

BRITISH MEDICAL JOURNAL



U. S. DEPT. OF AGRICULTURE
NATIONAL AGRICULTURAL LIBRARY

SATURDAY 7 SEPTEMBER 1968 OCT 1 1968

LEADING ARTICLES

Management of Endocrine Ophthalmopathy page 565 Toxic Substances in Endotracheal Tubes page 566 General-practitioner Obstetric Units page 567 Life as a Haemophiliac page 567 Sewage from Boats page 568 Probenecid and Renal Failure page 569 Löffler's Syndrome page 569 Axillo-femoral Bypass page 570 Cardiovascular Surgery page 570

PAPERS AND ORIGINALS

Long-term Anticoagulant Therapy after Myocardial Infarction in Women
CHR. F. BORCHGREVINK, CHR. BJERKELUND, A. M. ABRAHAMSEN, G. BAY, P. BORGES, B. GRANDE, I. HELLE, H. KJÖRSTAD, A. M. PETERSEN, T. RÖRVIK, R. THORSEN, AND A. ÖDEGAARD 571

Effects of Asbestos in Dockyard Workers GEOFFREY SHEERS AND ANN R. TEMPLETON..... 574

Chloroquine: Ophthalmological Safety, and Clinical Assessment in Rheumatoid Arthritis
S. P. B. PERCIVAL AND I. MEANOCK..... 579

Nephrotic Syndrome with Heart Disease: A Reappraisal P. J. HILTON, N. F. JONES, AND J. R. TIGHE..... 584

Effect of Neostigmine on Integrity of Ileorectal Anastomoses C. M. A. BELL AND C. B. LEWIS..... 587

Immunological Studies in Arteritis of the Aorta and Great Vessels R. A. ASHERSON, G. L. ASHERSON, AND V. SCHRIRE... 589

Value of Estimating Methylmalonic Acid Excretion in Anaemia A. E. GREEN AND G. D. PEGRUM..... 591

PRELIMINARY COMMUNICATIONS

Effect of Disodium Cromoglycate on Exercise-induced Asthma S. E. DAVIES..... 593

Hyperpyrexia During Anaesthesia G. G. HARRISON, J. F. BIEBUYCK, J. TERBLANCHE, D. M. DENT, R. HICKMAN, AND S. J. SAUNDERS 594

MEDICAL MEMORANDA

Congenital Absence of the Lumbar Spine R. G. REDHEAD, M. VITALI, AND DAVID H. TRAPNELL 595

MIDDLE ARTICLES

The Patient and the X-ray Department
A. A. WILD AND J. EVANS..... 607

Practical Method of Drug Administration in a Peripheral Hospital
W. J. H. LECKIE AND H. CLANSEY..... 609

New Appliances
Punch for Biopsy Examination of Nerve Endings in Skin 612

Personal View GRIFFITH EDWARDS..... 613

BOOK REVIEWS 604

NEWS AND NOTES

Motoring 626

Epidemiology 627

Medical News 628

CURRENT PRACTICE

Drowning STANLEY MILES..... 597

Today's Drugs Management of Patients with Upper or Lower Urinary Tract Infection..... 600

Any Questions ? 603

CORRESPONDENCE 614

OBITUARY NOTICES..... 621

SUPPLEMENT

Scotland's Green Paper..... 105

Was it a Drug ?..... 105

Correspondence

Letters to the Editor should not exceed 500 words.

"Five-day Courses" and Respiratory Infections. A. F. Foster-Carter, D.M.	614
Subdural Haematoma and Effusion in Infancy. M. A. Falconer, F.R.C.S.	614
Infection Risks of Haemodialysis. S. Shaldon, M.D.	614
Hepatitis-free Plasma Protein Solution. N. A. Matheson, F.R.C.S.	615
Waiting for Doctor. D. J. P. Gray, M.B.	615
Macrolides and Lincomycin. A. M. Geddes, M.R.C.P.ED.	616
Kwok's Quease. W. M. L. Turner, M.D.; P. A. Andersen, M.B.	616
Preservation of Independence. P. A. T. Wood, M.B.	616

Declaration of Sydney. W. A. Cobb, M.R.C.S.	616
Penicillin-induced Haemolytic Anaemia. Mary A. Rossiter, D.C.H., and others.	616
Gas Mixtures for Calibration. E. J. M. Campbell, F.R.C.P., and Helen M. Pope.	617
Hereditary Quivering of the Chin. Rosemary J. Simpson, M.B.	617
Cerebral Malaria. R. G. Oriscello, M.D.; D. H. Smith, D.T.M.&H., and P. S. Harper, M.R.C.P.	617
Intraperitoneal Blood Transfusion. Major D. E. Bradford, M.R.C.P.ED.	618
Doctor or Social Worker? Mary E. Brennan, D.C.H.	618

