regularly for four months when she had amenorrhoea. She continued all her therapy for a further two months, during which amenorrhoea persisted. She insists that she neither missed nor delayed taking a pill. At this stage (3 months amenorrhoea) she had a pregnancy test which was positive so she discontinued the oral contraceptive. Her last menstrual period finished on 3 March 1971, and she bore a normal female child (5½ lbs) on 15 December.

In recent years we have come to regard pregnancy as virtually impossible for a woman taking oral contraception correctly, and the occasional amenorrhoea experienced by many subjects as of no consequence.¹ Earlier, however, some concern was felt about the efficacy of oral contraceptives in a subject who was concurrently taking regular doses of certain other drugs (including those drugs used in treatment of epilepsy) on account of a laboratory investigation which had shown in mice that such drugs could stimulate enzymes which promote metabolism of the contraceptive.² The F.P.A. *Clinic Handbook*³ states that there is no evidence that this investigation has any relevance to a woman taking ovarian steroids at oral contraceptive dosage. The case cited, however, suggests that epilepsy-therapy drugs may reduce the effectiveness of oral contraceptives, as indicated by the experiments with mice.—I am, etc.,

IDA E. KENYON

Hale, Cheshire

- ¹ Mears, E., *A Review of Oral Contraception*, p. 27, Burgess Hill, Shering Chemicals Ltd., 1971.
- ² Family Planning Association, *Medical Newsletter*, 1966, no. 23, p. 3.
- ³ Family Planning Association, *Clinic Handbook*, p. 45, London, F.P.A., 1970.

Occupational Health Service

SIR,—Dr. P. R. Richards's letter (12 February, p. 438) is misleading. No employer who has half an eye to the true interests of his business in both financial and human terms will long tolerate a doctor seeking opportunities quietly "to bury the subject under the carpet."

Perhaps some of the difficulties which Dr. Richards relates stemmed from the personal style of those trying to influence the organizations in which they worked. "To fight their employer" is likely to be a less successful strategy than trying to change the climate of the organization so that management and doctor come nearer to sharing a common set of values. Co-operation is then a more appropriate behaviour than fighting.

It is to the mutual advantage of worker, employer, and doctor for the latter to pursue his work energetically and forcefully. At the same time the interests of a public increasingly concerned with safe products and a healthy environment will be served.—I am, etc.,

F. W. BEST

Epsom, Surrey

SIR,—It is surprising to read the sort of views expressed by Dr. P. R. Richards (12 February, p. 438) coming from someone acquainted with industrial services in this country.

The situation he describes may occur in some industries, but we think it must be comparatively rare for an industrial medical officer's loyalties to his employer and to his patients to be in conflict. We are concerned

not only with the treatment of disease and injury at work, but with the prevention of these by ensuring a safe working environment and fitting any patient with disability into suitable work within his capacity. This means he will be working efficiently and it follows that the interests of patient and employer almost invariably coincide; if this were not so why should the company bother to employ a doctor at all? It can seldom be true that promotion and career prospects are enhanced by toadying to management.

To suggest that certain doctors in occupational health services have abrogated their duty to their patients in order to lead a quieter life is both absurd and a slur on this branch of medicine. Whether or not a national occupational health service is established as part of the N.H.S., as an independent body, or as an amalgamation of existing industrial medical services with these, is irrelevant from the ethical point of view. It is the integrity of the doctor involved which is important.—We are, etc.,

K. N. J. POCOCK
Chief Medical Officer

J. D. BARRETT
Medical Officer, Luton Plant

R. A. BATTEN
Medical Officer, Luton

R. W. BOWMAN
Medical Officer, Dunstable Plant

Vauxhall Motors Ltd.,
Luton, Beds

SIR,—Dr. P. R. Richards's contention (12 February, p. 438) that doctors working in industry have great problems regarding loyalty is an often repeated myth. Occupational health physicians have the same ethical code as the profession in general, and base their decisions on scientific and medical principles in the interest of the patient. The respect of management and unions and effectiveness as an adviser would be quickly lost by any sign of bias on the part of the doctor.

The suggestion that some doctors opt for a quiet life as a company servant conflicts with the statement that "their promotion and career prospects depend largely upon the service they give to their employer." A doctor basing decisions on the wishes of his employer would be seen to be of little value to the company. Most employers have an enlightened approach towards doctors working in industry and expect them to give unpalatable advice at times. By the same token, the employer benefits when the doctor's advice is accepted by the workers because he is known to be a man of integrity.

It should be remembered that without the contribution to occupational health by the medical services of large and small industrial concerns the skills and experience in this field of medicine presently available would be virtually non-existent in Britain.—I am, etc.,

D. P. MANNING

Southport, Lancs

Ampicillin and "Sore Throat"

SIR,—We have been following with interest the correspondence arising out of your leading article on "Skin Reactions to Ampicillin" (22 January, p. 195). We feel, however, that not enough emphasis is being placed on the preventive aspects, for though it has been

acknowledged for some years now that a very high proportion of patients suffering from glandular fever will develop a rash if given ampicillin, there has been no significant reduction in the number of such patients hospitalized with this rather distressing and often protracted form of skin reaction. This is undoubtedly due to the widely prevalent practice of treating "sore throats" with ampicillin, with the result that by the time the correct diagnosis of glandular fever is made more often than not the patient has already received ampicillin. The remedy of the situation lies in wider publicity of the fact that the only significant bacterial organism involved in "sore throats" is β -haemolytic streptococcus, for which penicillin is by far the most effective antibiotic available and also the cheapest. Use of an alternative drug, such as ampicillin, which is costlier, potentially less effective, and liable to produce unpleasant side effects in those patients who later turn out to be suffering from glandular fever, can only be regarded as bad practice of medicine.—We are, etc.,

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G. BAUMGARD

Department of Infectious Diseases,
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Manchester

Skin Reactions to Ampicillin

SIR,—With reference to your leading article (22 January, p. 195) we feel that several points of distinction should be emphasized between the maculopapular rash associated with ampicillin therapy and the maculopapular rash sometimes occurring as a Jarisch-Herxheimer reaction in the initial treatment of infectious syphilis with penicillin. In the past year we have seen two patients suffering from early syphilis in whom this confusion arose.

A 31-year-old nurse presented to her family doctor in early February 1971 with vague complaints of malaise, sore throat, and joint pains and was prescribed ampicillin 250 mg 6-hourly. Within 24 hours she had developed a macular rash and pyrexia and the treatment was discontinued as this was thought to be an ampicillin reaction. In May 1971 she presented with meningismus, polyarthralgia, generalized lymphadenopathy, and a generalized maculopapular rash which was eventually diagnosed as secondary syphilis.

On 5 May 1971 a 19-year-old female was admitted to hospital in Belfast with superficial slightly tender lymphadenopathy and mucous membrane lesions. A provisional diagnosis of infectious mononucleosis was made and treatment with ampicillin started for a presumed associated respiratory tract infection. After 500 mg of ampicillin orally a generalized macular rash especially prominent on the palms and soles was noted. Treatment with ampicillin was discontinued and the advice of a consultant dermatologist taken. In this case the correct diagnosis of reaction to the antibiotic treatment of early syphilis was made.

The Jarisch-Herxheimer reaction in early syphilis occurs in the first 12 hours following penicillin therapy and is frequently associated with pyrexia.¹ It is associated with the development of a maculopapular skin eruption resembling secondary syphilis and if cutaneous secondary syphilis is already