I agree with Dr. Todd that aspirin may well have been a proper drug to prescribe for the "subjects" that he questioned. He tells us that, as a profession, our fault is not the failure to give treatment, but the giving of too much treatment. "Steroids, chloroquine, gold, and phenylbutazone are all dangerous drugs which should be reserved for the severely afflicted but which are too often given to patients with minor diseases who 'demand' that something be done."

If treatment means just the prescription of drugs he has a case, but every experienced family doctor and many consultants know that proper advice is advice proper to the individual patient, and that the prescription of drugs forms only a small part of the management of the patient. When we see an out-patient for the first time, we do not know if this patient is suffering from "a minor disease," or will in five years' time be "severely afflicted" and be suitable for treatment with "dangerous drugs"—a stage at which these drugs may be dangerous but will almost certainly be ineffectual in preventing disability.

Complications usually arise because these drugs are given in unnecessarily large doses and for too long a period of time. If the doctor, before prescribing, listens carefully to what his patients tell him, he will realize that in many of his patients the dominant complaint is not the morning stiffness, pain, and joint swelling, which are accepted as characteristic of early rheumatoid arthritis, but anxiety, frustration, and a fear of crippling which are common early manifestations of this disease and can be relieved by sympathy and willingness to understand the patient and his problem, accompanied sometimes by a prescription for one or two aspirin.

In a few patients the symptoms and signs that are manifest are due essentially to the structural changes of early rheumatoid disease. In those patients gold and steroids may be properly prescribed in the early, curable stage of the disease. A simple test can often help in deciding to which group the patient belongs. If at the end of the first consultation a large dose of corticotrophin is given intramuscularly, and the patient is asked to report by telephone at 8 o'clock next morning, those patients who belong to the first group will usually report nausea, headache, and no, or very little, improvement in their joint symptoms; whereas those in the second group will report a "dramatic" improvement, relief of pain, stiffness, often a diminution of joint swelling, an ability to get out of bed, and often dress for the first time in months with speed and comparative ease. That this is a diagnostic test, and that the relief will only be of short duration, should be explained to the patient.—I am, etc.,

London W. 1.

FRANCIS BACH.

Unusual Urinary Contaminants

SIR,—The report of a case in which pollen grains are identified in the urine of a female animal attendant (31 July, p. 302) prompts this letter, indicating that while uncommon this source of contamination may not be rare.

A fresh midstream specimen of urine was received in a sterile Universal container from

a woman aged 52 after operation. The urine was examined microscopically unstained, and an object seen. Its size was about 30 microns. No motility was apparent. Rather like Dr. R. A. Holman's example, the wall appeared thin but double; within the object no nucleus could be discerned. The "cytoplasm" exhibited slow Brownian movement. From one pole a "vapour trail" appeared to be arising. Although I am familiar with the possible occurrence of pollen in urine as a contaminant, careful and prolonged observation with added glucose failed to induce formation of a germination tube.

Repeated catheter specimens were free of contamination and the object was reported as a contaminant "yeast." Examination of the ward revealed a similar situation to that described by Dr. Holman.

I am grateful to Mr. C. Smith for drawing my attention to the object in the first place.—I am, etc.,

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Disinfectants for Use in Hospitals

SIR,—On 13 February (p. 408) you published a report on this subject by a Public Health Laboratory Service Committee, of which I was secretary. In this report phenolic disinfectants were recommended for general use; in the absence of any better test it was suggested that "the Chick-Martin coefficient can be employed to arrive at a use-dilution provided that only known broad-spectrum fluids are used."

Further experience has shown that this proviso was in fact necessary. There are on the market a few phenolic fluids of the clear soluble type which are said to have a C.M. coefficient of 1.5 or over but which, when tested, are found to have a narrow antibacterial spectrum. These fluids may well be sufficiently active against the standard strain of *Salmonella typhi* used for the C.M. test, yet they are much less active against such resistant organisms as the pseudomonads. So far there are no official arrangements for the quality control of disinfectants for hospital use; it may therefore be of interest to record the way in which such phenolic fluids are at present evaluated in this laboratory.

Two simple tests are used both of which have now been described in detail elsewhere.¹ First, the minimum inhibitory concentration (M.I.C.) is determined against several organisms, using a standard technique and standard strains. This serves several purposes: it gives an indication of the antibacterial spectrum, because for such phenolic fluids there is a good correlation between the bacteriostatic and bactericidal activity; it enables the most resistant strain to be selected for further tests; and it suggests whether, in such tests, simple dilution will be enough to neutralize any disinfectant carried over or whether specific neutralizing agents will be needed. A capacity use-dilution test is then done, with and without yeast. In principle the test organism used would be that found by the M.I.C. determination to be the most resistant, but in practice this has always been the standard strain of *Pseudomonas aeruginosa* NCTC 6749. Unknown disinfectants

are tested at the maker's recommended use-dilution and then at half or double this, as indicated. Finally, safe use-dilutions can be suggested for clean or dirty situations.

The use of the capacity test is discussed in detail in the paper quoted. Our experience is that it is simple and more reproducible than we had hoped and that it gives results that are intrinsically credible. Black and white fluids (to BS 2462) and some clear soluble fluids show up well, but others are revealed as being substantially inactivated by organic matter or as having a dangerously narrow spectrum.

Our results indicate yet again that there is a need for the evaluation of new disinfectant fluids. Although the tests we have described are straightforward, it would not be economic for them to be made on samples bought by individual hospitals. Much advantage would be gained from bulk purchase and regular quality control by such bodies as regional hospital boards.

Technical methods are now becoming available for the evaluation of disinfectants—what is lacking is the administrative machinery to exploit them.—I am, etc.,

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REFERENCE

- ¹ Kelsey, J. C., Beeby, Melanie M., and Whitehouse, C. E., *Mon. Bull. Minist. Hlth. Lab. Serv.*, 1965, 24, 152.

Immunization Against Poliomyelitis

SIR,—Your leading article (21 August, p. 436) on immunization in poliomyelitis concludes with the statement that the present recommended schedules can be reviewed when full information becomes available on the extent to which victims of the disease at Blackburn had or had not been previously immunized. May I point out that in December 1964 the then London County Council sent a letter to all general practitioners in the County of London informing them that from 1 January 1965 vaccination and immunization records relating to persons over the age of 16 would no longer be accepted nor qualify for payment. This apparent saving of money is now made to look foolish, for records of all immunized persons will be of vital interest.

I am sure that no practitioners have refused to immunize people over 16 because of this cut in payment, and I urge the new London boroughs to request that all immunization records be returned to them in future, whether they pay us or not, in the interests of public health.—I am, etc.,

London S.E.7.

CYRIL FOX.

Immunization Against Whooping-cough

SIR,—Dr. R. M. Forrester's letter (24 July, p. 232) on this question is to be welcomed, particularly where he questions the safety as well as the efficacy of the vaccine. He is right to state that (some) doctors in public health are worried, but no less cause for concern is the too common ignorance of the possibility and nature of these reactions. I would like to mention two illustrative incidents with triple vaccine where children have collapsed in the manner in which he describes.