Purgatives and the Colon. F. H. Askew, M.P.S., and G. F. Somers, D.Sc.	618
Headache on the Pill. Aviva Wiseman, M.R.C.S.; Ellen C. G. Grant, M.B., and Eleanor Mears, M.B.	619
Propranolol in Myocardial Infarction. A. Gedeon, M.D.; K. Hazell, F.R.C.P.ED.	619
Diagnostic "Labelling." A. P. Bray, F.F.A.R.C.S.	620
Hospital Career Structure. N. V. Williams, D.P.H.; J. H. M. Walker, F.R.C.S.	620
Secret Merit Awards. V. Marks, M.R.C.P.ED.	620
Medical Assistant Grade. G. R. G. Mackarness, D.P.M.	620

"Five-day Courses" and Respiratory Infections

SIR,—Last week one of the leading pharmaceutical companies sent a postal advertisement to the medical profession announcing that their range of penicillins was being marketed in liquid form. The heading reads, "One bottle stays the prescribed course," and the leaflet explains that "this development reflects current medical thinking that, for maximum benefit, a course of antibiotic therapy should be of at least five days' duration." This statement, coming from what may be regarded as an authoritative source, cannot be allowed to pass unchallenged. Notwithstanding the sophisticated insertion of the words "at least," the general purport of the advertisement is designed to reinforce the widespread and dangerous misconception that antibiotics should be prescribed in limited courses.

I have never been able to discover how this idea of a "five-day course" originated, but when applied to the treatment of respiratory infections it is responsible for a great deal of unnecessary illness and avoidable hospital treatment. Time and again a patient suffering from acute bronchitis or upper respiratory infection is given five days' supply of antibiotic tablets and is told by his doctor that this is a "five-day course." Consequently, when the tablets run out the patient ceases to take the antibiotic, regardless of his condition at the time, and a few days later he has to be admitted to hospital with pneumonia. Also the dosage given in such "courses" is often inadequate. Usually 250 mg. of tetracycline or ampicillin four or even three times daily is prescribed, when 500 mg. q.d.s. may well be necessary—at least for the first day or two—depending upon the severity of the infection.

An additional danger lies in the fact that when a patient is receiving an antibiotic his sputum is almost always free from pathogens, whether the antibiotic is controlling the infection or not, and this effect often persists for some days after the withdrawal of the drug. Consequently when he is admitted to hospital it is usually impossible to identify the causal organism and study its antibiotic sensitivity.

The conception of an antibiotic "course," whether of five or any other number of days, is completely illogical. Once started, an antibiotic should only be stopped when there is good evidence that the infection has been eliminated. When an antibiotic is prescribed for a respiratory infection the doctor should always arrange to see the patient again before the tablets run out. He should then decide by the usual criteria (control of symptoms, presence or absence of purulent sputum, fever, or leucocytosis) whether or not to continue the treatment. The risk of continuing an antibiotic, if necessary for several weeks, is negligible compared with the risk of a serious recrudescence of the infection if it is stopped too soon.—I am, etc.,

A. F. FOSTER-CARTER.

Brompton Hospital,
Frimley Branch,
Surrey.

Subdural Haematoma and Effusion in Infancy

SIR,—Mr. Kenneth Till, in reporting his observations in 116 infants, claims that treatment by subdural pleural shunt is preferable to the older method of removal of the subdural membrane by craniotomy (17 August, p. 400). However, in presenting his data has he really shown this? I submit that he has not, and that the matter is still *sub judice*, largely because his observations lack proper controls.

In his Table IV he compares two nearly equal groups of children treated in these ways, and writes that in the group treated by a shunt operation "a higher proportion were found to develop with normal intelligence, although the follow-up period for these patients was shorter." Yet the two groups are not comparable, for they have not been matched case for case for controls. Presumably the average age of the infants in both groups at the time of operation was 5 to 7 months, and yet the group of 42 infants treated by craniotomy alone were followed up

for an average of 5 years and 4 months, indicating that their average age at the time of assessment was 5 years 10 months. In contrast, the group treated by subdural pleural shunt contained 34 infants, who were followed up for an average period of only 1 year 6 months. This would make the average age of these infants at the time of assessment at just 2 years.

How can one therefore make a valid comparison between two groups of children, one assessed at an average age of just 2 years (the shunt group) and the other assessed at an average age of 5 years 10 months (the craniotomy group)? This, however, is what the author has done, and he infers that in the shunt group assessed at an average age of just 2 years 86% were of normal intelligence, none was educationally subnormal, and 11% were ineducable; whereas in the craniotomy group assessed at an average age of 5 years 11 months 66% were of normal intelligence, 21% were educationally subnormal, and 7% were ineducable. I submit that these are not valid statistical comparisons.—I am, etc.,

MURRAY A. FALCONER.

Guy's Maudsley
Neurosurgical Unit,
London S.E.5.

Infection Risks of Haemodialysis

SIR,—I have read with interest the report of the working party to the Public Health Service on prevention of spread of infection in haemodialysis units (24 August, p. 454). Although I have had seven years' experience of maintenance haemodialysis and have been responsible for the treatment of over 70 patients, I do not feel sufficiently qualified to comment on the remarks on hepatitis, as I have seen this occur only once in a patient in over 100 patient-years with this form of treatment. In spite of this, it may be of some interest for you to note that I have never employed any of the precautionary methods recommended by the committee to prevent the spread of hepatitis, but instead have avoided the use of blood transfusions,¹