compared with 45 units before pregnancy) in the lactating group despite the increased carbohydrate allowance.

All but two of the diabetic mothers were delivered between 37 and 39 weeks' gestation; 26 (54%) were delivered by caesarean section, 11 (23%) had a forceps delivery, and 11 had a normal delivery. This compares with national rates for non-diabetics of 14% having forceps and 9% caesarean deliveries.¹ Neither the mode of delivery, gestational age, birth weight, duration of diabetes, nor the presence of retinopathy affected the choice of infant feeding or duration of lactation.

Comment

The results show that diabetic women allowed an additional 50 g carbohydrate in the daily diet can breast feed as successfully as non-diabetic women and that the problems they encounter are similar.

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Oropharyngeal *Haemophilus ducreyi* infection

Extragenital chancroid is rare. We report on three patients with the condition in whom *Haemophilus ducreyi* was isolated from the oropharynx.

Case reports

Case 1—A 23 year old homosexual man presented with a sore throat of five days' duration that had started two days after anogenital and mutual orogenital contact with a casual partner. Examination showed no clinical or microbiological evidence of anogenital infection. The buccal mucosa was hyperaemic and showed adherent candidal plaques, and there were three painful palatal ulcers (figure). Dark field microscopy of the abraded ulcers did not show *Treponema pallidum* but showed typical budding forms of *Candida albicans*, which was also recovered in culture. *H ducreyi* was isolated from a swab of purulent exudate from the ulcer bases directly plated on to modified haemin medium and incubated for 48 hours at 33°C in 5% carbon dioxide.¹ The isolate's identity was confirmed by typical colonial morphology, Gram stained appearance, starch aggregation, requirement for X but not V factor, and positive results of tests for alkaline phosphatase and nitrate reduction. It did not produce β -lactamase. Culture and serological investigations gave no evidence of other ulcer pathogens. Although nystatin oral suspension rapidly cleared the adjacent candidal lesions, the palatal ulcers took 16 days to heal. *H ducreyi* was reisolated from the now healthy oropharynx four weeks later but was successfully eradicated by co-trimoxazole 960 mg twice daily for seven days.

Case 2—A 29 year old man presented with penile sores of two days' duration. He gave a three year history of recurring genital ulcers after peno-vaginal and orogenital contact with a prostitute in Bangkok, when he had simultaneously acquired gonorrhoea and genital herpes. Both herpes simplex virus (HSV 2) and *H ducreyi* were isolated from his penile ulcers, which resolved after seven days of saline bathing alone. He was without signs of infection at reattendance four weeks later, when separate swabs were taken from the urethra, subpreputial sac, and oropharynx (because of the history of orogenital contact). A β -lactamase producing strain of *H ducreyi* was isolated from all three sites. He was treated with erythromycin 1 g daily for 14 days. Subsequent attempts to isolate the organism were unsuccessful, although his genital herpes recurred.

Ulcers on soft palate and uvula from which *C albicans* and *H ducreyi* were isolated.

Case 3—A 27 year old man was referred by his girlfriend one week after she had presented with extensive lesions of primary genital herpes. Her initial symptoms had appeared within one day after their having mutual orogenital contact. Both denied other sexual contact, or partners, within the preceding 12 months. Herpes simplex virus (HSV 1) and *H ducreyi* were isolated from her vulval ulcers. He had no history or signs of oropharyngeal or genital abnormality, although two serum samples showed persisting high levels of antibodies to herpes simplex virus. *H ducreyi* was isolated from his oropharynx but not from penile swabs. In both patients the isolates, which did not produce β -lactamase, were eradicated by co-trimoxazole 960 mg twice daily for seven days.

Comment

We are not aware of any previous reports of oropharyngeal *H ducreyi* infection confirmed by culture. *H ducreyi* may be found in genital ulcers caused by herpes simplex virus,¹ and asymptomatic carriage occurs.² The pathogenic importance of our observations is uncertain. In case 1 the organism may have been a secondary bacterial invader causing delayed resolution of buccal candidal lesions, whereas longstanding asymptomatic carriage was likely in the two other patients. In case 2 the infection was probably acquired in the Far East, where β -lactamase producing strains of *H ducreyi*, often showing multiple antibiotic resistance, are common.³⁻⁵

Further study is required of the oropharynx as a reservoir of both symptomatic and asymptomatic *H ducreyi* infection.

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