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LEADING ARTICLES

Perforated duodenal ulcer.....	489	Cigarette smoking in pregnancy.....	492
Patients' days.....	490	Cough suppressants for children.....	493
Prostatic cancer: policies for progress.....	490	Hypospadias.....	493
Psoriatic arthritis: to lump or to split?.....	491	Training for the social services.....	494

PAPERS AND ORIGINALS

Mountain sickness, retinal haemorrhages, and acclimatisation on Mount Everest in 1975	CHARLES CLARKE, JIM DUFF ..	495
Co-trimoxazole in prevention of bacteriuria after prostatectomy	N H HILLS, M I BULTITUDE, SUSANNAH EYKYN.....	498
Postoperative hypoglycaemia in small children	STEPHEN WARE, J P OSBORNE.....	499
Completeness of statutory notification for acute bacterial meningitis	M J GOLDACRE, D L MILLER.....	501
Immunoglobulin synthesis in the "resting" breast	J O DRIFE, D B L MCCLELLAND, ANNE PRYDE, M MAUREEN ROBERTS, I I SMITH.....	503
Simplified ECG monitoring with an electrode mat	ANDREW J MACNAB, ROSEMARY POPE.....	506
Seasonal allergic symptoms due to fungal spores	PAUL D BUISSERET.....	507
Prazosin: severe side effects are dose-dependent	CLIVE ROSENDORFF.....	508

MEDICAL PRACTICE

A general practitioner in an ophthalmology accident and emergency department	MARY PRICE, CALBERT I PHILLIPS.....	509
Emergency medical care	HUGH CONWAY.....	511
Statistics at Square One: XV—The χ^2 tests (continued)	T D V SWINSCOW.....	513
Hospital life a century ago	W B HOWIE, S A B BLACK.....	515
Letter from Southern Illinois: Twenty years on	B W MCGUINNESS.....	518
Any Questions?	514, 517, 519
Materia Non Medica—Contributions from JOHN RUSHTON, LEONARD GOODMAN, DENIS GIBBS.....		520
Personal View	H G NICOL.....	521

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CORRESPONDENCE—List of Contents..... 522

BOOK REVIEWS..... 533

NEWS AND NOTES

Epidemiology—Acute viral hepatitis B; Kidney transplants.....	536
Parliament—Health Services Bill: end of committee stage	537
Medical News—Scottish Hospital Advisory Service reports	538

OBITUARY NOTICES..... 535

SUPPLEMENT

Juniors' contract dispute—HJSC plans 24-hour strikes; Letter from Mr Ennals.....	540
Pressures of work on doctors and family	CELIA OAKLEY 541
GMC: Disciplinary Committee.....	543
Hospital Junior Staffs Committee.....	543
Evidence to the Royal Commission.....	544

CORRESPONDENCE

Candida albicans and polyene antibiotics Rosalinde Hurley, MRCPATH, and J T Wright, MB.....	522	Inaccessible specialist H B Wright, FRCS.....	526	Marital urinary infection Lieutenant-Colonel B Simpson, FRCPED....	529
Community medicine J G Avery, MB; R B Robinson, MFCM; M S Rigler, MB.....	522	Fetal transfusion syndrome D Fried, MD, and A Chanukoglu, MD.....	526	Alpha-fetoprotein in amoebic liver abscess M Damisah, HND, and others.....	529
Thyrototoxic vomiting M Saarni, MD, and E Koivunen, MD; T Kiernan, MD, and M McElligott, FRCPI....	523	Carpal tunnel syndrome and tennis elbow C F V Murray-Leslie, MRCP, and Verna Wright, FRCP.....	526	Oral irritation with gentian violet P Horsfield, DCH, and others.....	529
Management of diabetic pregnancy D A Pyke, FRCP, and others.....	524	Fear of ECT M A Simpson, MRCPsych.....	526	Platelet and coagulation studies in patients treated with bromocriptine J Conard, MD, and others.....	529
Urinary retention in women R Hole, FRCS; G J Jarvis, BM.....	524	Oesophageal cancer R E Lea, FRCSed.....	527	Atmospheric pollution by anaesthetic agents D A B Hopkin, FFARCS.....	530
Abortion and maternal deaths C Brook.....	524	Preventive nutrition R Y Taylor, MFCM.....	527	Hazards of smallpox vaccination G T Watts, FRCS.....	530
Meditation or methyldopa? P G F Nixon, FRCP, and D H Dighton, MRCP.....	525	The placenta as an immunological barrier R Finn, FRCP, and others.....	527	United profession J R Caldwell, MB; G S R Little, FRCGP; J F Gould, FRCSed.....	530
Consent and intrauterine contraception Sir Norman Talbot, FRCOG.....	525	Cold extremities and beta-blockers D B Trash, MRCP, and others.....	527	Plight of the younger consultant surgeon P J B Smith, FRCS, and F D Skidmore, FRCS..	531
Uraemic bullae G A Coles, MD, and Kate Verrier Jones, MRCP.....	525	Doctors, contraception, and sterilisation P W Lambden, MB.....	528	Medical manpower and hospital staffing F S A Doran, FRCS.....	531
Myocardial bleeding in haemophilia D J B Thomas, MRCP, and others.....	526	Cardiac failure N Pascal, MD.....	528	Prescription charges J T Hart, FRCGP.....	531
Hypophosphataemic osteomalacia in patients receiving haemodialysis K Y Ahmed, DM, and others.....	526	"Pastoral Paediatrics" H G Calwell, MD.....	528	Consultants' increments R A Wood, FRCPED.....	531
		Epilepsy and the pill A P K John, BM.....	528	Juniors' contract dispute D Hall, MB.....	532
		Management of sexual dysfunction Marion Swan, MB, and L J Wilson.....	528	Industrial action Mary J O'Sullivan, MRCS.....	532
		Out-of-hours calls in general practice M J Aylett, MRCP.....	529		

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 report³ 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 Stewart⁵ 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