of course, complained of two or even more symptoms, but one in three complained of none at all. Of interest also is that the incidence of monilial vaginitis corresponded closely with that occurring in women in general,² though the impression was that (as with loss of libido, headaches, etc.) it occurred much more often in women taking the pill.

When I related to age group and parity (1) the number of patients complaining of no symptoms and (2) the number discontinuing the method because of symptoms the latter generally began to exceed the former after the age of 30, especially in patients with more than one child. These findings equate with the common experience that oral contraceptives seem to suit the young nullipara better than the older multipara.—I am, etc.,

M. J. V. BULL

Oxford

- ¹ Herzberg, B. N., Draper, K. C., Johnson, A. L., and Nicol, G. C., *British Medical Journal*, 1971, 3, 495.
² Morris, C. A., *Journal of Clinical Pathology*, 1969, 22, 488.

Corticosteroid Withdrawal in Asthma

SIR,—Beclomethasone dipropionate aerosol has recently been introduced as an alternative to corticosteroids or corticotrophin in patients with asthma. We wish to report two cases which illustrate the possible dangers involved in transferring asthmatics from systemic corticosteroids to the beclomethasone aerosol. One patient was admitted in status asthmaticus and the other developed symptoms of acute adrenal insufficiency.

Case 1.—A woman aged 47 with extrinsic asthma for nine years had been treated with corticotrophin 10–20 units daily for the past two years. She was grossly Cushingoid. Before starting treatment with beclomethasone her plasma cortisol was 11 µg/100 ml and after tetracosactrin stimulation it was more than 30 µg/100 ml. Her asthma was well controlled by beclomethasone and the corticotrophin was withdrawn. Six weeks later she began to wheeze. She had been advised to take her reserve supply of prednisone under these circumstances but she did not do so, as she feared the return of her Cushingoid appearance. Three days later she was admitted, grossly cyanosed, in status asthmaticus; her arterial PO_2 was 24 mm Hg. She had no signs of adrenal failure. After treatment with intravenous hydrocortisone and aminophylline together with antibiotics and oral prednisone she made a slow recovery.

Case 2.—A man aged 23 had had extrinsic asthma for 20 years. He had received prednisone 10 mg daily for eight years. His asthma was satisfactorily controlled on beclomethasone and his prednisone was gradually reduced. While still taking prednisone 10 mg daily his plasma cortisol was 2 µg/100 ml, and after tetracosactrin stimulation it was 3 µg/100 ml. Four weeks after prednisone had been withdrawn he developed a cold. He did not have purulent sputum but he became weak and drowsy. He complained of abdominal discomfort and vomited. On admission to hospital he was confused and had gross muscular weakness. He had no wheeze and his peak flow was unchanged at 400 l./min. He had no abdominal signs. His blood pressure was 110/70 mm Hg (previous readings had been 130/90 mm Hg). His serum sodium was 126 mEq/l. and serum potassium 3.5 mEq/l. His plasma cortisol was 7 µg/100 ml. He received intravenous hydrocortisone and saline and recovered fully within 12 hours.

This report emphasizes the potential problems arising when long-term corticosteroid

therapy is discontinued. Our patients receiving beclomethasone are given a reserve supply of prednisone with instructions to use it and contact their doctor immediately if their asthma deteriorates or they feel unwell. In addition, they are told to continue to carry their steroid card together with a letter which mentions the risk of status asthmaticus and adrenal insufficiency. We have also warned their general practitioners that these patients are at special risk.—We are, etc.,

J. C. BATTEN
S. W. CLARKE
IAN GREGG
MARGARET E. HODSON

Brompton Hospital,
London S.W.3

Paralytic Ileus in Strongyloidiasis

SIR,—It was with great interest I read the account by Dr. J. B. Cookson and others (30 December, p. 771) of a case of strongyloidiasis, though I felt there were some inconsistencies in their report. Although the infestation may well have produced a paralytic (adynamic) obstruction as an end result (as the barium meal and laparotomy findings suggest) it seems that the obstruction was initially dynamic in nature since the patient complained of abdominal pain, and bowel sounds were heard on abdominal auscultation. Clinically, therefore, it would appear that the obstruction was initially dynamic—an enteric paralysis resulting from myenteric fatigue. This is the end-stage of dynamic obstruction of any origin and possibly not a specific immediate effect of strongyloidiasis, as the title of this paper would suggest.—I am, etc.,

M. J. WORLD

Stevenage, Herts

Colleagues in Africa

SIR,—The letter from Dr. A. Barlovatz (16 December, p. 670), who writes after a lifetime of service in Zaire prompts me, a newcomer to the Zairois scene to point out that the picture he gives is certainly not uniform throughout the country. His figures underline the grave shortage of medical personnel and the very great need for expatriate doctors for many years to come, and I am sure that no Zairois, whether medical or lay, would like the impression to be given that expatriate doctors are no longer welcome.

