

TO-DAY'S DRUGS

Capreomycin

Capreomycin is a new antibiotic with anti-tuberculous activity which is undergoing clinical trial in various countries in Europe as well as in the U.S.A. On 15 January a symposium was organized by the manufacturers, Lilly Research Laboratories, at which European physicians discussed its possible significance and clinical usage. The meeting was held at the Royal Society of Medicine.

Ethical Problems

The chair was taken by Professor J. G. SCADDING (London), who in his opening remarks spoke of the great difficulty nowadays of carrying out trials of new antituberculous agents, since the initial treatment had become so effective and standardized that it was hard to find ethical justification for using a new drug except in heavily resistant cases. Each investigator was likely to have only a small number of such patients, and it therefore became important, at such a meeting as this, to pool the available experience. He was followed by Dr. E. M. SPROSTON, of Eli Lilly, who spoke of the dilemma of the pharmaceutical houses; despite the difficulties described by Professor Scadding they were nevertheless required to collect information for bodies such as the Committee on the Safety of Drugs before a drug could be marketed. Dr. T. M. WILSON (Manchester) described his experience with 22 patients treated with Capreomycin. Ten of these were drug-resistant to almost all other forms of therapy and the other 12 had been taken off conventional treatment because of allergic reactions. In all cases Capreomycin had been combined with other drugs, such as ethionamide, isoniazid, or P.A.S. The maximum period of follow-up was 15 months, and while it was too early for a final assessment the results appeared to be encouraging. Sputum conversion had occurred in all patients who

had had over four months' treatment, and resistance to Capreomycin had developed in only one case. No toxic effects had occurred, but eosinophilia had been noted in six of the patients.

In-vitro Studies

Two reports of *in-vitro* studies followed. The first was by Dr. L. G. BRUCE (Glasgow), who recorded good *in-vitro* action against the tubercle bacillus, which in his experience seemed to suggest better results than occurred in clinical practice. Dr. Bruce's talk was recorded, since he had been prevented by illness from attending. Dr. NOEL RIST (Paris) described studies on cross-resistance. Capreomycin *in vitro* was highly cross-resistant with both kanamycin and viomycin. In his opinion it should only be used as a "second-line" drug, in combination with two other drugs, and in maximal dosage.

Clinical Reports

Dr. P. H. BRAUN (Davos) described a trial in which he had treated 30 cases of fresh open-lung tuberculosis with Capreomycin; 25 of the patients had Capreomycin alone. Conversion of sputum and improvement in the x-ray picture occurred in just under half the patients. A less encouraging report was read by Professor G. GUNELLA (Bologna), who, after finding the antibiotic to be potent against tubercle bacilli *in vitro*, had treated 15 resistant cases without either sputum conversion or clinical improvement.

Other reports by Drs. K. M. CITRON (London), H. W. G. LOUDON (Croydon), J. MACNAMARA (Edinburgh), C. J. STEWART (Ipswich), and A. PINES (Ware Park) described small numbers of patients, all highly resistant to conventional therapy, in whom Capreomycin had been tried together

with other antituberculous agents. The paucity of larger series reflected the uncertainty in the United Kingdom about the ethical position which had been voiced by Professor Scadding in his introduction. This was expounded in more detail by Dr. P. A. EMERSON (London) when he described the work of the clinical trials subcommittee of the British Tuberculosis Association. The rigid view that it was not ethically justifiable to use a new antibiotic as a "first-line" drug in clinical trials was contested by Dr. L. MILLER (London), who thought it might be justifiable to give such a drug for a few weeks, with the patient's full understanding and agreement. Professor J. W. CROFTON (Edinburgh) was inclined to agree with this. The question of carrying out trials in developing countries was also raised. Dr. J. R. BIGNALL (London) closed this part of the discussion by suggesting that there might be an indication for an international body for the organization of clinical trials on tuberculosis, possibly controlled by the World Health Organization.

Finally a review of the work on Capreomycin to the present date was given by Dr. F. LATHAM (Eli Lilly). It was plain that this was an interesting drug and one which might one day have a value in the treatment of resistant tuberculosis. So far, however, it had not reached the stage of commercial marketing and it was not possible to predict with any certainty what its eventual future might be.

Correction.—In the article on Drugs and the Treatment of Gout (16 January, p. 174) we referred to a publication which reported good results with indomethacin in a dosage of 100 mg. three times daily. We are informed by the manufacturers (Merck, Sharp, and Dohme) that this dosage referred to a compressed-tablet formulation which has since been withdrawn owing to unpredictable absorption rate. The drug is now marketed in capsules and the recommended dose for acute gout is 2×25 mg. capsules three times a day until signs and symptoms subside.

ANY QUESTIONS?

We publish below a selection of questions and answers of general interest.

Atropine Premedication in Glaucomatous Patients

Q.—Should atropine be omitted in pre-medication for anaesthesia in patients suffering from glaucoma? If so, what alternative is there?

A.—There is no risk in the administration of atropine parenterally in the usual therapeutic dose range to patients suffering from chronic wide-angle glaucoma. However, in those patients with a history of angle-closure glaucoma the risk is slight. It would therefore be wise to ensure miosis by the instillation of physostigmine into the conjunctival sac before the administration of atropine as part of premedication.

Electrocautery for Plantar Warts

Q.—Is treatment by electrocautery suitable for plantar warts, and, if so, is there any particular type of cautery that should be used?

A.—The electrocautery is not a satisfactory device for the treatment of plantar warts. It is very difficult to judge the depth of the lesion in an intact wart. Some dermatologists like to use the electrocautery after the wart has been removed by curettage. However, when this is done healing takes longer, the risk of secondary infection is greater, scarring may eventually result, and it is not certain that the cure rate is any better than with curettage alone.

There does not therefore seem to be any decisive advantage in using the electrocautery, although some dermatologists prefer to do so. The ordinary instrument at a dull-red heat is used, and a local anaesthetic is necessary.

Herpes Gestationis

Q.—What advice on future pregnancies should be given to a woman whose first pregnancy was complicated by herpes gestationis near term, though the baby was healthy when born?

A.—Herpes gestationis tends to recur in subsequent pregnancies, though it does not always do this. When it does, however, the tendency is for it to manifest itself earlier in each subsequent pregnancy. With modern treatment using corticosteroids as advised by Russell and Thorne¹ and Vickers² the situation will be kept under control and there will