ing to remedy the serious difficulties in the hospital service, because the maldistribution which needs correction is: (1) The disproportion between the excessive number of temporary posts in the training scheme and the restricted number of permanent posts in the consultant establishment; (2) The disproportion between the ages of the existing consultants, most of whom are squashed into an age group which is far too narrow. It is nothing to do with the geographical distribution of registrars.

Intermittent claudication

Dr. G. LAWTON (Royal Northern Hospital, London N.7) writes: Mr. J. A. Dormandy and his colleagues have produced two excellent papers on the clinical, haemodynamic, rheological and biochemical findings in patients with intermittent claudication and the prognostic significance of these findings (8 December, pp. 576 and 581). It is recorded that 67% of their patients smoked cigarettes, about half of them more than 15 per day, and in the series there was a 4·5:1 predominance of males over females.

Eastcott[1] was one of the first to show the almost invariable consumption of cigarettes in male patients presenting with intermittent claudication and this has been confirmed by Oldham,[2] and Begg.[3] Given the 4·5:1 ratio of male to females and the overall figure of 67% smoking cigarettes, it does seem that both the number of patients smoking and the quantity smoked are unusually low. Most patients now know that doctors disapprove of smoking and will tend to minimize their smoking habits. . . . It is possible that the quantity of cigarettes smoked as recorded by the observer is a function of the particular observer. . . . Assessment of the prognostic significance of stopping smoking in those patients who had been persuaded to do so as part of a prospective study might yield valuable information. Perhaps Mr. Dormandy and his colleagues would consider in the future correlating smoking with the various parameters already studied.

1 Eastcott, H. A. G., *Lancet*, 1962, **2**, 1117.
1 Oldham, J. B., *Journal of the Royal College of Surgeons, Edinburgh*, 1964, **9**, 179.
3 Begg, T. B., *Practitioner*, 1965, **194**, 202.

Consultant Crisis

Dr. J. W. TODD (Farnham, Surrey) writes: Your leading article (15 December, p. 630) states that "today too many consultants find themselves overworked, and their professional satisfaction dwindling." I am unaware of this from my own observations. . . .

Salaries in the Health Service

Mr. STEVEN PREECE (Liverpool University Hospital Group Headquarters, Liverpool) writes: With reference to Dr. W. Fowler's letter (8 December, p. 616) on the new salary scales for administrators, it should perhaps be remembered that the responsibilities of administrators, unlike those of clinicians, have been substantially increased by the reorganization of the Health Service. And even with the new salary scales Health Service administrators are still, comparatively, poorly paid. As the Health Service grows more complex the need for good administrators becomes ever more pressing. But in recruiting managers the Health Service is in direct competition with both industry and the other branches of the public service. Neither the Health Service nor the medical profession can, therefore, benefit from keeping administrators' salaries as low as possible. It seems to me rather that the work of all of us in providing the best service for the patient would be eased if we could ensure that all Health Service salaries were such as to attract the highest possible calibre of staff in all disciplines. . . .

Vision on the Road

Dr. J. B. MORWOOD (Banstead, Surrey) writes: With reference to your leading article (15 December, p. 628) now that cataract operations have to be reported by aphakic motorists to their insurance companies it is very desirable for them to be able to state that full aperture lenses are being worn and that the visual field is therefore as wide as possible. . . .

Antibiotic-induced Meningitis

Mr. M. GIBBS and Dr. D. J. HANSMAN (Adelaide Children's Hospital, S. Australia) write: Dr. W. I. H. Shedden (22 September, p. 638) refers to the occasional development of meningitis "during *appropriate* antimicrobial therapy" (our italics) and mentions our report,[1] which described the failure of a child with meningococcal infection to respond to treatment with lincomycin. In fact, the point of our communication was to show that lincomycin was an inappropriate drug in infections caused by *Neisseria meningitidis* because meningococci are naturally resistant to lincomycin (and 7-chlorolincomycin). As to the original issue raised in the paper by R. J. Mangi *et al.*,[2] and your leading article (18 August, p. 366)—whether cephalothin therapy in some way specifically predisposes to the development of meningitis —we are sceptical. Complications such as meningitis may occur in infections treated with other antibiotics, including penicillin. . . . In conclusion, it is suggested that meningitis may complicate a bacterial infection despite chemotherapy in at least two circumstances: firstly, if an otherwise potent drug, such as benzylpenicillin or ampicillin, is given in a dosage or by a route which results in inadequate plasma and tissue levels; secondly, if the drug is unsuitable, such as lincomycin or cephalothin in meningococcaemia.[2 3]

