uncomplicated viral hepatitis patients with a high E.S.R. are likely to be of the short incubation period type.

Giles and her colleagues⁶ found that in about one-third of their patients the antigen could only be demonstrated during the incubation period, so that it is possible that patients with a low E.S.R. who are antigen-negative by the double-diffusion test may be of the long incubation period type. Further investigation is necessary, using more sensitive tests, to show whether this is so. Krugman *et al.* found that the thymol turbidity test was usually normal in the long incubation period type and high in the short incubation period type.¹ These findings, and those of the E.S.R., could be explained by changes in the serum proteins.

Most laboratories are unable to do the simple double-diffusion test because of the scarcity of the specific antibody. The E.S.R. can be done in all types of hospital and it is hoped that may prove an additional help in the differentiation of the two types of viral hepatitis.—I am, etc.,

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- ¹ Krugman, S., Giles, J. P., and Hammond, J., *Journal of the American Medical Association*, 1967, **200**, 365.
- ² Cossart, Y. E., and Vahrman, J., *British Medical Journal*, 1970, **1**, 403.
- ³ Dacie, J. V., and Lewis, S. M., *Practical Haematology*, 4th edn. London, Churchill, 1968.
- ⁴ Blumberg, B. S., Melartin, L., Guinto, R. A., and Werner, B., *American Journal of Human Genetics*, 1966, **18**, 594.
- ⁵ Giles, J. P., McCollum, R. W., Berndtson, L. W., Jr., Krugman, S., *New England Journal of Medicine*, 1969, **281**, 119.

Trichomonas and Oxytetracycline

SIR,—I wish to report the case of a 66-year-old female patient whom I first saw during the course of a geriatric domiciliary visit. Having just recovered from an episode of acute on chronic bronchitis, she was still taking oxytetracycline 250 mg four times daily, as prescribed by her general practitioner. She was on no other treatment.

I found the course of her recovery satisfactory and was about to leave when she confided that she was considerably bothered by pruritus vulvae together with vaginal discharge. She refused hospitalization previously when she was being treated for bronchitis, and again in this case she would not go to a gynaecological clinic. In view of this I re-visited her, armed with Cusco's speculum, microscope slides, and three different culture media (Stuart's Sabouraud's, and Feinberg-Whittington).

These investigations resulted in the bacteriological diagnosis of a trichomonal vaginitis, for which metronidazole 200 mg three times daily for one week was prescribed. Follow-up examination ten days later showed no improvement, and the Feinberg-Whittington medium yielded a positive culture again. By this time her lungs had cleared completely and so it was possible to stop treatment with oxytetracycline while repeating a week's course with metronidazole. Two further follow-up tests showed complete clearance of her discharge together with negative bacteriological tests.

The first interesting point emerging from this case is that the possibility of the infection being sexually transmitted could be ruled out with certainty. The second point is even more interesting as it would appear that oxytetracycline and metronidazole might

show therapeutic antagonism with regard to the latter agent's effect on the protozoan *Trichomonas vaginalis*. This combination of oxytetracycline with metronidazole must be a common occurrence in venereology and gynaecological clinics, considering the frequency of mixed infections.

I wonder if any of your readers could confirm or refute the validity of my hypothesis, based on chance observation.—I am, etc.,

STEPHEN SZANTO

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What Price Fellowship?

SIR,—Most of my medical colleagues have received from the Royal Society of Health invitations to become Fellows of the society.

The invitations, whose style seems inspired more by Madison Avenue than by a royal society's secretary, amount to little more than offers to sell the letters F.R.S.H., for use after one's name, in exchange for \$21 per annum. They do, however, have slightly more style than comparable "mail order" degrees from one-room California colleges or divorces from a Mexican border town. While the invitations cause considerable amusement and several talking points, the derision that they cause spreads, so that I have already admitted to my colleagues that I only paid slightly more for my fellowship of a royal college.

I realize that invisible exports are a vital part of the economy, but there must surely be less demeaning ways of attracting dollars into the country. I cannot imagine that the president of the Royal Society of Health disagrees with this point of view.—I am, etc.,

NEVILLE ROSEN

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U.S.A.