Unlike the situation in England, a large proportion of doctors in Zaire work in administrative posts, and it is not surprising that all these should go to national personnel. However, there are many areas like the one served by this Hospital, where I am the only doctor along a 150-mile (240-km) stretch of road with a population of 100,000 people who would "fête" any doctor of whatever nationality willing to serve them. Many such hospitals are now without even one doctor (a similar population in England has 150 doctors)—as this one will be unless a replacement is soon found for my furlough.

Of course, there are many problems confronting a foreigner in a newly independent state, even in a mission hospital (the church, too, is newly independent!). However, I can say that never has any Zairois interfered

with a clinical decision of mine and not often in a policy decision either. The county authorities have generally been very helpful and only today I received a letter thanking me for the new work we are undertaking against leprosy. The two nearest Zairois doctors have both stayed in our house and there is a cordial relationship. I have also been asked twice to organize elective periods for final-year students from the national medical school, though this has unfortunately not been possible owing to pressure of other commitments.

Zaire cannot offer you a lifetime's career in medicine. Such prospects now must obviously go to Zairois doctors. BUT she does offer, in hundreds of places, challenging opportunities to do worthwhile work, immeasurably appreciated by the local population, for short and medium terms and innumerable opportunities for "Burkitt-type" research too. You don't have to publish in Zaire itself!—I am, etc.,

D. K. MASTERS
Medical Director

Pimu Missionary Hospital,
Lisala,
Zaire

Toxicity of Benorylate

SIR,—Recently a new antirheumatic medicine, Benoral, was produced and widely advertised as useful for arthritis and allied forms of rheumatism. It contains 40% w/v of benorylate (4-acetamidophenyl O-acetylsalicylate). I prescribed a course in the recommended dosage for 11 of my patients, of whom eight were unable to persist with the treatment because of toxic symptoms. One of three who completed the course derived some benefit from it. The toxic symptoms included a dramatic loss of hearing, tinnitus, nausea, and a feeling of disorientation. These are the classical symptoms of salicylate toxicity and are remarkable only because of the speed with which they occurred and the acute form in which they presented. Several of the patients developed the symptoms after the second dose of Benoral and few could take more than four doses. After they had recovered from their symptoms (in about 48 hours) I persuaded several of them to resume on half doses but all had to stop because of deafness or tinnitus.

I have reported these cases to the manufacturers. It would be valuable to know if others using this preparation have had a similar experience.—I am, etc.,

R. EDGAR HOPE-SIMPSON

Cirencester, Glos.

Cervical Carcinoma in Young Women

SIR,—I would like to report two cases of cervical carcinoma in situ found on routine testing of young women in the past three months in a general practice of 4,000. This high incidence is contrary to the official view that cervical carcinoma is a disease of middle age.

The women are aged 27 and 21 respectively, both are on "the pill," and the first reports showed non-specific inflammation. Although no repeat smear was recommended by the pathologist this was done six months later and carcinoma in situ was reported.

The diagnosis in the first case has been confirmed by cone biopsy; the second is awaiting treatment. A third young woman seen during the same period had a suspicious smear and cone biopsy was performed, but carcinoma was not found.

One must conclude that with such a high incidence of chance (i.e., symptom-free) findings there is a need for young women to be educated to undergo screening. It is to be hoped that the N.H.S. will see the necessity for G.P.s to be encouraged to participate in this.—I am, etc.,

E. ANN TAIT

London N.W.1.

Antibiotic Sensitivity of *Escherichia coli*

SIR,—The "clinical notes" depicted in an advertisement for Keflex (cephalexin monohydrate) appearing in the *B.M.J.* (30 December, p. iv) describe a strain of *Escherichia coli* which is sensitive to ampicillin but resistant to nitrofurantoin. Such a result is a reversal of the usual experience of clinical bacteriologists since, nowadays, strains of *E. coli* are sensitive far more often to nitrofurantoin than to ampicillin. In this hospital, for example, the majority of strains of *E. coli* isolated in urinary tract infections continue to be nitrofurantoin-sensitive, but ampicillin resistance is not uncommon.

In a recent multicentre survey of the sensitivities of urinary tract pathogens¹ (in which *E. coli* was the predominant organism isolated) a "league table" of percentage sensitivities was constructed. The top three drugs recommended for starting treatment of both inpatients and outpatients were trimethoprim/sulphamethoxazole (co-trimoxazole), nitrofurantoin, and nalidixic acid. The figures given for ampicillin sensitivity placed this drug low on the list of primary choices for outpatients and lower still for inpatients.

The results of the sensitivity tests portrayed in the advertisement represent only a minority of urinary pathogens and, if taken to be typical, might serve to restrict the choice of drugs available to a practitioner for initial treatment.—I am, etc.,

R. FRAZER WILLIAMS

Booth Hall Children's Hospital,
Manchester

¹ MacAlister, T. A., et al., *Postgraduate Medical Journal*, (Suppl. September), 1971, 47, 7.

Cholera in the Nineteenth Century

SIR,—I was interested to read Dr. N. Howard-Jones's account of the Gelsenkirchen typhoid epidemic of 1901 (13 January, p. 103). In certain aspects it was remarkably similar to the last major cholera epidemic in London in 1866, which accounted for nearly 6,000 deaths, mostly occurring in an area where the water supply was provided by the East London Water Company from the River Lea, as pointed out by Dr. William Farr, principal statistician in the Registrar General's Office.¹ A subsequent inquiry showed that the water company had been supplying unfiltered water in breach of the law, yet the difficulty of legal proof was so great and the maximum penalty so small that no prosecution ever took place.

