matitis that has been rather neglected in the past. It also emphasized the importance of obtaining a full environmental history on patients with complaints involving the skin or mucosae and of proving an allergic cause by patch testing.

We hope that our findings will be published in full in the near future.—We are, etc.,

V. KIRTON
D. S. WILKINSON

Wycombe General Hospital,
High Wycombe, Bucks.

Deputizing Services

SIR,—With reference to Dr. I. P. F. Mungall's comment (31 March, p. 799) on the calculation by Dr. B. T. Williams and others (10 March, p. 593) that 92% of night calls in Sheffield were handled by the deputizing service, the latter authors gave reasons why they thought this to be an overestimate. I can confirm that this figure bears no relation whatever to reality. I have personally made innumerable night calls and submitted a claim form on one occasion only. Like most other family doctors, I dislike thoroughly the idea of asking a sick patient or his anxious relatives to confirm my claim that I have actually paid him a visit and therefore do not ask them to do so.—I am, etc.,

H. M. HALLE

Sheffield

Advertising of Antibiotics

SIR,—We are concerned about the content of current advertisements for antibiotics, some of which have appeared in the *B.M.J.* A recent example is an advertisement for amoxycillin (Amoxil), which is being recommended for the treatment of throat infections in spite of the fact that the large majority of these conditions, if of bacterial aetiology, are caused by *Streptococcus pyogenes* for which benzylpenicillin is the antibiotic of choice. Further, amoxycillin is closely related to ampicillin (they differ only by an OH group), a fact not mentioned in the advertisement, and it is now well recognized that ampicillin is contraindicated in glandular fever, a common cause of sore throat, because of the frequent occurrence of skin rash. Many other advertisements for amoxycillin have also failed to mention its close similarity to ampicillin, which includes an identical antibacterial spectrum. Doctors could be misled into believing that ampicillin and amoxycillin are different compounds and therefore prescribe amoxycillin for infections which have failed to respond to ampicillin. Professor Garrod[1] has recently drawn attention to the consecutive prescribing of chloramphenicol under two different trade names.

Ceporex, one of the two forms of cephalexin sold in Britain, has recently been extensively advertised for the treatment of bronchitis in spite of the fact that the most important bacterial pathogen in exacerbations of chronic bronchitis is *Haemophilus influenzae*, an organism which is frequently relatively resistant to cephalexin.

Two pharmaceutical companies have recently introduced a new oral cephalosporin called cephradine (Eskacef; Velosef). It is claimed that it is effective in eradicating penicillinase-producing staphylococci in spite of the fact that the minimum inhibitory concentration of this organism for cephradine is said to be 18·7 μg/ml while the mean peak serum concentration following the recommended dose of 500 mg is stated to be 11 μg/ml. If these facts are true then in our opinion penicillin-resistant staphylococci are, for practical purposes, resistant to cephradine. In the advertising booklet produced by one of the companies marketing this antibiotic the sensitivity to cephradine of various organisms, including penicillinase-producing staphylococci, is compared only with those of ampicillin, tetracycline, and chloramphenicol. Surely it is now universally accepted that chloramphenicol should not be prescribed systemically for conditions other than typhoid fever or severe haemophilus infections, and it would therefore seem inappropriate to include this antibiotic in such a comparative table. It would have been much more useful to compare the sensitivities of organisms to cephradine with those to penicillin, cloxacillin, lincomycin, co-trimoxazole, and the other cephalosporins.

The tetracyclines are contraindicated in children and in pregnant women because of their staining and possible hypoplasia-producing action on developing teeth. In spite of this, recent advertisements for doxycycline (Vibramycin) include obstetric and gynaecological infections among the indications for this antibiotic; the paediatric dosage is also prominent. The advertisement does mention the side effects of the antibiotic, but the dental implications are not spelled out in detail.

We recognize the necessity for these advertisements and have no objection to healthy competition between pharmaceutical companies. We would, however, urge their medical departments to curb the enthusiasm of commercial colleagues in the content of their promotional literature.—We are, etc.,

J. D. WILLIAMS

Dudley Road Hospital,
Birmingham

A. M. GEDDES

East Birmingham Hospital

1 Garrod, L. P., *British Medical Journal*, 1972, 4, 473.

Anticoagulants after Mitral Valvotomy

SIR,—In a leading article last year (11 March 1972, p. 641) you discussed my full use of anticoagulants in patients with mitral valve disease not needing surgery.[1] You also mentioned operation under cover of anticoagulants—a practice which I have long followed.

It had not been my practice to use anticoagulants after successful valvotomy, as suggested in your leader. Because of your recommendation I have reviewed the systemic emboli occurring postoperatively in my patients. In the 12-year period from 1960 to 1972, 285 patients have had mitral valvotomy. In this group there have been noted 17 cases of systemic embolism. These have occurred from one to 12 years after operation. Six of the patients were in sinus rhythm. The group was far from homogeneous and the numbers were much too small for statistical analysis. In a number of cases there were also contraindications to the use of anticoagulants. Only three patients retained the result of a good mitral valvotomy and had systemic embolism.