SIR,—The multiplicity of initials that British doctors have after their names is a source of confusion and envy to my North American colleagues. Sensibly, they have limited their credentials to the letters M.D., but there can be no doubt that many of them crave the royal flavour of additional letters after their names.

One organization which sets out to take advantage of this trait is the Royal Society for the Promotion of Health, which has recently circularized some of my house officer friends here, asking them to allow their names to be put forward for election to the fellowship of this society "because of their professional status" and "carrying the designation F.R.S.H.". With their application they are told to send in a subscription of \$21 so that they may join "the largest organization of its kind in the world".

My colleagues have sought my advice as to the significance of these initials, imagining that they carry the same weight as the M.R.C.P. or F.R.C.S., and obviously many American physicians have been attracted, for another 5,000 of them belong to this society. The president of the society advertising in this fashion is Lord Cohen of Birkenhead, president of the General Medical Council.—I am, etc.,

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Backache

SIR,—Mr. G. V. Chamberlain in his article entitled "Backache—II" (17 April, p. 159) deals very adequately with the increased strain on the back joints and the ligaments which guard them, in the section on pregnancy and its after effects. However, I feel his treatment of bed rest and exercises is defeatist, as in most of these women the backache in pregnancy is due to the lax ligaments allowing the facet joints to become deranged. The treatment of this is a simple specific manipulation, without an anaesthetic, of one of the lumbar facet joints, or of the sacroiliac joint itself. The fact that this condition can be cured by one or two very gentle specific manipulations of the lumbar facet or sacroiliac joints without an anaesthetic does not appear to be widely enough known.

In my experience such procedures have no adverse effect on the pregnancy.—I am, etc.,

JOHN H. DAVIDSON

London W.1

Chemotherapy of Bronchitis

SIR,—Tetracyclines have been used in the treatment of bacterial infections of the respiratory tract, especially pneumonia and bronchitis (17 January 1970, p. 125). Pneumococci resistant to tetracyclines have been widely encountered and a high incidence of such strains has been reported recently from Liverpool.¹ Tetracycline-resistant strains of *Haemophilus influenzae*, another important respiratory pathogen, have been less frequently seen and we know of no record of resistance among capsulated strains. We wish to report the isolation of a strain of *Haemophilus influenzae* type B resistant to tetracycline from a patient with postoperative respiratory infection.

The patient was a woman aged 27 years who developed fever (39.5°C) and cough with mucopurulent sputum about 11 hours after tubal ligation; a specimen of sputum yielded a marked growth of *Haemophilus influenzae* type B. There was no record of recent tetracycline therapy. She was treated with physiotherapy and was well enough to be discharged from hospital after four days.

When tested by the disc diffusion method on heated blood agar the haemophilus was resistant to tetracycline (10 µg per disc) but sensitive to streptomycin (20 µg), erythromycin (2 µg), and ampicillin (2 µg). In a quantitative test by the plate titration method the minimal inhibitory concentration of tetracycline hydrochloride was 25 µg per ml. This degree of resistance would exclude the possibility of effective therapy with tetracycline in normal dosage.—We, are, etc.,

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Sydney, N.S.W.,
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¹ Percival, A., Armstrong, Elizabeth C., and Turner, G. C., *Lancet*, 1969, **1**, 998.

Tick-borne Typhus in England

SIR,—I read with interest a report of African tick typhus in your Epidemiology section (23 January, p. 240). The patient was an

English girl visiting the country from Nigeria. Her illness was mild and her symptoms settled without treatment.

I should like to report the case of a 63-year-old New Zealand man who came to England via South Africa and Rhodesia. While in Rhodesia he developed a febrile illness, and approximately 14 days after the onset of his symptoms he came to Charing Cross Hospital. Although conscious, he was confused and unable to give an accurate history. The tongue was dry and furred, there was air hunger, and he had a macular rash all over the body. His temperature was 101°F. (38.3°C.) and the pulse was 120 per minute. The lungs were clear clinically and radiologically and there were no other abnormal physical signs.

