Since the discovery of campylobacter enteritis in the 1970s (Dekeyser et al., 1972; Skirrow, 1977) this disease has emerged as the most frequent cause of infectious diarrhoea—with the possible exception of rotavirus. Interest in the genus Campylobacter was revived, and improved laboratory methods led to the description of several new species. C. jejuni, and less commonly C. coli, cause campylobacter enteritis, but C. fetus subsp. fetus is the type species of the genus. C. fetus is mainly of veterinary importance but is an uncommon cause of systemic infection in debilitated or compromised patients. C. laridis (Benjamin et al., 1983) is found as an intestinal commensal of seagulls, although it has occasionally been isolated from the faeces of patients with diarrhoea, and once from blood (Tauxe et al., 1985). C. cinaedi and C. fennelliae are two new campylobacter species associated with proctitis in homosexual men (Totten et al., 1985) though their pathogenicity is not established, C. sputorum and the recently described C. concisus are apparently commensals found in the gingival crevices (Tanner et al., 1981). The discovery of C. pyloridis in the gastric mucosa of patients with histologically confirmed gastritis has aroused great interest amongst gastroenterologists because of its possible role in the cause of peptic ulcer disease.

In England and Wales in 1985, almost 24,000 laboratory isolations of C. jejuni and C. coli were reported to the Communicable Disease Surveillance Centre (CDSC), London, (unpublished). Of course, this figure represents only a small proportion of the total number of infections as only about one in five patients is likely to contact his doctor (Mentzing, 1981). In most cases campylobacter enteritis is a self-limiting illness that lasts about five days (Mentzing, 1981) and is characterized by diarrhoea (often with blood), abdominal pain, nausea, headache, fever, and myalgia (Skirrow, 1984). Only a small percentage require hospital admission; seven in a waterborne outbreak affecting 2000 people in Sweden (Mentzing, 1981) and 14 of 2500 children affected in a milkborne outbreak in Britain (Jones et al., 1981). Bacteraemia is also rare; it was recorded in 40 of the 24,000 cases of campylobacteriosis reported to CDSC in 1985 (unpublished).

The treatment of campylobacter enteritis (caused by C. jejuni and C. coli) should consist of non-specific supportive and symptomatic treatment as for any other case of diarrhoea. Generally speaking C. jejuni and C. coli are resistant to penicillins, cephalosporins (except cefotaxime), trimethoprim, sulphamethoxazole, rifampicin and vancomycin; they are highly susceptible to erythromycin, tetracycline, aminoglycosides, clindamycin and ciprofloxacin; chloramphenicol is moderately active (Vanhoof et al., 1978; Walder, 1979; Fliegelman et al., 1985). The most useful agent for a patient with uncomplicated enteritis is erythromycin. It has the advantage of a narrow spectrum of activity and low toxicity. The stearate, which is acid-resistant, has been widely used because some is converted to the active base in the duodenum, before absorption, where it can exert a direct action on the infecting organism. Erythromycin stearate 500 mg bd. in adults and 40 mg/kg/day for children for five days is recommended in those patients that require treatment. Higher doses should not be given as they are liable to cause acute abdominal pain, and even vomiting.

Resistance to erythromycin has been reported in proportions ranging from less than 1% of strains in the United Kingdom (Telfer Brunton, Wilson & Macrae, 1978) and Canada (Karmali, De Grandis & Fleming, 1981) to 3–8% in Belgium (Vanhoof et al., 1978, 1982), 7.5% in Italy (Figura, Rossi & Marr, 1985) and 17% in Sweden (Svedhem, Kayser & Sjögren, 1981). The latter figure is misleadingly high owing to the choice of cut off point indicating resistance. Almost all erythromycin resistant campylobacters prove to be C. coli.

As an alternative to erythromycin, the tetracyclines are worth considering, but they have the disadvantage of a broad spectrum of activity and they are contraindicated in...
chronic (type B) gastritis. Conversely few with patients with histologically confirmed active and duodenal ulceration has also been present. An association between C. pyloridis normal gastric mucosa have organisms be effective. untried but there is every reason to expect it to life-threatening infections. Ciprofloxacin is first choice for the treatment of patients with (MIC 12-5 mg/1) and this makes gentamicin a gentamicin-resistant strain has been reported patient with campylobacter meningitis full dosage it would be the first choice for a amphenicol is only moderately active but in consideration. As a few strains will be exception to this rule may be the treatment of young children and infants attending day-care centres. Septicaemic and seriously ill patients with C. jejuni/coli infection and all those with C. fetus infection must receive special C. pyloridis infection and all those with C. jejuni/coli. Relapse (rather than reinfection) with C. pyloridis is a problem. Therefore a combination of bismuth salt plus a high dose of an antibiotic such as pivampicillin (which is absorbed through the gastric mucosa) or amoxycillin might be required. The success of bismuth salts in the treatment of duodenal ulceration may be partly explained by their antimicrobial effect. Trials on the treatment of peptic ulceration have shown that bismuth salts give a lower relapse rate than H2 antagonists. As between 60% to 90% of patients with lesions seen at endoscopy have C. pyloridis infection (Marshall et al., 1985; Johnston, Reed & Ali, 1986) it may be appropriate to combine H2 antagonist treatment with an antimicrobial to reduce ulcer relapse. Trials are in progress comparing ulcer relapse rates following treatment with H2 antagonist alone, with H2 antagonist and antibiotic, and with bismuth salt and antibiotic. These results are awaited with interest.
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