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SUPPLEMENT

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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Candida albicans and polyene antibiotics

SIR,—The only fungus regularly associated with vaginal candidosis is *Candida albicans*. Only this species and *Torulopsis glabrata* are associated with pruritus, although other species of *Candida*, including *C parapsilosis*, may occasionally be isolated from the vagina.[1] Reference to "the fungus" in your leading article with vaginal candidosis (14 February, p 357) might then reasonably be supposed to refer to the thrush fungus, *C albicans*, and not to other species. Your editorial comment of 19 June (p 1529) does little, to our minds, to amplify your statement that amphotericin is exceptional among antifungal agents used for treatment of vaginal candidosis in that resistance to it may develop in the fungus. Further, your comments introduce other matter that cannot be substantiated.

It is misleading to suggest that the sensitivity of *C albicans* and other species of fungi to amphotericin B declines on exposure to the drug without elaborating the circumstances. The reference to Csonka,[2] who, in a brief clinical paper comparing the efficacy of amphotericin B and nystatin pessaries in treatment of candida infection of the vagina, deals neither with declining sensitivity to amphotericin nor with comparative minimum inhibitory concentrations (MICs) of the drugs, seems irrelevant.

Resistance to amphotericin occurring naturally is not "comparatively rare"; it is unknown in *C albicans*. Drouhet's report[3] related to a single strain of *C parapsilosis*, a fungus inherently less susceptible to polyene therapy, and his studies showed that the MIC increased both for heptaenes, including amphotericin B, and tetraenes, including nystatin. Resistance can be induced experimentally both to amphotericin B and to nystatin, and you are in error to state otherwise.[4] The observation of reduced sensitivity is of little clinical consequence, since loss of virulence is reported in such strains; moreover, the induced resistance is reversible on withdrawal of the polyene to which the strain has been exposed. Thus there can be no selective breeding of resistant strains.

We know of no evidence that the fungus causing vaginal candidosis (*C albicans*) is ever found naturally to be resistant to amphotericin B (or to nystatin, for that matter) despite the many thousands of isolates scrutinised in diligent searches. The emergence of drug resistance is neither to be expected nor feared on theoretical grounds, for the reasons stated by Stewart[5] in previous correspondence rebutting allegations of nystatin resistance in candida, and it cannot be advanced as a reason for withholding amphotericin B in topical treatment.

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[1] Hurley, R, *et al*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1973, **80**, 253.
[2] Csonka, G W, *British Journal of Venereal Diseases*, 1967, **43**, 210.
[3] Drouhet, E, *Modern Treatment*, 1970, **7**, 539.
[4] Athar, M A, and Winner, H I, *Journal of Medical Microbiology*, 1971, **4**, 505.
[5] Stewart, G T, *British Medical Journal*, 1967, **2**, 57.

Community medicine

SIR,—As a recently appointed district community physician, I can only express profound disappointment that Dr W S Parker (26 June, p 1588, and 7 August, p 367) should consider that community physicians have their hands tied behind their backs. The rising tide of criticism and comment is not in any way surprising when any new concept is introduced into medical practice. But this is no reason for accepting that we are doomed, nor that we are inevitably to be absorbed into a "defective, hospital orientated, lay administrative system."

At a time when so many of our colleagues are so sadly preoccupied with pay-beds and contracts it is the community physician perhaps more than anyone else who may act as an agent of stability in the Health Service. While it has been fashionable to point out the possible demerits of reorganisation (too many tiers, fragmentation from social services, proliferation of administration, etc), mention is seldom made of the real opportunity to provide a fully comprehensive Health Service to everyone within the new framework. Here the district community physician in particular has a key role as usually the only member of the district management team with a truly community perspective. It remains very much up to the district community physicians to strike a balance in the management of the Health Service by fully stating the community point of view. On the planning of the future development of the Service the district community physician is again a key figure as the representative of the district management team on all health care planning teams. Here he has a most excellent opportunity to participate actively in the development of future services. Given good liaison with his consultant, general practitioner, nursing, and