Analysis of individual cases suffering postoperative systemic embolism suggested that the majority came under the following headings: (1) poor valvotomy because of the pathology of the valve; (2) considerable mitral incompetence; (3) considerable cardiomegaly; (4) considerable valve calcification; (5) re-stenosis; and (6) a group of patients who seemed to be particularly prone to embolism. It is therefore now going to be my practice to anticoagulate only these particular groups of patients and not patients who have had a successful mitral valvotomy with atrial appendicectomy.

Numbers are too small to allow valid conclusions to be drawn, but it did appear that in the postoperative group the recovery from even quite large cerebral emboli was better than in the preoperative group.—I am, etc.,

HUGH A. FLEMING

Papworth Hospital,
Cambridge

1 Fleming, H. A., and Bailey, S. M., *Postgraduate Medical Journal*, 1971, 47, 599.

Fashions in Duodenal Ulcer Surgery

SIR.—In your leading article (10 March, p. 563) you rightly take a cynical view of the claims made for each new operation for duodenal ulcer. It should be pointed out, though, that recent trends represent a retreat from former over-enthusiasms.

Starting with simple, revocable gastroenterostomy, attempts to raise the cure rate led to partial gastrectomy and ultimately to vagotomy combined with gastrectomy. As you point out, only three of Dragstedt's first 15 patients required additional surgery to relieve gastric retention following truncal vagotomy, yet the addition of a "drainage" procedure soon became routine, even though the majority of patients do not require it and may be harmed by it.

As a former seeker after 100% effectiveness through vagotomy combined with mucosal antrectomy,[1] I changed some three years ago to proximal gastric vagotomy without "drainage." I did so not because I believed the new operation to be better, but because it seemed to be the least assault upon the patient. Its safety makes Mr. J. F. Newcombe's report of a fatality (10 March, p. 610) unique. I accept that the operation will fail unpredictably in some patients, but other procedures can be added if, and only if, the patients display their need for them. Out of 63 patients treated I have so far had to re-operate on only one for recurrent ulcer and one for gastric retention. I regret the extra operation on these two patients but am overwhelmingly more relieved at sparing the other 61 patients an unnecessary procedure that might be harmful and irrevocable.—I am, etc.,

JERRY KIRK

London W.1

1 Kirk, R. M., *American Journal of Surgery*, 1972, 123, 323.

Contraceptives on the N.H.S.

SIR,—The addition of family planning to the services to be provided by the general practitioner under the N.H.S. has so far been greeted by complete silence, possibly because

most family doctors do not understand what the Minister has in mind.

If the G.P. is to provide contraceptive services, two problems are at once apparent. Firstly, in the average practice and particularly in young communities, there will be a staggering increase in the workload. Secondly, there is increasing criticism that family doctors have less time for their patients; family planning requires special skills and is unusually time-consuming. The involvement of the G.P. in family planning under the N.H.S. may be a social and political ideal, but while the unwanted birth rate may fall, so may the time devoted to the care of the sick and those in need.

The availability of "free" contraception is not in question. The ability of G.P.s to cope with this extra burden is in doubt.—I am, etc.,

IAN G. HAMILTON

Harlow,
Essex.

SIR,—It was with some misgiving that I read in my morning paper that as from 1 April 1974 all contraceptives are to be made available on National Health Service prescription.

Some seven months ago my partner and I found that the number of women in our practice on the pill was assuming such proportions that we were unable to be as thorough in our six-monthly check-ups as we wished. We therefore decided to employ on a sessional basis a woman doctor who devotes all her available time to family planning work. The result has been most encouraging and the 75p for prescribing the pill has been a great help in her remuneration.

Can I take it that as from 1 April 1974 family planning will be yet another item the general practitioner must carry out with no extra remuneration? If so, I am sure a great many G.P.s will discontinue any form of regular examination for these women. Even at the present time numerous women arriving in this area have been astonished to learn that they are unable to obtain a repeat prescription without an examination.

So far as condoms are concerned, I did not study medicine with the ideas of supplying these articles. If the general public are to have condoms on the N.H.S. I suggest that family planning clinics supply them, or possibly the local health or welfare departments. As a medical examination is not necessary before a condom is worn I do not propose to issue prescriptions for these articles and feel that many G.P.s will follow suit.—I am, etc.,

J. CANTOR

Faversham,
Kent.

SIR,—From 1 April 1974 oral contraceptives (and other contraceptive devices) will be available on prescription subject to the ordinary charges. This raises some interesting points.

General practitioners will now have a great deal of extra work thrust upon them. They will have to carry out regular checks on all women on the pill. The side effects are far from negligible, ranging from rapid weight increase to thromboembolic complications.