On admission, a leucocyte count was 8,300/cm³, of which 92% were neutrophils. The Paul Bunnell test was negative, and no malarial parasites were seen. The urine was normal and culture was sterile. Two days later, the leucocyte count was 15,000/cm³, and the blood film showed a few atypical lymphoid cells. The cerebrospinal fluid was normal. By this time, the patient was delirious and he was so ill that hydrocortisone 100 mg six hourly, penicillin, 2 mega units six hourly, and chloramphenicol 500 mg six hourly were given empirically by intravenous infusion, two days before the tests indicated that the diagnosis was typhus. The response to therapy was immediate. Overnight, the cerebral clouding vanished and the patient became rational. The temperature was normal within 24 hours and remained so thereafter. Hydrocortisone was continued for two days and chloramphenicol for two weeks.

The Weil-Felix reaction showed an agglutination titre of 1/180, for *Proteus* OX-K, and the rickettsial complement fixation test was positive against the epidemic typhus antigen to a dilution of 1/250. Neither epidemic louse born typhus nor scrub typhus are recorded in South Africa or Rhodesia. The most likely causative organism was the African tick-borne typhus *Rickettsia conorii*. Unfortunately, the Weil-Felix reaction is not specific in this case, and there is considerable antigenic overlap between the types of typhus.

It is important to realize that tick-borne typhus is a risk in people coming to Britain from Africa and that the illness can run a very severe course.—I am, etc.,

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Ocular Bobbing

SIR,—Ocular bobbing is a distinctive movement disorder seen in a variety of related forms which, in a recent review, we classified as "typical," "monocular," and "atypical."¹

"Typical" ocular bobbing occurs in patients with paralysis of horizontal conjugate eye movements and consists of abrupt, spontaneous downward jerks of the eyes with a slow return to the mid-position. The "monocular" type reflects co-existing unilateral third nerve paresis in addition to the bobbing. The "atypical" type includes either a variation unexplained by associated ocular motor palsy, or bobbing with intact spontaneous or reflex horizontal eye movements. We presented nine cases and discussed the causes and prognostic significance of the disorder.

In our literature review, we neglected to include two Japanese language publications on the subject, which I mention here for completeness.

Okamoto *et al.*² described a 7-year-old boy with an intrinsic pontine tumour who had the "typical" form of ocular bobbing. Kawanami *et al.*³ misused the term "ocular bobbing" in describing a patient with ocular myoclonus. Regularity, pendular phases, and associated synchronous movements of mid-line structures should readily distinguish ocular myoclonus from bobbing.

Since publication of our report, Borit mentioned ocular bobbing occurring in Leigh's necrotizing encephalomyelopathy, a metabolic disorder of infancy and childhood.⁴—I am, etc.,

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¹ Susac, J. O., Hoyt, W. F., Daroff, R. B., and Lawrence, W., *Journal of Neurology, Neurosurgery, and Psychiatry*, 1970, 33, 771.

² Okamoto, S., Hayashi, M., and Shintani, A., *Clinical Neurology (Tokyo)*, 1968, 8, 257.

³ Kawanami, S., Shida, K., and Kuroiwa, Y., *Clinical Neurology (Tokyo)*, 1969, 9, 447.

⁴ Borit, A., *Archives of Ophthalmology*, 1971, 85, 438.

* * A leading article on this subject appeared on 8 May, p. 295.—Ed., *B.M.J.*

Wound Dehiscence after Caesarean Section

SIR,—Dr. James Mowat and Dr. John Bonnar (1 May, p. 256) are to be congratulated on their report showing the advantage of the transverse incision. I would suggest that the incision they describe should continue to be known as the Pfannenstiel, both to give honour to the great gynaecologist who described it, and also to distinguish it from the transverse rectus-cutting incision, which finds little favour, and the skin-only transverse incision, which combines the disadvantages of both vertical and transverse incision.

