J R Coll Physicians Edinb 2008; 38:380–2

TREATMENT OF SECONDARY SYPHILIS

Sir,

We read with interest the article 'Palmoplantar keratosis as a primary presentation of secondary syphilis' (Ghadiri-Sani M, Mann I, Lobo M, Jawad ASM. *J R Coll Physicians Edinb* 2008; 38:215–7).

The patient discussed in the article was diagnosed with secondary syphilis and received a 28-day course of oral penicillin.

We would like to point out that the 28-day course of oral penicillin is not a recommended regime in the UK for the treatment of secondary syphilis without neurological or eye involvement. As per the current UK guidelines,[1] the recommended treatment for such a patient would be either procaine penicillin IM for 10 days or a single IM dose of benzathine penicillin.

In general the management of syphilis varies depending on the clinical stage, which is assessed by taking into account the clinical history, examination and serological tests. The management of congenital syphilis and syphilis in pregnancy is more complicated, and obstetric, midwifery and paediatric specialists should be involved.

A brief account of the management of syphilis in a non-pregnant adult patient is given below.

Benzathine penicillin 2.4 MU IM single dose or procaine penicillin 600,000 units IM daily for 10 days are the recommended treatment regimens for early syphilis, including primary, secondary and early latent stages. Alternative regimens for early syphilis include oral administration of doxycycline, azithromycin, amoxicillin and erythromycin.

The preferred treatment option for late latent, cardiovascular and gummatous syphilis would be either three doses of benzathine penicillin 2.4 MU IM each, given at one week intervals, or procaine penicillin 600,000 units IM OD given for 17 days. The alternative regimens include oral doxycycline and amoxicillin.

The treatment of neurosyphilis, including neurological and ophthalmic involvement in early syphilis, would be either procaine penicillin 1.8–2.4 MU IM, along with oral probenecid for 17 days, or benzylpenicillin IV for 17 days.

It should also be noted that both benzathine and procaine penicillin are unlicensed in the UK. Treating physicians should be aware of the possible side effects such as Jarisch-Herxheimer reaction, procaine reaction and anaphylactic shock and their management.

HIV-positive individuals should be given treatment appropriate for the stage of their illness.

All patients should be followed up to rule out any reinfection or relapse. The recommended minimum clinical and serological follow-up for early syphilis should be at months one, two, three, six and 12, then six-monthly until VDRL or RPR becomes negative or serofast. In case of late syphilis, minimum serological follow-up is three monthly until serofast state is reached.

Partner notification is an essential aspect of syphilis management and should be done in liaison with genitourinary medicine clinics.

With the continued relatively high incidence of syphilis it is important that clinicians in all specialties are aware of the varied ways in which this infection can present.

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Steve Baguley

Consultant in Genitourinary Medicine, Woolmanhill Hospital, Aberdeen

Reference

1 Kingston M, French P, Goh B et al. UK *National guidelines on the management of syphilis 2008*. London: British Association for Sexual Health and HIV; 2008. Available from: http://www.bashh.org/documents/1771

Authors' response:

We thank Drs Nair and Baguley for their interest in our recently published article. Our patient was diagnosed with secondary syphilis and received a 28-day course of amoxycillin 2 gm po tds, plus probenecid 500 mgs po qds for 28 days. The patient refused to have injectable penicillin. The reason for receiving a 28-day course and not 14 days was because the patient was suspected of having neurosyphilis as he had recently suffered from affective psychosis; his symptoms were controlled on olanzapine and citalopram. The current UK national guidelines on the management of syphilis [see above] recommend the above regime as an alternative for patients with early syphilis and neurological and/or ophthalmic involvement (see page 14 of these guidelines). The duration recommended is 28 days. Interestingly, our genitourinary consultant who recommended the treatment regime is one of the authors of the UK national guidelines.