1 Hansman, D., and Gibbs, M., *New England Journal of Medicine*, 1972, **287**, 201.
2 Mangi, R. J., Kundargi, R. S., Quintiliani, R., and Andriole, V. T., *Annals of Internal Medicine*, 1973, **78**, 347.
3 Almond, H. R., *New England Journal of Medicine*, 1969, **281**, 218.

Treatment of Bronchitis

Dr. I. M. JONES (Codford St. Mary, Wilts) writes: In your leading article entitled "Treatment of Acute Exacerbations of Chronic Bronchitis" (24 November, p. 437) you convincingly emphasize the need for prompt and vigorous treatment of all bacterial infections. You then proceed to a discussion of the merits of various antibiotic drugs which omits some salient points. For example, there is no mention of the fact that the action of tetracyclines and co-trimoxazole in chest infections is predominantly bacteriostatic as opposed to bactericidal;[1] the considerable incidence of dermatological and gastrointestinal complications with therapeutically effective doses of ampicillin;[2] the nephrotoxicity sometimes associated with tetracyclines and co-trimoxazole;[3-5] that cephalexin, excreted through the renal tubules, has not produced nephrotoxicity as is reported with cephaloridine,[6] which is excreted through the glomeruli; and the immunosuppression[7] and blood dyscrasias[8] associated with co-trimoxazole.

It has been my experience that while no drug has proved universally effective in the treatment of bronchitis, cephalexin usually gives a decisive response achieved by bactericidal action and accompanied only rarely by side effects of minimal severity. I do not think this can be said of any other antibiotic. . . .

1 Lacey, R. W., and Lewis, E., *British Medical Journal*, 1973, **4**, 165.
2 *Textbook of Medical Treatment*, ed. S. Alstead, A. G. Macgregor, and R. H. Girdwood, p. 16. Edinburgh and London, Churchill, 1971.
3 Kalowski, S., Nanra, R. S., Mathew, T. H., and Kincaid-Smith, P., *Lancet*, 1973, **1**, 394.
4 Edwards, O. M., Huskisson, E. C., and Taylor, R. T., *British Medical Journal*, 1970, **1**. 26.
5 Brown, C. B., *British Medical Journal*, 1971, **4**, 428.
6 James, D. G., and Walker, A. N., *British Journal of Hospital Medicine*, 1971, **6**, 795.
7 Arvilommi, H., Vuori, M., and Salmi, A., *British Medical Journal*, 1972, **3**, 761.
8 Dawson, D. W., and Routledge, R. C., *British Medical Journal*, 1971, **4**, 364.

Diet in the Elderly

Dr. D. ABELSON (Lankenau Hospital, Philadelphia, Pennyslvania) writes: The excellent article by Dr. D. Corless (20 October, p. 158) fails to mention ill-fitting upper dentures as a major cause of inadequate nutrition, which nearly led to the premature demise of at least one octogenarian of my acquaintance. . . . Long years of toothlessness had led to resorption of the dental ridges, so that there was little for the denture to cling to; and as soon as he opened his mouth to insert a morsel of food, down came the portcullis with a slam . . . . A new era dawned when a fresh set of dentures was obtained and, with the aid of tragacanth, secured somewhat precariously to the roof of his mouth. . . .

Pain after Birth

Dr. A. YEADON (Medical Director, Davies and Geck, Gosport, Hants) writes: In your leading article (8 December, p. 565) you draw attention to Mrs. Susan Baker's excellent survey into the causes of postnatal perineal discomfort.[1] Among many other factors Mrs. Baker examined the influences of techniques of suturing perineal tears and episiotomies. It was perhaps unfortunate that the only suture materials referred to in her survey were catgut and catgut combined with black silk and hardly surprising that no significant difference in discomfort was ob-