Their report discusses only the "burst abdomen," but, as they suggest, the incidence of later incisional hernia should also be reduced by the Pfannenstiel incision. The times have surely gone when the gynaecologist's trademark was a ventral hernia in the lower abdomen, and the time has come when this incision should be the routine one in our speciality. It is not an easy one, and attention to technique is needed,¹ also good assistance, but most of all the co-operation of our anaesthetic colleagues in providing safe relaxation, which can best be provided by one of the methods of regional block.—I am, etc.,

BRYAN WILLIAMS

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Sussex

¹ Williams, B., *Journal of Obstetrics and Gynaecology of the British Empire*, 1960, 67, 853.

Aspirin and Renal Papillary Necrosis

SIR,—Professor H. E. de Wardner and Dr. K. G. Koutsaimanis (3 April, p. 45) are incorrect when they state that consumption of aspirin has yielded only two victims with renal papillary necrosis. They seem to have overlooked a number of clinical reports in which papillary necrosis has been associated with consumption of aspirin and not phenacetin or paracetamol.¹⁻⁷ Aspirin given alone or in combination with other analgesics

regularly causes papillary necrosis in experimental animals, and this lesion can occur in individuals taking large amounts of aspirin. In contrast, phenacetin does not produce typical papillary necrosis in animals, even when given in massive doses, and analgesic nephritis has not been described in man with phenacetin alone.

Analgesic abusers rarely take plain aspirin. They prefer mixed analgesics, which until recently usually contained phenacetin. The figures for the total national consumption of aspirin and phenacetin quoted by Professor H. E. de Wardner and Dr. K. G. Koutsaimanis give no indication of the relative incidence of abuse of these two drugs, and it is therefore quite unrealistic to assume that aspirin is "safer" than phenacetin on this basis. I am in complete agreement with Dr. R. S. Nanra and Dr. P. Kincaid-Smith (3 April, p. 45), and the nephrotoxicity of aspirin should not be underestimated. The evidence strongly suggests that analgesic nephritis in Britain is caused largely by aspirin consumed in the form of popular analgesic mixtures. Phenacetin probably plays a very minor role in respect of nephrotoxicity, but its effect on the central nervous system⁸ may account for its popularity with analgesic abusers.—I am, etc.,

L. F. PRESCOTT

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¹ Prescott, L. F., *Scottish Medical Journal*, 1969, 14, 82.

² Gault, M. H., Rudwal, T. C., Engles, W. D., and Dossetor, J. B., *Annals of Internal Medicine*, 1968, 68, 906.

³ Harvald, B., *American Journal of Medicine*, 1963, 35, 481.

⁴ Olafsson, O., Gudmundsson, K. R., and Brekkan, A., *Acta Medica Scandinavica*, 1966, 179, 121.

⁵ Bulger, R. J., Healey, L. A., and Polinsky, P., *Annals of the Rheumatic Diseases*, 1968, 27, 339.

⁶ Lawson, A. A. H., and Maclean, N., *Annals of the Rheumatic Diseases*, 1966, 25, 441.

⁷ Murray, R. M., Lawson, D. H., and Linton, A. L., *British Medical Journal*, 1971, 1, 479.

⁸ Prescott, L. F., Steel, R. F., and Ferrier, W. R., *Clinical Pharmacology and Therapeutics*, 1970, 11, 496.

Encouraging Recruits to Medicine

SIR,—From the start of my clinical training I have been taught that two of the marks of a good doctor are a sense of responsibility to his patients and the ability to see them as human beings. It now seems strange to be urged by Dr. D. J. MacMyn (1 May, p. 281) to regard my parents as a continuing source of financial support regardless of the effect it may have on them.

I have no doubt that my father would, if necessary, have postponed his retirement and lowered his standard of living to see me through medical school. I am sure that I "would have been none the worse for that." But would he have been?

The present shortage of doctors seems to indicate that the medical profession is in need of recruits whose parents' income forces them into a sober consideration of money.—I am, etc.,

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Superannuation and Substandard Lives

SIR,—The letters by Drs. K. D. Allardyce (17 April, p. 165), and P. H. Sutton (8 May, p. 342) show that the woolly thinking about medical "fitness" for superannuation schemes