matitis that has been rather neglected in the past. It also emphasized the importance of obtaining a full environmental history on patients with complaints involving the skin or mucosae and of proving an allergic cause by patch testing.

We hope that our findings will be published in full in the near future.—We are, etc.,

V. KIRTON
D. S. WILKINSON

Wycombe General Hospital,
High Wycombe, Bucks.

### Deputizing Services

SIR,—With reference to Dr. I. P. F. Mungall's comment (31 March, p. 799) on the calculation by Dr. B. T. Williams and others (10 March, p. 593) that 92% of night calls in Sheffield were handled by the deputizing service, the latter authors gave reasons why they thought this to be an overestimate. I can confirm that this figure bears no relation whatever to reality. I have personally made innumerable night calls and submitted a claim form on one occasion only. Like most other family doctors, I dislike thoroughly the idea of asking a sick patient or his anxious relatives to confirm my claim that I have actually paid him a visit and therefore do not ask them to do so.—I am, etc.,

H. M. HALLE

Sheffield

### Advertising of Antibiotics

SIR,—We are concerned about the content of current advertisements for antibiotics, some of which have appeared in the *B.M.J.* A recent example is an advertisement for amoxycillin (Amoxil), which is being recommended for the treatment of throat infections in spite of the fact that the large majority of these conditions, if of bacterial aetiology, are caused by *Streptococcus pyogenes* for which benzylpenicillin is the antibiotic of choice. Further, amoxycillin is closely related to ampicillin (they differ only by an OH group), a fact not mentioned in the advertisement, and it is now well recognized that ampicillin is contraindicated in glandular fever, a common cause of sore throat, because of the frequent occurrence of skin rash. Many other advertisements for amoxycillin have also failed to mention its close similarity to ampicillin, which includes an identical antibacterial spectrum. Doctors could be misled into believing that ampicillin and amoxycillin are different compounds and therefore prescribe amoxycillin for infections which have failed to respond to ampicillin. Professor Garrod[1] has recently drawn attention to the consecutive prescribing of chloramphenicol under two different trade names.

Ceporex, one of the two forms of cephalexin sold in Britain, has recently been extensively advertised for the treatment of bronchitis in spite of the fact that the most important bacterial pathogen in exacerbations of chronic bronchitis is *Haemophilus influenzae*, an organism which is frequently relatively resistant to cephalexin.

Two pharmaceutical companies have recently introduced a new oral cephalosporin called cephradine (Eskacef; Velosef). It is claimed that it is effective in eradicating penicillinase-producing staphylococci in spite of the fact that the minimum inhibitory concentration of this organism for cephradine is said to be 18·7 $\mu$g/ml while the mean peak serum concentration following the recommended dose of 500 mg is stated to be 11 $\mu$g/ml. If these facts are true then in our opinion penicillin-resistant staphylococci are, for practical purposes, resistant to cephradine. In the advertising booklet produced by one of the companies marketing this antibiotic the sensitivity to cephradine of various organisms, including penicillinase-producing staphylococci, is compared only with those of ampicillin, tetracycline, and chloramphenicol. Surely it is now universally accepted that chloramphenicol should not be prescribed systemically for conditions other than typhoid fever or severe haemophilus infections, and it would therefore seem inappropriate to include this antibiotic in such a comparative table. It would have been much more useful to compare the sensitivities of organisms to cephradine with those to penicillin, cloxacillin, lincomycin, co-trimoxazole, and the other cephalosporins.

The tetracyclines are contraindicated in children and in pregnant women because of their staining and possible hypoplasia-producing action on developing teeth. In spite of this, recent advertisements for doxycycline (Vibramycin) include obstetric and gynaecological infections among the indications for this antibiotic; the paediatric dosage is also prominent. The advertisement does mention the side effects of the antibiotic, but the dental implications are not spelled out in detail.

We recognize the necessity for these advertisements and have no objection to healthy competition between pharmaceutical companies. We would, however, urge their medical departments to curb the enthusiasm of commercial colleagues in the content of their promotional literature.—We are, etc.,

J. D. WILLIAMS

Dudley Road Hospital,
Birmingham

A. M. GEDDES

East Birmingham Hospital

1 Garrod, L. P., *British Medical Journal*, 1972, 4, 473.

### Anticoagulants after Mitral Valvotomy

SIR,—In a leading article last year (11 March 1972, p. 641) you discussed my full use of anticoagulants in patients with mitral valve disease not needing surgery.[1] You also mentioned operation under cover of anticoagulants—a practice which I have long followed.

It had not been my practice to use anticoagulants after successful valvotomy, as suggested in your leader. Because of your recommendation I have reviewed the systemic emboli occurring postoperatively in my patients. In the 12-year period from 1960 to 1972, 285 patients have had mitral valvotomy. In this group there have been noted 17 cases of systemic embolism. These have occurred from one to 12 years after operation. Six of the patients were in sinus rhythm. The group was far from homogeneous and the numbers were much too small for statistical analysis. In a number of cases there were also contraindications to the use of anticoagulants. Only three patients retained the result of a good mitral valvotomy and had systemic embolism.

Analysis of individual cases suffering postoperative systemic embolism suggested that the majority came under the following headings: (1) poor valvotomy because of the pathology of the valve; (2) considerable mitral incompetence; (3) considerable cardiomegaly; (4) considerable valve calcification; (5) re-stenosis; and (6) a group of patients who seemed to be particularly prone to embolism. It is therefore now going to be my practice to anticoagulate only these particular groups of patients and not patients who have had a successful mitral valvotomy with atrial appendicectomy.

Numbers are too small to allow valid conclusions to be drawn, but it did appear that in the postoperative group the recovery from even quite large cerebral emboli was better than in the preoperative group.—I am, etc.,

HUGH A. FLEMING

Papworth Hospital,
Cambridge

1 Fleming, H. A., and Bailey, S. M., *Postgraduate Medical Journal*, 1971, 47, 599.

### Fashions in Duodenal Ulcer Surgery

SIR.—In your leading article (10 March, p. 563) you rightly take a cynical view of the claims made for each new operation for duodenal ulcer. It should be pointed out, though, that recent trends represent a retreat from former over-enthusiasms.

Starting with simple, revocable gastroenterostomy, attempts to raise the cure rate led to partial gastrectomy and ultimately to vagotomy combined with gastrectomy. As you point out, only three of Dragstedt's first 15 patients required additional surgery to relieve gastric retention following truncal vagotomy, yet the addition of a "drainage" procedure soon became routine, even though the majority of patients do not require it and may be harmed by it.

As a former seeker after 100% effectiveness through vagotomy combined with mucosal antrectomy,[1] I changed some three years ago to proximal gastric vagotomy without "drainage." I did so not because I believed the new operation to be better, but because it seemed to be the least assault upon the patient. Its safety makes Mr. J. F. Newcombe's report of a fatality (10 March, p. 610) unique. I accept that the operation will fail unpredictably in some patients, but other procedures can be added if, and only if, the patients display their need for them. Out of 63 patients treated I have so far had to re-operate on only one for recurrent ulcer and one for gastric retention. I regret the extra operation on these two patients but am overwhelmingly more relieved at sparing the other 61 patients an unnecessary procedure that might be harmful and irrevocable.—I am, etc.,

JERRY KIRK

London W.1

1 Kirk, R. M., *American Journal of Surgery*, 1972, 123, 323.

### Contraceptives on the N.H.S.

SIR,—The addition of family planning to the services to be provided by the general practitioner under the N.H.S. has so far been greeted by complete silence, possibly because