These events are vividly described by

Francis Sheppard² in his book, *London: The Infernal Wen*.²—I am, etc.,

TONY DUGGAN

Wellcome Museum of Medical Science,
London N.W.1

¹ *Registrar General's Weekly Return of Births and Deaths in London*, 28 July 1866. London, H.M.S.O.

² Sheppard, F., *London 1808-1870: The Infernal Wen*. London, Secker and Warburg, 1971.

Source of Extrarenal Renin

SIR,—Dr. A. Medina and others in their article on changes of blood pressure, renin, and angiotensin after bilateral nephrectomy (23 December, p. 694) refer to an extrarenal source of renin to explain its now well-confirmed persistence in plasma after bilateral nephrectomy. Although several organs yield renin-like material on extraction, data are not available to identify the source of this renin in nephrectomized patients.

Some years ago I obtained data¹ on normal patients during abdominal surgery which indicated a possible splanchnic source of renin-like activity. I wonder whether Dr. Medina and his colleagues have any similar data from their patients or whether they could obtain such data by sampling portal and peripheral blood simultaneously if their patients were subjected to abdominal surgery for some other reason or possibly at the time of renal transplantation.—I am, etc.,

DAVID E. BARNARDO

Queen Mary's Hospital,
Rochampton, London S.W.15

¹ Barnardo, D. E., Strong, C. G., and Baldus, W. P., *Journal of Laboratory Clinical Medicine*, 1969, 74, 495.

Future of the B.M.A.

SIR,—At a well-attended meeting of the Worcester and Bromsgrove Branch on 22 January 1973 the following resolutions were passed with only one dissentient vote:

1. That the Representative Body should consider the Reports of Council (*Supplement*, 22 July, p. 47, and 16 September, p. 163) relating to the reorganization of the B.M.A.

2. That the (Branch) Secretary be instructed to seek the necessary support from other Branches and Divisions to call a Special Representative Meeting in order to have the Council's recommendations for the reorganization of the B.M.A. discussed.

At the meeting the overwhelming importance of finding an early and practical solution to the present medicopolitical impasse was recognized. There are two essentials to this end. Firstly, there must be a mutually acceptable basis upon which discussions can take place to achieve agreement. We believe that Council's proposals could provide such a basis. Secondly, a period of time is necessary for such discussions. The occasion of an S.R.M. would enable the Representative Body (by some form of delegation of its own choosing and suitable to this special occasion) to arrange to engage in the continuing discussions which are needed. This would avoid the present handicap in negotiation resulting from the necessarily infrequent meetings of the Representative Body.

May we, through you, Sir, seek the sup-

port of many other Branches and Divisions towards convening a Special Representative Meeting for this purpose.—We are, etc.,

JOHN G. BALL

Chairman, Worcestershire L.M.C.

PHILIP JONES

President,
Worcester and Bromsgrove Branch, B.M.A.

MACPHERSON KNOWLES

Chairman, Worcester City L.M.C.

Kidderminster, Worcs.

SIR,—We, the undersigned members of the Executive Committee of the West Essex Division of the B.M.A., wish to make it known that we are anxious about the rift between the General Medical Services Committee and the rest of the profession. Our representative (a general practitioner) attended the Special Representative Meeting with a clear view of the Division's feelings in favour of the Chambers proposals. He voted for acceptance in principle of the report in the clear knowledge of its significance and not in the heat of the moment.

The pamphlet S.C.12 received from the G.M.S.C. states the choice offered to the family doctor: Do the family doctors want to be represented by (1) a committee elected in effect by all G.P.s or (2) by G.P.s elected through an organization of doctors in all branches of medicine and limited to members of that organization alone?

The pamphlet seemed to expect an affirmative answer to proposal 1, but we feel that our needs are exactly stated in the proposal 2 and that this was the expressed wish of the Representative Body. The first alternative seems to us to nullify all our attempts to bring hospital doctors and general practitioners closer and we feel that all branches of the profession should face the future together along the lines of the Chambers Report.

We are concerned that those taking part in the referendum may well only hear the G.M.S.C. side of the argument and hence we send you this letter.—We are, etc.,

O. ROSS

I. HAMILTON

S. SCOTT

H. GRVILLS

Z. SHARNAGIEL

D. WRIGHT

D. BATEMAN

J. HILL

Harlow, Essex

Oxford Street Traffic Regulations

SIR,—At its last meeting the council of the Metropolitan Counties Branch of the B.M.A. expressed concern at the potential hazards for both doctors and patients resulting from the new traffic regulations for the Oxford Street area.

I have therefore been requested by the Branch council to urge doctors who are delayed as a result of the new regulations when visiting patients to send details immediately to the Secretary of the Association.—I am, etc.,

F. V. GRIFFITHS

Honorary Secretary,
Metropolitan Counties Branch, B.M.A.

London W.C.1