An entirely new precedent has been created in that the family doctor will be expected to prescribe on demand, and for social reasons, a potentially dangerous drug. Cases have already occurred where a member of the profession has had to face the courts when a patient for whom he has prescribed oral contraceptives has died as a result. Should every woman demanding the pill be asked to sign a statement that she takes it at her own risk? Doctors are entitled to some such protection.—I am, etc.,

T. J. BURKE

Lytham St. Annes, Lancs.

SIR,—Contraception on the N.H.S. from April 1974. Why not now?—I am, etc.,

W. D. HOSKING

Pulborough, Sussex.

Holiday Cruises

SIR,—With the growing popularity of package tour holidays an ever-increasing number of people are embarking on holiday cruises each year. Many of these are elderly and infirm and some have been encouraged by their family doctor to take a sea voyage to convalesce from a recent debilitating illness. It is most important that such individuals should take with them full medical reports of their condition and current medications so that the ship's doctor is aware of the clinical situation should a deterioration in health occur while at sea.

The majority of British shipping companies have medical services based ashore whose medical staff are available for advice and who are familiar with the medical problems of passengers at sea. They are usually able to ensure medical support aboard a ship, together with special facilities such as diet or a wheelchair, which can be reassuring to a passenger and add to the enjoyment and safety of the holiday.—I am, etc.,

P. O. OLIVER
Group Medical Director

Cunard Steam-Ship Company Ltd.,
Southampton

Compulsory Powers to See Case-notes

SIR,—The medicolegal report (10 March, p. 623) and the letter from the Secretary of the Medical Protection Society (24 March, p. 746) are slightly puzzling.

Ever since the National Health Service Act the position with regard to destruction of the patient's records has been statutory, although it was modified a little by the Public Records Act, 1958 (see circular HM (61) 73[1]).

Briefly, the position now is that no part of any patient's records, however trivial, may be destroyed until six years after the conclusion of treatment unless the patient should die in hospital, when the period is reduced to three years. At the expiry of that period the general day-to-day notes and the *x*-ray films may be destroyed, but the case summaries must be kept indefinitely. Presumably if before the lapse of six years a patient should re-attend at the hospital then the time would start to run again from this date and the older records would be still fully preserved.

I hardly think that it is reasonable to ask for the keeping of records much beyond this statutory minimum. The sheer physical problems of storage become very considerable at a large hospital.—I am, etc.,

H. GLYN JONES

Queen Mary's Hospital,
Sidcup, Kent

1 National Health Service, *Preservation and Destruction of Hospital Records*, H.M. (61) 73, London, Ministry of Health, 1973.

School Eye Clinics

SIR,—While welcoming the review by Dr. R. M. Ingram (3 February, p. 278) I would strongly disagree with the suggestion to move the school eye clinics to inside a hospital. First, the school eye clinic is a development of the public health services and as such its role is mainly preventative. Their officers are expected to be on the look out for eye troubles, to chase up defaulters, and to ensure if possible that glasses are in fact obtained and worn when ordered. This is quite different, and rightly so, from what pertains in a hospital clinic where the patient should firstly be seeking help in some respect; where, though appropriate treatment or advice is offered, it is up to the patient whether he accepts it or not—unsolicited advice is not uncommonly ignored. Also if the patient does not voluntarily return for follow-up he is unlikely to value his visit if finally persuaded to return.

One result immediately following the introduction of the school eye service in 1910, and attributed to it, was the marked decline in the incidence of divergent strabismus. This was because myopia was discovered early and corrected by glasses. One wishes that the preventative aspects of convergent strabismus and amblyopia were as good. Dr. P. A. Gardiner (3 March, p. 552) shows what can be done, but unfortunately it is the exception. Convergent strabismus generally arises much younger, around two years, and I have heard of school clinics that do not see preschool children. The sooner it arises the sooner it is necessary to get ahead with treatment, but there is little (apart from operation) which cannot be done in a school clinic with some orthoptic help. This is an age when the child or parent may be put off by the thought of going to hospital. I believe it would be most retrograde to expect them to do so when treatment can be done in the less frightening atmosphere of the school clinic. By all means have a separate children's eye clinic in the hospital for those whose conditions necessitate hospital treatment, but I do not think this is necessary or desirable for the ordinary school eye clinic children. Nor do I think it wise to push children whose only trouble is refractive error out of the school clinic service after the first visit, as, though there are other services by ophthalmic medical practitioners and opticians, they have no means of chasing up defaulters. I know of children of both sexes who keep quiet about their visual difficulties just because they do not wish to wear glasses, and of parents who agree with them or are under their thumb, or who do not bother or are too busy or forgetful to see about the child's glasses and follow-up.

Of course arrangements vary in different regions. The work need not be undertaken by a consultant, and a registrar, even a senior registrar, has scarcely the right experience for it. In our area serving a popula-