Ali SM Jawad

Consultant in Rheumatology, Royal London Hospital

DIAGNOSIS OF AMYLOIDOSIS

Sir,

The paper entitled 'The challenging diagnosis of cardiac amyloidosis' (Gavin A, Coats CJ, Wallace W, Flapan AD. *J R Coll Physicians Edinb* 2008; 38:196–206) highlights the heterogeneity of symptoms at presentation and the difficulties in diagnosis and management of patients with cardiac amyloidosis. Reducing the time from onset of symptoms to time of diagnosis remains difficult and at

present depends on general physicians and especially those treating chronic inflammatory conditions having a high index of suspicion.

The authors correctly establish that AA amyloidosis is the most common form of the disease worldwide. However, it may well be the case in Western populations with access to biologic drugs that AA amyloidosis becomes rarer due to better control of the underlying inflammatory process.

In a recent study of etanercept in AA amyloidosis, serum amyloid A (SAA) levels were reduced in the majority of patients to a level that would be expected to cause stability or regression of amyloid deposits.[1] Biologics are therefore an alternative to the cytotoxic regimens which carry significant risks, including malignancy and cardiotoxicity in drugs such as cyclophosphamide.

The use of laboratory assays such as N-terminal pro-brain natriuretic peptide (NT-proBNP) and troponin is not established in AA amyloid. Whether these can be used to risk stratify for mortality in AA amyloid remains an important research question.

Martin E Perry
Specialist Registrar in Rheumatology, Centre for Rheumatic Disease, Glasgow Royal infirmary

Reference

1 Perry ME, Stirling A, Hunter JA. Effect of etanercept on serum amyloid A protein (SAA) levels in patients with AA amyloidosis complicating inflammatory arthritis. *Clin Rheumatology* 2008; 27:923–5.

BOSWELL AND ST KILDA

Sir,

The excellent article on the St Kilda boat cough (Stride P. The St Kilda boat cough under the microscope. *J R Coll Physicians Edinb* 2008; 38:272–9) deals extremely well with all aspects of the problem, but it might be worth noting that the subject did reach a wider audience through being mentioned in perhaps the most famous biography in the English language, James Boswell's *Life of Johnson*. In it, the boat cough is mentioned twice. In one of these references, Boswell relates that Macaulay had asked him as a point of principle whether he should include in his book something he genuinely believed to be true, even though it would make him the subject of ridicule, referring to the account of the boat cough. Boswell encouraged him, and Johnson praised Macaulay's 'magnanimity' for this.

Earlier Johnson and Boswell had discussed the matter. The former said: 'Macaulay… wanted to be thought a smart modern thinker, and yet affirms for a truth that when a ship arrives there all the inhabitants were seized with a cold.'[1]

An alternative theory – from the late Reverend Mr Christian of Dorking – is put forward, that a northeast wind which is necessary for ships to land brings an 'epidemick cold', and one gets the impression that both Johnson and Boswell consider this a much more sensible explanation than absurd theories about contagion ascribed to a 'Dr John Campbell, the celebrated writer'.

It should also be remembered that Johnson was a High Anglican with a strong prejudice against the Church of Scotland. This may explain some of his hostility to Macaulay.

It is interesting that in the eighteenth century men of learning still considered themselves competent and were expected to pronounce on any subject, there not being as yet a separate scientific discipline. Even undoubtedly great intellects were not immune to the human tendency to accept more readily opinions in conformity with their established beliefs.

Gillon C Ferguson
Retired Consultant Physician, Northampton

Reference

1 Boswell J. *The life of Samuel Johnson LL. D.* Everyman's Library, in two vols. London: Dent, 1949. p.345

THE DIRECTION OF THE COLLEGE

Sir,

I recently received two separate letters asking me to contribute to a College Library Appeal, and an advertisement for the appeal appeared in Issue 2 of the *Journal*. The College can be justifiably proud of its library, but it was not clear to me why the library needs support beyond that supplied by the College itself, and how much financial support is required. Furthermore, it was not clear whether the appeal came from our President, the Council or the College Library Committee.

Additionally, this appeal raises fundamental questions regarding the present function of the College. I find it hard to understand why a forward-looking Royal College should place such emphasis on maintaining what is a historical library rather than an educational tool. Our forefathers created the library by generously gifting books to promote knowledge of medicine, but medical education has moved on, aided by the development of new communication systems, including the internet. I would suggest that if the overriding College priority in the twenty-first century is the enhancement of a historical library, then the College has lost its way. The practice and organisation of medicine is changing rapidly all over the world, and if our College is to maintain its role as a leader in promoting clinical excellence, our Fellows and Collegiate Members will need to consider College priorities carefully and actively.

