tice of 5,400 patients 66 strains of *Staph. aureus* were isolated. Of these, 36% were sensitive to penicillin, 71% sensitive to tetracycline, and 94% sensitive to erythromycin. Gram-negative pathogens were rarely isolated from such lesions. A study of strains of *Escherichia coli* causing urinary infection¹ over a five-year period (total number of isolates 225) showed that in 1968, 99% were sensitive to ampicillin and 90% to sulphonamide, whereas in 1972, 66% were sensitive to ampicillin and 44% to sulphonamide.

It is likely that the emergence of these resistant organisms is associated with a standard antibiotic prescribing policy in the practice, since 1967, of penicillin for skin and upper respiratory tract infections and of sulphonamide or ampicillin for urinary infections. The acquisition of resistance by common bacterial pathogens to frequently used antibiotics seems to be almost as great a problem in our general practice as in Dr. Whitehead's hospital population.—We are, etc.,

B. T. B. MANNERS
P. R. GROB
G. P. J. BEYNON
F. J. GIBBS

Addlestone, Surrey

¹ Manners, B. T. B., Grob, P. R., Dulake, C., and Grieve, N. W. T., *Proceedings of Second National Symposium on Urinary Infection* (1972). In press.

SIR,—It is commonly believed that staphylococci encountered in the community are predominantly sensitive to penicillin while those in hospital are largely insensitive, a view perhaps encouraged by Dr. J. E. M. Whitehead (28 April, p. 224).

I have recently taken nose and throat swabs from all boys entering this detention centre over a six-month period, who came from a large area of the north of England. Staphylococci were isolated from 132 out of 315 boys (42%). These strains were insensitive as follows: penicillin 78%; streptomycin 2%; cloxacillin 1%; cephaloridine 1%; erythromycin 2%; tetracycline 2%; co-trimoxazole 3%.

It would seem that crystalline penicillin can no longer be considered the drug of first choice in the treatment of staphylococcal infections, though this assumes that the strains isolated from carriers are those which could cause sepsis.—I am, etc.,

AUBREY COLLING

H.M. Detention Centre,
Kirklevington Grange,
near Yarm, Yorks

Pulmonary Embolism from a Femoral Bypass

SIR,—The hazards of a Thomas femoral bypass must be kept in mind when choosing this access to the vessels for chronic haemodialysis. A 24-year-old woman was referred to us in November 1972 with terminal renal failure. After seven unsuccessful attempts to create an arteriovenous fistula, to graft a saphenous loop, and to insert Scribner shunts in different sites a Thomas femoral bypass was eventually performed on the left femoral vessels. In February 1973

she received a cadaver homograft which functioned immediately. Soon after the transplantation clotting of the shunt was noted. Anticoagulant therapy was started to preserve the patency of the bypass in case of rejection but we had to stop anticoagulants after three weeks because of severe operative wound bleeding. From then on the shunt seemed to be obstructed by clots without any symptoms of thrombosis in the lower limb.

The function of the homograft was good (serum creatinine 1.3 mg/100 ml) when suddenly the patient died of cardiac arrest, 39 days after the transplantation. Massive pulmonary embolism was found at necropsy. An organized clot was found in the femoral vein, beginning 15 cm beneath the venous patch of the shunt and clearly disrupted a few millimeters above it. This case prompts us to recommend particular precautions in cases of femoral shunt obstruction, and to advise early removal of the prosthesis with femoral vein ligation in case of posttransplantation thrombosis.—We are, etc.,

ALAIN MEYRIER
VICTOR SCETBON
JACQUES-DOMINIQUE FIEUX

Nephrology and Transplantation Units,
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Cubital Tunnel Syndrome

SIR,—Messrs. T. J. Wadsworth and J. R. Williams in their article (17 March, p. 662) failed to indicate that it was Drs. W. Feindel and J. Stratford who first named and defined the cubital tunnel.^{1,2} These authors drew an analogy between it and the carpal tunnel, described the mechanisms of compression in and clinical features of the cubital tunnel syndrome, and indicated that in some cases simple surgical decompression obviated the need for the more extensive and, in my opinion, frequently ineffective surgical procedures mentioned by Messrs. Wadsworth and Williams.—I am, etc.,

C. F. BOLTON

Victoria Hospital,
London, Ontario

¹ Feindel, W., and Stratford, J., *Canadian Medical Association Journal*, 1958, 78, 351.

