vestigations were all normal except for an E.S.R. of 88 mm/hour. In view of the normal temperature and white cell count the patient was observed and the hip returned to normal over four days.

The second patient was a woman aged 42 years with a similar negative past and present medical history and clinical findings. The major site of pain was above the greater trochanter and the hip fixed in a similar position. The onset of pain had occurred slightly under twelve hours prior to admission. Investigations were all normal except for an E.S.R. of 15 mm/hour. In view of the experience with the first patient, the negative clinical findings other than those relating to the right hip, and negative investigations, this patient was also observed and the symptoms and signs settled in a similarly short time. No antibiotics or other medicament were prescribed in either case.

It is suggested that both patients suffered from the same condition. Had both patients been children it is suggested that they would have been considered to have been exhibiting the classical features of observation hip. As in the childhood condition no aetiological factor was demonstrated, nor is one suggested. It may be considered that there is at least a case for conservatism in the adult in what might otherwise, on the clinical findings, be considered bacterial arthritis of the hip.—We are, etc.,

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- 1 *Joints and their Diseases*. London, British Medical Association, 1970.
- 2 Bradford, E. H., *American Journal of Orthopaedic Surgery*, 1912, 9, 354.
- 3 Miller, O. L., *Journal of the American Medical Association*, 1931, 96, 575.
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- 5 Borella, L., Goobar, J. E., Summitt, R. L., and Clark, G. M., *Journal of Pediatrics*, 1963, 62, 742.
- 6 Eyre-Brook, A. L., *Journal of Bone and Joint Surgery*, 1960, 42B, 11.
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Bacterial Assay of Urine

SIR,—The dip-slide technique for bacterial assay of urine has been found to be a competent method for isolating the usual organisms responsible for urinary tract infection.¹ Being a simple device, reliable in transport, and commercially available, it would appear to be an ideal method for field detection of urinary salmonella carriage. We therefore compared the capacity of the Uricult dip-slide system (Orion Pharmaceutical Company, Helsinki, Finland) with routine laboratory methods for isolating salmonella from urine.

Morning urine specimens were planted, with a cotton swab, on to bismuth sulphite, SS, and MacConkey agar plates directly, and after overnight enrichment at 37°C in an equal volume of selenite broth. All plates were incubated at 37°C for up to 48 hours. The Uricult dip-slide was inoculated from a urine sample that had been enriched by overnight incubation at room temperature in an equal volume of selenite broth. The Uricult was then itself incubated for 24 hours at room temperature.

One hundred and forty-five specimens from 43 subjects were assayed by both routine and Uricult techniques. *S. typhi*

was isolated from six specimens taken from one patient and *S. paratyphi* A was isolated from 20 specimens taken from four patients by both routine and Uricult methods. The remaining specimens were negative for salmonella by both techniques. These data suggest that the dip-slide system, when employed at room temperature, is as efficient at isolating salmonella as routine laboratory methods. Also, salmonella grows as a clear colony on MacConkey medium, which is one of the components of the Uricult system. Rarely is any other bacterium with this characteristic isolated from urine. Uricult, then, when employed at room temperature with selenite broth, a medium that does not require sterilization, has the capacity both to isolate and to identify salmonella, making it a device especially suitable for screening large populations in the field.—We are, etc.,

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- 1 Guttman, D., and Naylor, G. R. E., *British Medical Journal*, 1967, 3, 343.

Side Effects of Intermittent Rifampicin

SIR,—Dr. G. Poole and others (7 August, p. 343) and Drs. D. J. Girling and W. Fox (23 October, p. 231) raise very important questions as rifampicin by intermittent regimen has raised many new problems not observed before in daily use of rifampicin, or with intermittent administration of other tuberculostatics.

Since 1969 a controlled clinical trial with the assistance of W.H.O. has been carried under my co-ordination in some centres in Poland in patients with pulmonary tuberculosis whose previous treatment had failed. An intermittent regimen with rifampicin 1,200 mg plus ethambutol 50 mg/kg weight has been used in a once or twice weekly supervised regimen preceded by three months daily treatment with rifampicin 600 mg and ethambutol 25 mg/kg weight. We observed almost similar symptoms to those described by Drs. Girling and Fox. They were found in about 14% of 180 patients. Our first observations were reported at a symposium in Pellenberg in March 1971 and at the meeting of the Scientific Treatment Committee of the I.U.A.T. in July 1971 in Moscow.

We classified the patients with side effects as follows:

- (1) General manifestations without any clinical or laboratory findings;
- (2) Manifestations with a hepatic component;
- (3) Manifestations of anaphylactic type with leucopenia;
- (4) Haematological manifestations (very rare).

These adverse reactions occurred generally between 26-48 weeks of treatment, mainly after 12-14 weeks in the intermittent phase. They were more frequent in the once weekly treated group of patients than in the twice weekly regimen. In the majority of patients with these symptoms it was possible to renew treatment after desensitization.

The majority of patients with side effects after desensitization start their treatment again on an intermittent regimen with lower

doses—for example, 600-900 mg and up to 1,200 mg with good tolerance and no re-appearance of side effects. Some patients are given steroids on the same day as rifampicin, starting with 40-60 mg prednisone and then the dose is progressively lowered to 30, 20, and 10 mg. Such cover with prednisone has been maintained for a period of two to four months with good results. Only in cases with skin eruption, purpura, or other haematological abnormalities do we consider that treatment with rifampicin should not be started again.

The mechanism of this type of reaction is not fully known yet, and we agree with Drs. Fox and Girling that we should try to find further proper methods to prevent and to control these side effects during intermittent administration of rifampicin. Rifampicin in conventional daily dosage and in the intermittent application, as our observations and others have shown, is therapeutically very effective and a very powerful drug. The intermittent regimen with rifampicin can be one of the most valuable regimens to be applied in the treatment of tuberculosis on a large scale (lower costs, better supervision, etc.) provided that proper rifampicin regimens for this method of treatment are evaluated and that there are proper procedures and managements for prevention and control of side effects.—I am, etc.,

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Mefrusamide or Frusemide?

SIR,—In their report of a clinical trial of mefrusamide, Drs. W. H. R. Auld and W. R. Murdoch (25 December 1971, p. 786) give as one of its advantages that the action of mefrusamide was smooth and prolonged compared with that of frusemide. Might I suggest that this is not always an advantage?

I prescribe frusemide to be taken at 5 p.m., and I find that the diuresis is complete before the patient retires. Indeed, nocturia, an early sign of developing cardiac failure, frequently ceases. Patients subconsciously restrict fluids during a diuresis, and thus they retire at the stage of maximal dehydration. Paroxysmal nocturnal dyspnoea, the most serious sequel of congestive cardiac failure, is prevented, and not only does the patient benefit from an uninterrupted night's rest but so do I.—I am, etc.,

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Never too Old

SIR,—Early in December a woman was admitted to my hospital with a fracture of her femur that required surgical intervention. She was 102. I gave the anaesthetic, which lasted 28 minutes. Five minutes after the operation was completed she opened her eyes and exclaimed "Where is my money?" This was followed soon after by a second question "And where is my pension book?" She is sitting up daily and is most impatient to walk again.—I am, etc.,

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