The capacity to communicate has never been better, or quicker. I suggest all means at our disposal should be used now to determine where our College should be going and, consequently, where its priorities should lie.

John Munro
Retired Consultant Physician, Musselburgh

President's response:

I strongly agree with Dr Munro that the College should be focusing on twenty-first century educational content and methods. Indeed, this is precisely what we are doing. Thus Council agreed that the College's core resources should be used to support our priority areas of training, education and support of Fellows and Members rather than supporting our historical library. This is in line with views expressed by Fellows and Members in our recent electronic survey, where 80% plus rated as very important or important training, education, MRCP(UK) and representing the views of Fellows and Members, but the Library and the History of Medicine was rated as very important or important by only 50%. Nevertheless our heritage is clearly important, and so Council agreed that the 326 years of printed medical material should be retained and maintained but funded independently to release funds for other priorities. Thus an appeal was needed, and it was recognised that external donors would need to see that Fellows and Members had contributed, hence the letter to Fellows.

Neil Douglas
RCPE President

Honorary Librarian's response:

Since the President has replied to Dr Munro's comments about the College's priorities and explained why an appeal is necessary to provide funds – which the College is no longer in a position to provide – for the maintenance and development of the historic library collections, the specific purpose of the appeal, let me simply add some details.

Part of the College's duty as a registered charity is to make appropriate provision for the care and conservation of material that it owns which forms part of the national heritage; we also have a duty to make such material available for consultation by the public, and to interpret it to the public, as far as this is possible.

But there are considerations beyond that. It is indisputable that the Library can no longer provide a source of up-to-date technical information about current medical practice – indeed, no traditional library can now do this. But the practice of medicine involves more than up-to-date technical expertise; and knowledge of the historical development of medicine and the problems and aspirations of our predecessors is a valuable means of humanising what can only too easily be seen as just a technical exercise.

Dr Munro is correct that our predecessors gave many books to the Library; but the Library bought a great many more books on behalf of the College. Our collections are unusual in having been formed over the centuries to provide a contemporary working library for our Fellows (and, later, Fellows and Members). Since the collections have grown along with the growth of medicine, we now have a Library that provides both a wide overview and a huge amount of detail of the practice of medicine over more than 300 years. This is in contrast to many (fine) collections which are just that, items collected post hoc to illustrate the history of medicine. No matter which detailed aspect of medicine and its practice over three centuries one selects, the chance of finding in the Library's collections material relevant both in breadth and depth is very high. This means that the Library is a major scholarly source for historians of medicine; it is a world-class resource.

There is another point about funding. The Library's development and exploitation of its collections commands academic respect as is shown by our ability to attract successive grants from external bodies – notably the Wellcome Trust – won in competition with other, often much better funded, organisations. But such grants are inevitably for very specific pieces of work (for example, recently, the complete cataloguing of our unique collection of Sir James Y Simpson's pamphlets and of our Victorian collections) and they cannot provide support for the core infrastructure – all that routine expenditure without which the Library cannot continue to seek external funding and indeed cannot continue at all.

The College commands much affection from its Fellows and Members, and a considerable object of that affection is the Library and its historical collections, as is shown by the generosity of the Fellows in donating more than £100,000 so far to our appeal. Thus we are now in a position to extend the appeal to a wider public. The College has long used the Library as a major part of its public face, and it stands to gain considerably from an increase in the very positive publicity which the Library generates.

Finally, the authority for the appeal. It is surprising that Dr Munro was unclear about the source of the appeal since one of the letters he mentions was signed both by the President and by Sir John Crofton, a most distinguished past President, and the other was a personal letter from Sir John and Dr Morrice McCrae, which went only to Senior Fellows. He may rest assured that the appeal enjoyed the prior approval, and enjoys the continuing active support, both of Council and of the Library Committee, which recommended it to Council.

IML Donaldson
Honorary Librarian, RCPE