² Feindel, W., and Stratford, J., *Canadian Journal of Surgery*, 1958, 1, 287.

Cerebrospinal Fluid in Virus Meningitis

SIR,—Contrary to what Dr. E. H. Brown states in his article on enterovirus infections (21 April, p. 169), cerebrospinal fluid (C.S.F.) protein values over 100 mg/100 ml are encountered not infrequently in virus meningitis. Analysis of 113 cases of virus meningitis seen in this department during 1971 shows that in 9% the C.S.F. protein value was above this figure (see table). The analysis also confirms the findings of Dr. J.

C.S.F. Protein (mg/100 ml)	No. of Patients	C.S.F. Sugar (mg/100 ml)	No. of Patients
Below 15 ..	6	10-19 ..	None
15-45 ..	39	20-29 ..	None
46-70 ..	35	30-39 ..	6
71-99 ..	14	40-49 ..	20
100-199 ..	10	50-59 ..	27
Over 200 ..	None	Over 60 ..	54
Not examined ..	9	Not examined ..	6
Total ..	113	Total ..	113

Stevenson and myself (unpublished observations, 1969) and of Wilfert¹ that C.S.F. sugar values can be depressed in virus meningitis. The blood sugar levels were checked in many of these cases but found to be normal.—I am, etc.,

B. K. MANDAL

Department of Infectious Diseases,
Monsall Hospital,
Manchester

¹ Wilfert, C. M., *New England Journal of Medicine*, 1969, 280, 855.

General Practitioners' Superannuation

SIR,—I refer to the reply of the Secretary of State to the joint letter of the Chairman of the Compensation and Superannuation and General Medical Services Committees on the position of practitioners who retired before 25 March 1972 (*Supplement*, 21 April, p. 15) and offer the following observations.

Several things have been ignored, such as the case for a special increase for those caught retiring from January 1969 onwards, when the cruel inflationary spiral began to accelerate and the offer of a meeting was ignored. Curiously, the Minister breaks down his own case when he gives as his reason for back-dating the new formula a pious concern lest he cause any suffering to those G.P.s who retired in the period between 25 March 1972 and the date of termination of the negotiations.

An immediate increase of 50% for all of us who retired before 25 March 1972 would do much to remedy a difficult situation for all concerned.—I am, etc.,

N. F. FIELD

Brampton, Cumberland

Representation of Hospital Doctors

SIR,—I sense the depth of Dr. D. G. Ferriman's feelings and understand why he wrote as he did (5 May, p. 309). It is the paradox of politics that those who represent the rest do the best they can, yet the others, who might do the job better, don't come forward. Every year every Hospital Staff Committee has the opportunity to change its representatives on the Regional Committee for Hospital Medical Services. Every year each regional committee has the chance to change its representatives on the central committee. If changes are not more frequent—if the advantages of a democratic process are not seized and used—some blame must lie upon the apathy of the electorate.

Take a close look at what Dr. Ferriman calls the "Central/Regional structure" and consider the provisions made within the B.M.A. organization for the representation of hospital doctors. If you are a hospital doctor and have representatives upon your regional committee whom you don't like or don't trust you can change them by this time next year. Correspondingly, if you are a member of an R.C.H.M.S. you can, before the year is out, choose two different representatives to go to London (at the expense of the Hospital Medical Staff Defence Trust) to act for you and the good of the service.

For a while it was my pride and my privilege to serve upon the Central Consultants' and Specialists' Committee (as it then was) and later upon the C.C.H.M.S. Throughout that time we tried by bulletins,