# To-day's Drugs

*With the help of expert contributors we publish below notes on a selection of drugs in current use.*

**Tabs. ethinyloestradiol** *B.P.*
**Estigyn** (British Drug Houses).
**Eticyclin** (Ciba).
**Lynoral** (Organon).

Ethinyloestradiol, a semi-synthetic oestrogen, is the most potent oral oestrogen, being about 20–25 times as active as stilboestrol, but costing more. The justification for the higher cost would be a smaller incidence of intolerance than is shown to stilboestrol; unfortunately this is by no means certainly the case. The indications for ethinyloestradiol are the same as those for other oestrogens: replacement therapy in hypo-ovarianism (dose about 0.1 mg. daily in 20-day interrupted courses) and in the climacteric (about 0.01 mg. or less daily, again in interrupted courses); treatment of menstrual irregularities of functional origin (daily dose about 0.1 mg.); suppression of lactation (no two people seem to have the same views on the precise regime for this, so it probably does not matter); and palliative treatment of prostatic carcinoma (daily dose 0.1 mg. and upwards, according to clinical response), and of some post-menopausal patients with carcinoma of the breast.

In general, it may be said that if stilboestrol is tolerated in doses which are adequate for the purpose there is no reason to use any other oestrogen; if it is not, ethinyloestradiol in equivalent dosage may be tried. Some patients will tolerate it better, but others will not.

N.H.S. basic price: all preparations, 0.01-mg. tablets or linguets (eticyclin), 100 for 1s. 6d.

**Injection of cyanocobalamin** *B.P.*
**Anacobin** (British Drug Houses).
**Bitevan** (Evans Medical Supplies).
**Cobalin** (Paines and Byrne).
**Cobastab** (Boots).
**Cytamen** (Glaxo).
**Distivit $B_{12}$** (Distillers).
**Duodecibin** (Woolley).
**Fermin** (Richter).
**Megalovel** (Vitamins Ltd.).
**Rubramin** (Squibb).

Cyanocobalamin is of greatest value in the treatment of pernicious anaemia. In this disease there is a deficiency of it, so that instead of the normoblastic maturation in the bone marrow leading to the formation of normal red blood cells a megaloblastic reaction occurs, and pernicious anaemia develops. This faulty marrow response is corrected within a few days of adequate treatment with cyanocobalamin parenterally. It may be given in doses of: (1) initially, 250 $\mu$g. for two or three days in the first week, followed by 250 $\mu$g. twice weekly until the blood count is normal and symptoms of posterolateral sclerosis are minimal; then only should the dosage be reduced gradually until (2) a maintenance dose is reached, which may vary in different patients but is usually about 100–250 $\mu$g. weekly and then fortnightly. It is usually undesirable for prolonged maintenance therapy to be so infrequent as 50–100 $\mu$g. at monthly intervals. Some cases of tropical macrocytic anaemia and a few cases of sprue respond to treatment with cyanocobalamin.

N.H.S. basic price:—Six 1-ml. ampoules for injection, each containing 100 $\mu$g. cyanocobalamin: inj. cyanocobalamin. *B.P.*, 2s. 7½d.; anacobin, 2s. 7½d.; bitevan, 2s. 7½d., cobalin, 2s. 8d.; cobastab "viules," 2s. 7½d.; cytamen, 2s. 7½d.; duodecibin, 3s. 4½d.; fermin, 3s. 4d. Five 1-ml. ampoules of 100 $\mu$g.: distivit $B_{12}$, 2s. 2d.; megalovel, 2s. 6d. Rubramin, 5-ml. vial of 100 $\mu$g., 2s. 8d. Ampoules containing doses of different sizes are available.

# Correspondence

*Because of heavy pressure on our space, correspondents are asked to keep their letters short.*

## B.M.A. Clinical Meeting

SIR, — "Never a dull moment" — that is how a Southampton colleague described the B.M.A. Clinical Meeting as we came through the swing-doors of the Guildhall after the final general session. What a busy and enlightening experience the three days' meetings have been, especially for a member of an antipodean Branch, as I am.

From such a wealth of splendidly presented items it is hard to select any for special comment, and anyway individual tastes and interests differ. The colour televising of surgical operations from the Southampton General Hospital, the Transatlantic Clinical Conference, the clinical demonstrations at the hospitals—all were evidence of superb planning. And there was so much more.

The Annual Clinical Meeting has been well launched. Developing from this initial triumph, succeeding meetings in years to come will do much to assure the continued advancement of British medicine. All who contributed to this 1958 success have reason to be proud.—I am, etc.,

Adelaide, South Australia. A. R. SOUTHWOOD.

## Antibiotics in Acute Tonsillitis and Otitis Media

SIR,—I must take issue with Dr. Peter A. Walford (*Journal*, November 29, p. 1353) on this subject. To say that the rarity of rheumatic fever warrants the withholding of antibiotics in sore throats is as illogical as to say that because diphtheria is also so rare there is no point in continuing immunization. Incidentally I have yet to hear that the decline in diphtheria is attributed to a waning in virulence of the causative organism. Penicillin is just as specific a therapy for streptococcal sore throat as immunization is a specific prophylactic for diphtheria.

Since it is not refuted that acute nephritis and rheumatic fever follow streptococcal infections, it is logical to treat such infections as early as possible with the specific remedy. To withhold antibiotics for 24 to 48 hours, as Dr. John Fry did in his series of cases (*Journal*, October 11, p. 883), cannot, to my mind, give a true comparison between treated and untreated cases. The most striking results with penicillin in acute tonsillitis and otitis media are observed when the antibiotic is administered early in the infection, as is so often possible in general practice. Dr. Walford quotes a paper by Wilson[1] written in 1946, showing that after penicillin therapy there was some degree of hearing loss in 18% of his series of cases. However, the doses in use at that time would hardly be considered adequate by present-day standards. A more recent survey by Dixon[2] has shown that, in 114 otitis media infections treated with penicillin without myringotomy, there were only four cases of minimal hearing loss and there were no complications. The author concludes that this is a highly satisfactory result.

Dr. Walford asks for other practitioners' experiences of the incidence of acute nephritis and rheumatic fever. I can only say that in my own practice over eleven years (during which time I have used antibiotics extensively) I have seen no cases of either condition.—I am, etc.,

Twickenham. DAVID WHEATLEY.

REFERENCES
[1] Wilson, C. P., *J. Laryng.*, 1946, **61**, 404.
[2] Dixon J. W., ibid., 1958, **72**, 227.

## Resistant Staphylococci

SIR,—Dr. Mary Barber and her colleagues are to be congratulated on their efforts to clarify the problems associated with antibiotic-resistant staphylococcal infections (*Journal*, December 6, p. 1377). There are, however, two points on which further clarification might be possible.