase in importation of penicillinase-producing *Neisseria gonorrhoeae* that still continues must therefore reflect increasing and spreading prevalence of these strains abroad.

National data for Britain show that in 1981 penicillinase-producing *Neisseria gonorrhoeae* were identified in 0·76% of all postpubertal cases of gonorrhoea. This figure will be more than doubled in 1982, perhaps reaching 2%, with pockets of higher prevalence in some urban areas. It is therefore becoming increasingly important that physicians treating cases of gonorrhoea should monitor the prevalence of penicillinase-producing *Neisseria gonorrhoeae* in locally acquired disease. If this rises above 5%, consideration should be given to adopting general screening and changes in treatment measures as advocated by McCutchan *et al.*[1]

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A young woman with diabetes has pancreatic calculi. What treatment is advised?

The answer to this question depends not so much on the presence of pancreatic calculi as on the severity of the diabetes. If the young woman has ketonuria she needs treatment with insulin as well as appropriate dietary advice. The pancreatic calculi, however, probably indicate chronic pancreatitis; they occur together quite commonly in some parts of India[1] and Africa. Diabetes associated with chronic pancreatitis typically has a gradual onset and responds well to treatment with diet and a sulphonylurea. The cause of pancreatic lithiasis is not well understood, but studies in dogs have shown that partial, rather than complete, obstruction of pancreatic ducts favours the formation of calculi within them.[2] Interestingly, it was after Banting had read about a case of diabetes and pancreatic lithiasis[3] in 1920 that he started the work with Best that led to the preparation of insulin from pancreases the main ducts of which had been ligated to produce atrophy of the exocrine tissue.—J M STOWERS, professor of diabetes and endocrinology, Aberdeen.

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A damaged bitumen damp course in an old house was treated with silicone injection. Subsequently the occupants of the house suffered from coughs, headaches, and conjunctivitis, and part of the house was uninhabitable because of the persistent smell. Is silicone vapour likely to be the cause, and if so will it have any long term harmful effects?

Silicone treatment for rising damp entails the injection of a silicone foam polymer that gradually hardens to form a moisture proof layer. During the hardening process it gives off vapours that may be unpleasant. At least one school treated by this method has been closed for many months owing to a persistent formaldehyde odour that pupils and teachers found insufferable. The formaldehyde group is common in the structure of polymers. The exact cause is as yet not known, although the Building Research Establishment has stated that the odours are not toxic. I suspect that in the hardening of the silicone foam formaldehyde is given off and may persist for months in certain buildings. I do not think that any long term effects are likely as the concentrations are low. Formaldehyde is a pungent vapour that irritates the mucous membranes of the nose, upper respiratory tract, and eyes. If silicone foam treatment is being considered it is important to go to a reliable firm which will give a sound guarantee that the treatment will be effective against rising damp and that the product used will not release unpleasant, irritant vapours. —ANDREW B SEMPLE, emeritus professor of community and environmental health, Liverpool.