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Retention of urine in occult anorectal herpes

Urinary retention in patients with symptomatic anogenital herpes simplex infection is well documented. We report two cases of micturition difficulties in patients with occult anorectal infection.

Case reports

Case 1—A 23 year old man was transferred to the Whittington Hospital from HM prison with acute urinary retention which necessitated catheterisation. He gave a five day history of dysuria without urethral discharge and denied anal discomfort or discharge. The anus and perianal area appeared normal but proctoscopy showed a severely inflamed rectal mucosa. Both rectal and urethral smears contained multiple polymorphs but no organisms on Gram staining and were negative on culture for *Neisseria gonorrhoeae* and *Chlamydia trachomatis*. The rectal culture was, however, positive for herpes simplex virus. The catheter was removed after 24 hours but was reinserted because of continued retention. He required catheterisation for a further nine days, after which he managed to pass urine without further difficulty. The patient subsequently absconded from hospital and was not seen for follow up.

Case 2—A 30 year old homosexual man attended the department of genitourinary medicine on 6 April with a sore throat, headache, and enlarged cervical lymph nodes. One week later he developed perianal discomfort. Examination showed two small, dry perianal vesicles but no inguinal lymphadenopathy. Culture of the vesicles for herpes simplex virus was negative. Initial serological studies yielded a positive treponema haemagglutination test result and positive rapid plasma reagin test at a titre of 1/256, and so treatment for secondary syphilis was started in the form of procaine penicillin injections daily for 15 days. On 18 April he complained of difficulty in passing urine over the previous 48 hours but denied anal discomfort or discharge. The external genitalia and perianal area appeared normal but the bladder was enlarged to the level of the umbilicus. There was no sensory loss and the bulbocavernosus reflex was present. The rectal mucosa looked inflamed and Gram staining showed multiple polymorphs but no organisms. Cultures were negative for *N gonorrhoeae* and herpes simplex virus. He was admitted to hospital and continued to have difficulty in initiating micturition with a lack of sensation. The stream was very weak and he managed to pass only small amounts of urine at a time. Bethanechol chloride by mouth was prescribed with some improvement. Optimal response was achieved when the dose was increased to 20 mg four times a day. The medication needed to be continued for 12 days to control his symptoms. On 30 April repeat proctoscopy showed a normal rectal mucosa. Rectal swabs on this occasion were negative for *N gonorrhoeae* but positive for herpes simplex virus.

Comment

Herpes simplex virus infection of the anorectum in homosexual men was first described by Astruc in 1736. It is now considered to be the commonest cause of non-gonococcal proctitis in male homosexuals.¹ Asymptomatic herpes proctitis has been mentioned recently, though severe pain, tenesmus, and rectal discharge usually dominate the clinical picture.² Urinary retention associated with acute anogenital herpes is well described; however, in these cases there were easily recognisable features of herpetic infection.^{3,4}

We report what appear to be the first documented cases of urinary retention and micturition difficulties associated with occult herpes simplex

virus infection. Evidence of anorectal infection was suspected and was deliberately pursued, repeatedly in the second patient.

The development of urinary retention in some patients associated with paraesthesia of the second and third sacral dermatomes, neuralgia, constipation, and impotence has suggested a lumbosacral radiculomyelopathy or a localised meningomyelitis.^{3,4} Herpes simplex virus is neurotropic and has been isolated from trigeminal, vagal, superior cervical, and sacral ganglions.⁵

The use of bethanechol chloride in the second patient greatly helped to relieve his urinary difficulties and probably obviated the need for catheterisation. Bethanechol is a parasympathomimetic agent with the muscarinic properties of acetylcholine and has not to our knowledge been used previously in this setting. Whether the use of systemic acyclovir will shorten the course of neurogenic difficulties in micturition remains to be assessed.

In cases of urethral and vulval herpes, in addition to a neuropathic cause for urinary retention, a reflex inhibition secondary to severe pain on micturition may play a part.³ Relief of pain by local or systemic measures appears to be the appropriate management of such cases.

In summary, we emphasise the need to take a full sexual history and carefully and repeatedly to search for herpes simplex virus infection of the urethra and anorectum in all young patients with urinary retention or micturition difficulties.

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Irreversible pulmonary hypertension after treatment with fenfluramine

Pulmonary hypertension was associated with the appetite suppressant aminorex,¹ but attempts to induce it in animals have failed.² Pulmonary hypertension that resolved when treatment was stopped was also described in two patients taking the anorectic agent fenfluramine.³ We report severe irreversible pulmonary hypertension in a patient treated with fenfluramine.

Case report

A 58 year old woman was referred for investigation of worsening dyspnoea and right heart failure. Examination of the heart and lungs, an electrocardiogram, and a chest x ray film had been normal eight years previously when she had attended for intermittent claudication. Her weight then had been 72 kg and height 154 cm. She had next been seen aged 54 complaining of exertional dyspnoea. An apical systolic murmur was noted, and an electrocardiogram showed peaked P waves and an increase in right ventricular voltage. Diuretics conferred some benefit. Between the ages of 46 and 56 she received seven one month courses of fenfluramine and her maximum weight was 80.5 kg. She had smoked 20 cigarettes a day for over 20 years.

On examination she weighed 68.5 kg and was peripherally and centrally cyanosed. Blood pressure was 140/90 mm Hg, and her jugular venous pressure was raised above the angle of the jaw. There was a parasternal lift and a grade 3/6 pansystolic murmur maximal at the lower end of the sternum. She had pulsatile hepatomegaly and peripheral oedema, and the lungs were clear. An electrocardiogram showed sinus rhythm, biatrial enlargement, an axis of +120°, and incomplete right bundle branch block. A chest radiograph showed a cardiothoracic ratio of 170:295; prominent hilar vessels, and clear lung fields. Routine